IN THE UNITED STATES COURT OF FEDERAL CLAIMS

DOUG OMMEN, in his capacity as Liquidator of CoOportunity Health, Inc., et al.,	:	Case No. 17-957C
	:	Judge Lettow
Plaintiffs,	:	
v.	:	
THE UNITED STATES OF AMERICA,	:	
Defendant.	:	

THE UNITED STATES' MOTION TO DISMISS THE AMENDED COMPLAINT

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INTRODUCTION

Notwithstanding binding precedent issued months prior to the amended complaint, this case seeks $157 million from the risk corridors program of the Patient Protection and Affordable Care Act (the "ACA") under theories rejected by the Federal Circuit in four recent opinions—one of which affirmed this Court's decision in *Land of Lincoln Mutual Health Ins. Co. v. United States*, 129 Fed. Cl. 81 (2016) (Lettow, J.), *aff'd*, 892 F.3d 1184 (Fed. Cir. 2018). The statutory, contract, and Takings theories (Counts I, II, and V) asserted by Plaintiffs Doug Ommen and Dan Watkins, who bring this case in their capacity as liquidators (the "Liquidators") of a defunct issuer of health insurance plans, CoOportunity Health, Inc. ("CoOportunity"), fail as a matter of law under the Federal Circuit's holdings.

The Liquidators' remaining claims should also be dismissed, based on similarly uncomplicated legal principles. Counts III and IV are about payments that were owed to CoOportunity under various ACA programs that the Liquidators wanted paid directly to CoOportunity without offset for debts owed by CoOportunity under the same and similar programs. But it is well-established that "[t]he government has the same right 'which belongs to every creditor, to apply the unappropriated moneys of his debtor, in his hands, in extinguishment of the debts due to him.'" *United States v. Munsey Trust Co. of Washington, D.C.*, 332 U.S. 234, 239 (1947) (citation omitted). Counts III and IV therefore fail on the merits.

Well-settled principles also require dismissal of Counts VI and VII. The Liquidators bring Administrative Procedure Act ("APA") claims, challenging as arbitrary and capricious HHS's decision-making regarding the ACA risk adjustment program's methodology and participation requirements. Federal Circuit precedent establishes that this Court's jurisdiction does not encompass these APA claims. The amended complaint should be dismissed.

STATEMENT OF ISSUES

1. Whether the Liquidators' statutory, contract, and Takings claims fail as a matter of law pursuant to controlling authority.

2. Whether the Liquidators' challenge of the use of offset to collect a mutual debt should be dismissed.

3. Whether the Liquidators' claims under the APA should be dismissed for lack of jurisdiction.

BACKGROUND

I. Statutory Background

A. The ACA and Health Benefit Exchanges

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (the "ACA"), in March 2010. The ACA adopted a series of measures designed to expand coverage in the individual health-insurance market. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).[1] First, the ACA provides billions of dollars of subsidies each year to help individuals buy insurance. *Id.* at 2489. Second, the ACA generally required each individual to maintain

[1] HHS is responsible for overseeing implementation of major provisions of the ACA and for administering certain of its programs, either directly or in conjunction with states or other federal agencies. *See* 42 U.S.C. §§ 18041(a)(1), (b), (c)(1). HHS delegated many of its responsibilities under the ACA to the Centers for Medicare & Medicaid Services ("CMS"), which created the Center for Consumer Information and Insurance Oversight ("CCIIO") to oversee implementation of the ACA. *See* https://www.cms.gov/cciio. HHS, CMS, CCIIO, the Secretary of HHS, and Administrator of CMS are collectively referred to as "HHS."

coverage or pay a penalty. *Id.* at 2486.[2] Third, the ACA bars insurers from denying coverage or charging higher premiums based on an individual's health status. *Id.*

The ACA also created Health Benefit Exchanges ("Exchanges"), virtual marketplaces in each state where individuals and small groups can purchase pre-certified health insurance coverage and obtain federal subsidies. 42 U.S.C. §§ 18031-18041; 26 U.S.C. § 36B. While the ACA contemplated that each state would establish and/or operate its own Exchange ("State-based Exchange"), it also provided states with flexibility. In the event a state elected not to establish and/or operate an Exchange, the ACA's "state flexibility" provision, ACA § 1321, required HHS to do so on behalf of a state, which HHS does through "Federally-facilitated Exchanges." *See* 42 U.S.C. § 18041; 45 C.F.R. §§ 155.20, 155.105; Program Integrity; Exchange, SHOP, and Eligibility Appeals, 78 Fed. Reg. 54,070, 54,071 (Aug. 30, 2013).[3]

For consumers, Exchanges are the only forum in which they can purchase coverage with the assistance of federal subsidies. For insurers, Exchanges provide marketplaces to compete for business in a centralized location, and they are the only commercial channel in which insurers can market their plans to the millions of individuals who receive federal subsidies. All plans offered through an Exchange generally must be Qualified Health Plans ("QHPs"), meaning that they provide "essential health benefits" and comply with other regulatory requirements such as provider-network requirements, benefit-design rules, and cost-sharing limitations. 42 U.S.C. §§ 18021 and 18031; 45 C.F.R. parts 155 and 156.[4]

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[2] The Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054 (2017), enacted in December 2017, reduced the penalty to $0, beginning in 2019.

[3] HHS administers the Federal-facilitated Exchanges in Nebraska and Iowa. 45 C.F.R. §§ 155.20, 155.105, 155.106, 155.200.

[4] QHPs are offered in four different metal levels—bronze, silver, gold, and platinum—that correspond to the amount of coverage offered by the issuers.

To ensure that issuers operating on the Exchanges comply with these requirements, Congress required Exchanges to establish certification procedures consistent with the guidelines established by HHS. 42 U.S.C. § 18031(d)(4); 45 C.F.R. part 156. For Federally-facilitated Excahnges, HHS conducts an annual certification process. As part of this process, HHS requires insurers to execute an agreement known as a "Qualified Health Plan Certification Agreement and Privacy and Security Agreement," or "QHP Agreement" for short. In the QHP Agreement, issuers agree to adhere to privacy and security standards when collecting personally identifiable information from consumers who wish to apply for enrollment in an Exchange QHP (consumer data) and when conducting electronic transactions on the Federally-facilitated Exchange. 45 C.F.R. § 155.260(b)(2). Notwithstanding these requirements, an issuer's decision to offer QHPs on an Exchange in any given year is not a contractual commitment to the United States; it is a business decision accompanied by regulatory consequences.

The ACA also created a number of inter-related programs, the following of which are relevant to this case.

B. The CO-OP Program

The ACA established the Consumer Operated and Oriented Plan program to foster the creation of new consumer-governed, nonprofit health insurance issuers known as "CO-OPs." 42 U.S.C. § 18042(a)(1)-(2). This program provided loans for start-up costs ("start-up loans") and loans to enable CO-OPs to meet the solvency and capital reserve requirements of the states in which they are licensed to sell health insurance ("solvency loans"). *Id.* § 18042(b)(1). As a condition of the loans, the ACA requires CO-OPs to comply with all applicable federal and state law and to enter into a loan agreement providing comprehensive governance and funding provisions. *Id.* § 18042(b)(2)(C)(i)-(ii), (c)(5). Loan recipients that fail to make loan payments

when due are "subject to any and all remedies available to CMS under law to collect the debt." 45 C.F.R. § 156.520(d). With respect to the start-up loan, the underlying loan agreement expressly preserves HHS's right to collect the debt through offset. *See* Loan Agreement § 19.12 ("Lender shall have at its disposal the full range of available rights, remedies and techniques to collect delinquent debts . . . including . . . administrative offset"), attached to the first amended complaint ("FAC" or "Amended Complaint"), as Exhibit ("Ex.") A, Dkt. 20-1.

The CO-OP program is implicated in this case because CoOportunity received a start-up loan and a solvency loan, both of which are subject to the provisions of the CO-OP statute and regulations, and the Loan Agreement. HHS collected the start-up loan via offset in March 2015, after CoOportunity was declared insolvent and decertified from the CO-OP program. Although the United States has not been repaid any of the solvency loan, collection of that loan is not at issue in this case. The Liquidators argue that the start-up loan is not subject to setoff under state law (Count III) and the Loan Agreement (Count IV).

C. The ACA's Premium-Stabilization Programs (the "3Rs")

In an effort to mitigate the pricing risk and incentives for adverse selection, the ACA established three inter-related premium-stabilization programs modeled on preexisting programs established under the Medicare program.[5] Informally known as the "3Rs," these ACA programs began with the 2014 calendar year and include the reinsurance, risk corridors, and risk adjustment programs. In general, these programs aim to distribute risk among insurance plans by collecting money from plans that have incurred less risk in order to fund payments to other plans that have incurred higher costs for taking more risk. Each program targets a different type of risk.

[5] *Compare* 42 U.S.C. §§ 18061-18063 *with id.* §§ 1395w-115(a)(2), (b), (c), (e); *see also id.* §§ 18062(a); 18063(b); 42 C.F.R. § 423.329(b)-(c).

1. The Transitional Reinsurance Program

The transitional reinsurance program was created by section 1341 of the ACA. It was a temporary program for the 2014, 2015, and 2016 calendar years under which amounts collected from insurers and self-insured group health plans were used to fund payments to issuers of eligible plans that covered high-cost individuals. 42 U.S.C. § 18061. The ACA contemplated states administering their own reinsurance programs, with HHS responsible for operating the program in states that fail to do so. 42 U.S.C. §§ 18061(b), 18041(a)-(c). In practice, all states but one deferred to HHS to administer their reinsurance programs as set forth in the ACA's state flexibility provision, *id.* § 18041.[6] *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,759 (Feb. 27, 2015).

While the transitional reinsurance program is not substantively at issue in this case, the Liquidators argue that HHS's offsetting of reinsurance payables to CoOportunity against amounts owed to HHS under other ACA programs violated state and federal law (Count III) and the QHP Agreement (Count IV).

2. The Temporary Risk Corridors Program

The risk corridors program was created by section 1342 of the ACA. It also was a temporary program for the 2014, 2015, and 2016 calendar years under which amounts collected from profitable insurance plans were used to fund payments to unprofitable plans. *See* 42 U.S.C.

[6] At the request of the State of Connecticut, effective April 7, 2017, HHS also began operating the reinsurance program on behalf of Connecticut for the remainder of the 2015 benefit year and for the entire 2016 benefit year. *See* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Transitional-Reinsurance-Program-%E2%80%93-CMS-to-Begin-Operating-on-behalf-of-the-State-of-Connecticut.pdf.

§ 18062.[7] The risk corridors program mitigates risk for plans that underestimated their claims costs in the aggregate (including any required charges due to the government under the other 2Rs programs of reinsurance and risk adjustment). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (March 11, 2013).

Section 1342 directed HHS to establish a program whereby if participating plans' premiums exceeded costs by a certain amount (as determined by a statutory formula), the plans would pay a share of their profits to HHS—"payments in." 42 U.S.C. § 18062(b)(2). Conversely, if participating plans' costs of providing coverage exceeded the premiums they received by a certain amount (according to the same formula), the plans would be paid a share of their excess costs by HHS—"payments out." *Id.* § 18062(b)(1). The ACA did not appropriate any funding for risk corridors payments. Instead, Congress deferred the issue of funding to the annual appropriations process.

More than a year before any risk corridors payments could be made to insurers, Congress asked the Government Accountability Office ("GAO") to identify the sources of funding that would potentially be available for risk corridors payments. *See Dep't of Health and Human Servs.-Risk Corridors Program*, B-325630, 2014 WL 4825237, at *1 ("GAO Op.") (noting requests). In an opinion released in September 2014, the GAO identified only two possible sources of appropriated funds from which to make risk corridors payments: (1) the "payments in" amounts that HHS would collect from insurers under the risk corridors program (referred to as "user fees"), and (2) a lump sum appropriation for the management of CMS programs. GAO Op., 2014 WL

[7] Unlike the reinsurance and risk adjustment programs, the ACA established risk corridors as a federally-operated program.

4825237, at *2. The GAO emphasized that those sources would not be available unless Congress enacted language that appropriated those funds in future annual appropriations. *Id.* at *3, *5.

Congress did not reenact the same appropriations language for fiscal year 2015, the first year in which risk corridors payments to issuers could have arisen. In December 2014, Congress enacted legislation that appropriated the user fees, but explicitly barred HHS from using the only other potential funding source that the GAO had identified. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, 128 Stat. 2130, 2477. Congress reenacted the same funding restriction in an unbroken series of appropriations acts that covered each of the three years that the risk corridors program was in effect. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624; Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135.[8] Congress thus locked HHS into its previously announced intention to operate the risk corridors program in a budget neutral manner. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787 (March 11, 2014); *see also* 160 Cong. Rec. H9307-1, H9838 (daily ed. Dec. 11, 2014) ("In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect."), Appendix A8-A9.

In four recent decisions, the Federal Circuit gave effect to Congress's express restrictions on funding for risk corridors payments. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311,

[8] Prior to the enactment of the 2017 appropriations act, Congress also enacted continued resolutions that retained the funding limitations. *See* Continuing Appropriations Act, 2017, Pub. L. No. 114-223, div. C, 130 Stat. 857, 909; Further Continuing and Security Assistance Appropriations Act, 2017, Pub. L. No. 114-254, § 101, 130 Stat. 1005-06.

1329 (Fed. Cir. 2018) (reversing trial court and rejecting the issuer's statutory and implied contract claims for additional risk corridors payments); *Land of Lincoln Mutual Health Ins. Co. v. United States*, 129 Fed. Cl. 81 (2016) (Lettow, J.), *aff'd*, 892 F.3d 1184 (Fed. Cir. 2018) (affirming dismissal of statutory, express and implied contract, and Takings claims); *Maine Community Health Options v. United States*, 133 Fed. Cl. 1 (2017), *aff'd*, 729 Fed. Appx. 939 (2018) (affirming for reasons stated in *Moda*) ("Maine I"); *Blue Cross and Blue Shield of North Carolina v. United States*, 131 Fed. Cl. 457 (2017), *aff'd*, 729 Fed. Appx. 939 (2018) (same) ("BCBSNC").

Throughout the risk corridors program's three-year life-span, the total amounts of "payments in" fell short of the total amount requested by issuers in "payments out." CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (November 2017).[9] Accordingly, consistent with its three-year framework for administering the program, HHS has issued prorated payments to the extent of collections.

Through Counts I and II, the Liquidators seek risk corridors payments beyond CoOportunity's pro-rata amount under statutory and contract theories. At Counts III and IV, the Liquidators assert HHS improperly offset CoOportunity's pro-rata share of risk corridors payments against debts owed by CoOportunity to the United States.

3. The Permanent Risk Adjustment Program

The risk adjustment program was created by section 1343 of the ACA. It is a permanent program established by Congress to mitigate the impact of adverse selection that could occur among QHPs if plans, whether advertently or inadvertently, enrolled a disproportionate number of healthy or sick individuals. 42 U.S.C. § 18063. Risk adjustment mitigates this risk by

[9] Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

redistributing funds associated with actuarial risk among insurers within a predefined risk pool (or market) within a state. Once risk adjusted, plans with healthier-than-average enrollees (and therefore lower anticipated costs) must pay assessments (or charges) that fund payments to the insurers whose plans wind up with sicker-than-average enrollees (and therefore higher anticipated costs), thereby reducing incentives to avoid higher-risk enrollees.

Section 1343 directs HHS to "establish criteria and methods to be used in carrying out the risk adjustment activities under this section." 42 U.S.C. § 18063(b); *see also* 42 U.S.C. § 18041(a)(1) (directing HHS to issue regulations setting standards for meeting ACA requirements, including risk adjustment). Using the criteria and methods HHS establishes, section 1343 provides that each state "shall assess a charge on health plans and health insurance issuers . . . if the actuarial risk of the enrollees in such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year," and correlatively, that, a state "shall provide a payment to health plans and health insurance issuers . . . if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year." 42 U.S.C. § 18063(a). The ACA therefore contemplated states administering their own risk adjustment programs, with HHS responsible for operating the program in states that fail to do so. 42 U.S.C. §§ 18063, 18041(a)-(c). As with reinsurance, all but one state elected not to operate the risk adjustment program, deferring instead to HHS to establish and administer the program. *Id.* at § 18041(a)-(c).[10] Health

[10] Massachusetts operated the risk adjustment program for the 2014 through 2016 benefit years. Beginning with the 2017 benefit year, HHS has been responsible for operating the risk adjustment program in all 50 states and the District of Columbia.

insurance issuers that offer coverage within the individual or small group markets within a state are subject to risk adjustment, with limited exceptions. *Id.* § 18063(c).[11]

i. Scope of the Risk Adjustment Program

A plan is a "risk adjustment covered plan" if the plan offers "any health insurance coverage" in the individual or small group markets. 45 C.F.R. § 153.20.[12] Specifically emphasizing that plans offered by CO-OPs (such as those offered by CoOportunity) are included in risk adjustment, HHS's rules provide that all health insurance coverage is to be risk adjusted, unless a previously established exception applies, and that if any type of plan is subsequently determined not to be a "risk adjustment covered plan," the agency is required to specify this change in its annual payment notice, thus subjecting any future determination of excluded plans to notice and comment. Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,223 (March 23, 2012); 78 Fed. Reg. at 15,418. HHS has not deviated from the scope of participation since the program's inception.

[11] Plans in existence at the time the ACA was enacted in March 2010 are excepted from risk adjustment as they were grandfathered under the law and are subject to fewer requirements. Plans that were renewed prior to January 1, 2014, and are therefore not subject to most ACA requirements, also do not participate in the risk adjustment program.

[12] Regarding participation in risk adjustment, including limited exceptions not relevant here, HHS's standards in full provide that:

> [r]isk adjustment covered plan means, for the purpose of the risk adjustment program, *any* health insurance coverage offered in the individual or small group market *with the exception* of grandfathered health plans, group health insurance coverage described in § 146.145(c) of this subchapter, individual health insurance coverage described in § 148.220 of this subchapter, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.

45 C.F.R. § 153.20 (emphasis added).

In Count VII, the Liquidators challenge CoOportunity's participation in the program for the 2015 benefit year, alleging that HHS arbitrarily and capriciously refused to exempt CoOportunity.

ii. The Risk Adjustment Methodology

"Developing a risk adjustment program is methodologically and operationally complex." 77 Fed. Reg. at 17,230. After nearly two years of extensive consideration that included public meetings, in depth analysis by HHS's consultant, panel discussions, solicitation of input from state insurance commissioners, publication of a white paper entitled "Risk Adjustment Implementation Issues," and full notice and comment rulemaking, HHS set forth its complete risk adjustment methodology in painstaking detail in the final 2014 benefit year rule published on March 11, 2013. *See* 78 Fed. Reg. at 15,417-15,434. In order to maintain stability in the early years of the program, following notice with comment rulemaking, the finalized parameters of the 2015 benefit rule are substantively the same as those set forth in the 2014 benefit rule. 79 Fed. Reg. at 13,753.[13]

To greatly simplify, the risk adjustment methodology for benefit years 2014 and 2015 is an enrollee-data driven process involving three steps:

Measuring Enrollee Risk: First, the methodology measures the actuarial risk of each plan enrollee—that is, it measures the predicted relative cost of insuring each enrollee as compared to other enrollees. The methodology does so through metal-level differentiated "risk adjustment models" based on demographic data (age and sex) and diagnostic data (health conditions such as diabetes, asthma, and so on). 78 Fed. Reg. at 15,419. Diagnoses considered by the model are known as Hierarchical Condition Categories or "HCCs." *Id.* at 15,420. The model applies a

[13] Given the two-year administrative schedule attributable to each benefit year, by the time the 2014 benefit year transfers were announced on June 30, 2015, the risk adjustment rules for benefit year 2015 had already been set. 79 Fed. Reg. at 13,744.

statistical regression algorithm to a sample commercial data set that has been coded for HCCs, demographic factors, and actual insurance costs. The regression produces a weight or "coefficient" for each demographic and diagnosis factor that predicts the relative healthcare costs associated with those factors. *See id.* at 15,419-20.[14]

Plan risk score: Second, the model must aggregate the risk scores for each enrollee in each plan in order to determine an overall plan risk score—a prediction of how much healthier (or sicker) than average a plan's enrollees are as a whole, and so how much cheaper (or more expensive) they will be to insure relative to a plan of average actuarial risk. Aware that there is significant "churn" in insurance markets—enrollees picking up or dropping insurance during the benefit year—HHS designed its methodology to calculate risk on a "per member per month" basis so that risk scores reflect the amount of time an enrollee actually spends in a plan. 78 Fed. Reg. at 15,431.

Payment transfer formula: Finally, the model must compare the risk scores of each plan within a state market risk pool in order to assign monetary transfers that counteract the cost burden of insuring a sicker-than-average population (or the cost benefit of insuring a healthier-than-average population). The methodology does this through a complicated "transfer formula" that compares the predicted costs calculated for a plan based on its risk score to the predicted cost of a plan of average actuarial risk in that state's risk pool, using an adjusted weighted average of all

[14] For example, the coefficient for being a male aged 21-24 in a silver plan is .141. 78 Fed. Reg. at 15,422. And the coefficient for being diabetic in such a plan is 2.198. To determine the predicted relative cost of a particular enrollee, the model adds together the applicable coefficients. So a 21-year-old male enrolled in a silver plan who has no other health complications is scored a .141—the model expects him to cost about 14% of what an average enrollee costs to insure. And a 21-year-old male enrolled in a silver plan who has diabetes gets a score of 2.339 (2.198 + .141), so the model expects him to cost about 234% (more than twice as much) as the average enrollee to insure.

premiums in the risk pool as a measure of cost. 78 Fed. Reg. at 15,431. For some plans, this comparison yields a risk adjustment assessment (also called a "charge"), because their predicted costs are lower than the state average. For others, this comparison yields a risk adjustment payment, because their predicted costs are greater than the state average.

The entirety of this three-step process is referred to as the "risk adjustment methodology." 45 C.F.R. § 153.20; 77 Fed. Reg. at 17,222. When HHS announced risk adjustment transfers in June 2015 for the program's first year (2014 benefit year), it concluded that overall "the risk adjustment methodology is working as intended—by compensating issuers that enrolled higher risk individuals and protecting against adverse selection within a market within a state." CMS, Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year (June 30, 2015), at 1.[15]

The validity of HHS's decision-making regarding certain aspects of the 2014 and 2015 methodology are challenged under the APA by the Liquidators at Count VI.

iii. Legal Challenges to the Risk Adjustment Program

In 2018, two district courts, in Massachusetts and New Mexico respectively, resolved numerous APA challenges to HHS's risk adjustment methodology in favor of HHS, diverging from each other only as to whether HHS's use of the statewide average premium as a scaling measure in the transfer formula was arbitrary and capricious. *See Minuteman Health, Inc. v. United States*, 291 F. Supp. 3d 174 (D. Mass. 2018) (judgment in favor of the government on all theories); *New Mexico Health Connections v. United States*, 312 F. Supp. 3d 1164, 1218-19 (D.N.M. 2018) (judgment in favor of the government on all but one theory). In *New Mexico Health*

[15] Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf.

Connections, the New Mexico district court concluded that HHS had not provided an adequate explanation regarding budget neutrality. 312 F. Supp. 3d at 1218-19 (setting aside and vacating the agency action as to use of the statewide average premium for the 2014, 2015, 2016, 2017, and 2018 rules and remanding the case to the agency for further proceedings).

The government moved for reconsideration in *New Mexico Health Connections*, and while that motion was pending, HHS halted collecting remaining risk adjustment charges and making remaining payments attributable to benefit years 2014-2016.[16] Meanwhile, on July 24, 2018, HHS promulgated a final rule adopting the risk adjustment methodology HHS had previously established for the 2017 benefit year, with additional explanation regarding the use of the statewide average premium and budget neutrality. Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year, 83 Fed. Reg. 36,456 (July 30, 2018). The reissued 2017 benefit rule altered neither the risk adjustment methodology for benefit years 2014-2016 nor the previously calculated transfer amounts.

On October 19, 2018, the New Mexico district court denied reconsideration of its prior order, continuing to find that HHS had failed to adequately explain budget neutrality, notwithstanding, *inter alia*, that the Massachusetts district court reached the opposite conclusion. *New Mexico Health Connections*, No. 16-cv-00878, 2018 WL 5112912, at *6-7 n.5 (D.N.M. Oct.

[16] *See, e.g.*, HHS's July 7, 2018 Press Release titled "United States District Court Ruling Puts Risk Adjustment On Hold" available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-07.html, and a 2018 bulletin available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Implications-of-the-Decision-by-United-States-District-Court-for-the-District-of-New-Mexico-on-the-Risk-Adjustment-and-Related-Programs.pdf.

19, 2018); *see contra Minuteman Health*, 291 F. Supp. 3d at 201-202 (expressly rejecting the contention that HHS did not adequately explain its decision to run the program in a budget-neutral way).

In its October 19, 2018 order, the New Mexico district court distinguished vacatur from a nationwide injunction regarding the 2014-2018 methodology, and stated that it "did not in its [prior order], and is not now, issuing a nationwide injunction prohibiting enforcement of the rule" and that it is "not ordering HHS to take some action or refrain from taking some action." *New Mexico Health Connections*, 2018 WL 5112912, at *45-47, *50 n.28. Unequivocal that that the "remaining provisions" of the 2014-2018 methodology rules "stand," the court described its vacatur as "limited and tailored," "vacate[ing] *only* the 2014-2018 rules as to the statewide average premium rules." *Id.* at 50 (emphasis supplied). The *New Mexico Health Connections* decisions remain subject to appellate review.

Count VI's APA claims were considered in *Minuteman* and *New Mexico Health Connections*. At Count III, the Liquidators suggest that the February 2018 *New Mexico Health Connections* decision invalidates HHS's past use of offset.

D. HHS's Netting Regulation and Monthly Payment and Collections Process

To streamline its payment and collection process for the 3Rs and other enumerated ACA programs, HHS promulgated a regulation providing that it may net amounts owed by issuers against amounts HHS owes to the issuers under those programs. *See* 45 C.F.R. § 156.1215 (the "Netting Regulation"); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,322, 72,370-71 (Dec. 2, 2013) (explaining that netting will "permit HHS to calculate amounts owed each month, and pay or collect those amounts from issuers more efficiently"). Use of netting in its monthly payments and collections cycle

allows HHS to make timely payments to insurers that are due funds under the 3R programs. 78 Fed. Reg. at 72,370.

The Liquidators argue that HHS's use of netting to administer the 3Rs programs violates federal and state law (Count III) and the QHP Agreement (Count IV).

II. CoOportunity Health

CoOportunity is a former Iowa CO-OP that issued health insurance plans sold on the Exchanges in Iowa and Nebraska from January 1, 2014 until February 28, 2015. FAC ¶¶ 75-83. During its short existence, CoOportunity participated in the 3Rs programs and received a total of $145.3 million in CO-OP loans from HHS, comprised of $14.7 million in start-up funds and $130.6 million in solvency funds. FAC ¶¶ 13, 31, 37, 77.

At CoOportunity's inception, both Iowa and Nebraska insurance law required the solvency loan to be recognized as surplus and not as debt. FAC ¶ 33; Loan Agreement Appendix 10, Dkt. 20-1, pages 73-74. In order to satisfy these states' requirements, the parties amended the Loan Agreement with a promissory note reflecting, *inter alia*, that repayment of the solvency loan is subordinated to policyholders and not subject to offset. *Id.* The parties did not execute a similar promissory note for CoOportunity's start-up loan; nor did state insurance regulators ask the parties to do so.

After operating for just over a year, the Iowa Commissioner of Insurance deemed CoOportunity's financial condition "hazardous," requiring in December 2014 that the struggling company be operated under the Commissioner's supervision. FAC ¶ 80.[17] Unable to turn the company around, the Commissioner moved an Iowa state court for an order of liquidation,

[17] Plaintiff Doug Ommen's statutory predecessor-in-interest, Nick Gerhart, served as Iowa Commissioner of Insurance during this time.

effective February 28, 2015 (the "Liquidation Order"). FAC ¶¶ 81-83; Dkt. 20-6, Ex. F. Consequently, CoOportunity defaulted on its CO-OP loans. FAC ¶ 85.

Meanwhile, HHS's administration of the 3Rs programs continued unabated. In summer 2015, the agency determined that CoOportunity's estate was entitled to receive reinsurance payments for the 2014 benefit year but owed HHS 2014 risk adjustment charges for some of its market segments as well as consumer subsidy overpayments. FAC ¶ 105(a).[18] Consistent with its regular practice under the Netting Regulation, beginning in the August 2015 payment cycle, HHS netted the reinsurance, risk adjustment, and consumer subsidy payables and receivables, and remitted the balance to CoOportunity's estate, including some 2014 reinsurance and risk adjustment payments.[19]

Subsequently, on November 19, 2015, HHS announced that CoOportunity's risk corridors calculated payment for the 2014 benefit year was $130 million, of which HHS would pay a prorated amount of $16.3 million in the forthcoming payment cycles. FAC ¶ 105(b); *see also* CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, at Tables 16, 28.[20] Around this time, because CoOportunity was both insolvent and indebted to the United States, HHS placed an administrative hold on the company's accounts, with the result that the pro-rated risk corridors payment was not released to the estate but rather was held for offset to collect debts owed to the United States. FAC ¶¶ 105(b), 107-108. HHS continued to net CoOportunity's

[18] *See also* 2014 Reinsurance and Risk Adjustment Summary Report at 19, 29 available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

[19] Notwithstanding this favorable circumstance, at Count VI, the Liquidators challenge the 2014 risk adjustment methodology as arbitrary and capricious.

[20] Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

payables and receivables, and shortly thereafter, in March 2016, HHS collected the start-up loan through offset against CoOportunity's remaining 3Rs receivables for the 2014 benefit year, including the prorated risk corridors payment. *Id.* ¶¶ 105(c)-(e), 107.

In early May 2016, the CoOportunity estate submitted to HHS the enrollee and other data required for HHS to calculate the company's payments or charges under the risk adjustment, reinsurance, and risk corridors programs for benefit year 2015.[21] In a letter dated May 24, 2016, the Liquidators wrote to HHS, criticizing the risk adjustment methodology. FAC ¶ 169; *see also* Count VI (same).[22] Acknowledging the absence of a regulatory mechanism for their request, the Liquidators nonetheless asked HHS to exclude CoOportunity from the 2015 risk adjustment program on fairness grounds. *See* Appendix at A1-A6; Count VII (same). The Liquidators did not ask, however, for CoOportunity to be excluded from the 2015 reinsurance program or that CoOportunity's 2015 risk corridors payment be reduced to reflect the absence of 2015 risk adjustment charges.[23]

On June 30, 2016, HHS announced that CoOportunity owed risk adjustment charges and was entitled to receive reinsurance payments for the 2015 benefit year. *See* 2015 Reinsurance and Risk Adjustment Summary Report, at 25, 37.[24] In the August 2016 payment cycle, HHS collected

[21] Although the Iowa Guaranty Associations continued to provide coverage to CoOportunity enrollees until August 1, 2015, the Liquidators submitted 3Rs data for only January and February 2015—the two months the company offered coverage before liquidation.

[22] The May 24, 2016 letter is not among the many exhibits to the Amended Complaint, but for completeness is provided to the Court with this motion as Appendix A1-A6.

[23] Relatedly, the Amended Complaint does not plead that the minimal time CoOportunity offered plans in 2015 renders the company's participation in risk corridors and reinsurance invalid under the APA; this theory is aimed only at 2015 risk adjustment. *See* Count VII.

[24] Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf.

a portion of CoOportunity's 2015 risk adjustment charges by netting from 2015 reinsurance payments due to CoOportunity. Since that time, HHS has not held funds payable to CoOportunity.[25]

In total, since CoOportunity's insolvency, HHS has netted approximately $30 million in risk corridors and reinsurance payments to CoOportunity's estate against the $14.7 million start-up loan and the $22.5 million 2015 risk adjustment charges owed by CoOportunity to the United States.

STANDARD OF REVIEW

When deciding a motion to dismiss upon the ground that the Court does not possess subject-matter jurisdiction pursuant to Rule 12(b)(1), the plaintiff bears the burden of establishing jurisdiction and must do so by a preponderance of the evidence. *Reynolds v. Army & Air Force Exch. Serv.*, 846 F.2d 746, 748 (Fed. Cir. 1988). Should the Court determine that "it lacks jurisdiction over the subject matter, it must dismiss the claim." *Matthews v. United States*, 72 Fed. Cl. 274, 278 (2006) (citations omitted).

To avoid dismissal under Rule 12(b)(6) for failure to state a claim, a plaintiff must "provide the grounds of [its] entitle[ment] to relief" in more than mere "labels and conclusions." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation and quotation marks omitted); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A "formulaic recitation of the elements of a cause of action" is insufficient. *Twombly*, 550 U.S. at 555. Rather, the complaint must "plead factual allegations that support a facially 'plausible' claim to relief." *Cambridge v. United States*, 558 F.3d 1331, 1335 (Fed. Cir. 2009). The Court must dismiss a claim "when the facts asserted by the

[25] *See* Order Staying Case, Dkt. No. 12 at 3; *see also* U.S. Reply in Support of Motion to Stay, Dkt. No. 9, Attachment A, Declaration of Elizabeth Parrish ¶¶ 7-8 (setting forth financial transfers between the parties as of August 2017).

claimant do not entitle [it] to a legal remedy." *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002).

The remainder of this motion addresses each count in the order presented in the Amended Complaint.[26] As explained below, Counts I-V should be dismissed under Rule 12(b)(6) for failure to state claims upon which relief can be granted. Counts VI and VII allege APA claims beyond the jurisdiction provided by the Tucker Act and should be dismissed under Rule 12(b)(1).

ARGUMENT

I. Binding Federal Circuit Precedent Requires Dismissal of Count I, the Liquidators' Claim for Risk Corridors Payments Arising Under ACA Section 1342

In Count I, the Liquidators disregard binding Federal Circuit precedent, repeating a theory that section 1342 obligates the United States to make additional risk corridors payments. FAC ¶¶ 174-80. Even with the benefit of an amended complaint, the Liquidators offer only the bare allegation that section 1342 mandates payment, mistakenly citing a portion of the Federal Circuit's opinion in *Moda* as apparent support for their claim. Count I should be dismissed as contrary to binding precedent.

The claim the Liquidators plead pursuant to section 1342 of the ACA in Count I is the same theory that the Federal Circuit has already considered and rejected. *Moda*, 892 F.3d at 1329 (reversing trial court and holding that issuer's "statutory claim cannot stand"); *Land of Lincoln*, 129 Fed. Cl. 81 (2016) (Lettow, J.), *aff'd*, 892 F.3d 1184 (Fed. Cir. 2018) (affirming dismissal of

[26] The counts of the Amended Complaint are misnumbered. To avoid confusion, this motion refers to the Complaint's first APA claim as Count VI, not Count V, as the Takings claim is the fifth count of the Amended Complaint.

statutory claim); *Maine I*, 133 Fed. Cl. 1 (2017), *aff'd*, 729 Fed. Appx. 939 (2018) (same); *BCBSNC*, 131 Fed. Cl. 457 (2017), *aff'd*, 729 Fed. Appx. 939 (2018) (same).[27]

As the Federal Circuit explained, the entitlement of insurers, such as CoOportunity, to additional risk corridors payments "depends on the intention of [C]ongress," and "the appropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program." *Moda*, 892 F.3d at 1323, 1329. After reviewing the same claim that the Liquidators now assert, the Federal Circuit held in *Moda*, "the statutory claim cannot stand." *Moda*, 892 F.3d at 1329. This Court need go no further. The Federal Circuit's holding in *Moda*, as well as its affirmances in *Land of Lincoln*, *Maine I*, and *BCBSNC*, require dismissal of Count I.

II. The Federal Circuit Has Also Rejected the Contract Theories For Risk Corridors Payments That the Liquidators Assert in Count II

In Count II, the Liquidators again ignore binding Federal Circuit precedent, contending that the United States breached the QHP Agreements, the Loan Agreement, an implied contract, and the covenant of good faith and fair dealing by not making risk corridors payments. FAC ¶¶ 182-95.[28] Like the insurers in *Land of Lincoln* and *BCBSNC*, the Liquidators premise their express contract claim on the "systems and processes" language in the QHP Agreements, FAC ¶¶ 70, 185, and general choice of law provisions, FAC ¶¶ 47, 188. And like the insurers in *Moda*, *Land of Lincoln*, and *BCBSNC*, the Liquidators seek to support their implied contract claim by relying upon

[27] On July 30, 2018, the insurer in *Moda* petitioned for rehearing *en banc* in the Federal Circuit. In the event the Federal Circuit were to grant *en banc* review or modify its opinion in *Moda*, we request the opportunity to supplement this motion with additional arguments as applicable to all counts.

[28] Although the Liquidators generally allege that the Loan Agreement was breached, they do not allege that any specific provision required HHS to make risk corridors payments or that any specific provision was breached by HHS.

section 1342, 45 C.F.R. § 153.510, and other conduct by HHS. Those same theories have already been considered and rejected by this Court and the Federal Circuit.

As explained more fully below, regarding the express contract claim, in granting judgment for the United States in an opinion since affirmed by the Federal Circuit, this Court held "[t]he plain language of the [QHP] agreements does not indicate any contractual commitment on behalf of HHS to make risk-corridors payments" and that the other provisions did not incorporate the risk corridors program into the agreement. *Land of Lincoln*, 129 Fed. Cl. at 109-10. Regarding the implied contract theory, the Federal Circuit held that "the circumstances of [the risk corridors program] and subsequent regulation did not create [an implied] contract promising the full amount of risk corridors payments." *Moda*, 892 F.3d at 1331. Consequently, Count II should be dismissed.

A. The QHP Agreements and Loan Agreement Are Unrelated to the Risk Corridors Program

The Liquidators contend that the Loan Agreement required that CoOportunity offer QHPs, which in turn required that CoOportunity enter into the QHP Agreements, and that the QHP Agreements and Loan Agreement give rise to express contractual rights to receive risk corridors payments. As this Court did in *Land of Lincoln*, the Court must begin its analysis with the plain language of the agreement. *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1038 (Fed. Cir. 2003) (en banc). Even a cursory reading of the Loan Agreement and QHP Agreements reveals that they have nothing to do with risk corridors. *See Land of Lincoln*, 129 Fed. Cl. at 109 ("The plain language of the [QHP] agreements does not indicate any contractual commitment on behalf of HHS to make risk corridors payments."); *BCBSNC*, 131 Fed Cl. at 478 ("[T]he contractual provisions [in the QHP Agreement] that Blue Cross relies upon to show that HHS is contractually obligated to make full, annual Risk Corridors Program Payments cannot be reasonably read to create such an obligation.").

"The [QHP] agreements do not explicitly refer to the risk-corridors program. Rather, they reflect [the issuer]'s agreement to comply with HHS's standards and the government's acceptance of [the issuer] into the Affordable Care Act's Exchange program." *Land of Lincoln,* 129 Fed. Cl. at 109 (citation omitted). As this Court observed, HHS's obligation "to implement systems and processes" must be read in the context of the agreements as a whole, which concern a QHP's handling of consumer data and use of HHS's "Data Services Hub Web Services." *Id.* Given this context, "systems and processes" must relate to the electronic system that HHS and the qualified health plan will be using, and the processes that support this electronic system." *Id.* "The 'systems and processes' language does not give rise to any risk-corridors obligations." *Id.*

Nor do the Loan Agreement and the QHP Agreements' general references to federal law and regulations incorporate the risk corridors provisions. *Id.* ("the general references to 'the laws and common law of the United States . . . does not incorporate the risk-corridors program into the agreement"). A court may not "find that statutory or regulatory provisions are incorporated into a contract with the government unless the contract explicitly provides for the incorporation." *St. Christopher Associates, L.P. v. United States*, 511 F.3d 1376, 1384 (Fed. Cir. 2008) (citation omitted); *see also Northrop Grumman Info. Tech., Inc. v. United States*, 535 F.3d 1339, 1344 (Fed. Cir. 2008); *Precision Pine & Timber, Inc. v. United States*, 596 F.3d 817, 826 (Fed. Cir. 2010). "Here, the general reference to federal law and HHS regulations does not expressly or clearly incorporate the specific risk-corridors provisions[.]" *Land of Lincoln*, 129 Fed. Cl. at 110. *See also Moda*, 892 F.3d at 1330-31 (rejecting the claim that the government breached a contract to make risk corridors payments).

B. The Federal Circuit Has Already Rejected the Liquidators' Implied Contract Theories

The Liquidators also rely on section 1342, 45 C.F.R. § 153.510, and HHS's "representations" as allegedly indicating both an intent to contract for, and an offer of, "full payment" of risk corridors. The Federal Circuit and this Court have soundly rejected the notion that this theory supports an implied contract.

"The requirements for establishing a contract with the government are the same for express and implied contracts. They are (1) mutuality of intent to contract; (2) consideration; (3) lack of ambiguity in offer and acceptance; and (4) actual authority of the government representative whose conduct is relied upon to bind the government." *Moda*, 892 F.3d at 1329 (citing *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997); *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995)) (internal citations and quotations omitted). The Liquidators do nothing but repeat the theories the Federal Circuit has rejected. As the Federal Circuit already held with regard to risk corridors, "no statement by the government evinced an intention to form a contract." *Moda*, 892 F.3d at 1330.

The Liquidators cannot overcome "the presumption . . . that a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-66 (1985) (internal quotations, citations omitted); *see also Moda*, 892 F.3d at 1329 ("Absent clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract."). Here, as the Federal Circuit found in *Moda*, "[t]he statute, its regulations, and HHS's conduct all simply worked towards crafting an incentive program." *Moda*, 892 F.3d at 1330; *see also Land of Lincoln*, 129 Fed. Cl. at 111-12 ("Section 1342 and the implementing regulations do not provide any express or explicit intent on behalf of

the government to enter into a contract with qualified health plan issuers. . . . Thus there is no apparent mutuality of intent to contract."); *BCBSNC*, 131 Fed. Cl. at 479 ("Neither Section 1342 nor its implementing regulations contain language that creates a contractual obligation with respect to the Risk Corridors Program Payments.").

Moreover, as the Federal Circuit has held, an unambiguous offer and acceptance cannot be inferred from the language or circumstances of the risk corridors program. *Moda*, 892 F.3d at 1330. "Section 1342 and the implementing regulations make no explicit reference to an offer or contract." *Land of Lincoln*, 129 Fed. Cl. at 112 (citing *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321, 329 (2012) and *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27-28 (2011)); *see also BCBSNC*, 131 Fed. Cl. at 479 ("Blue Cross does not identify any circumstances surrounding the enactment of the ACA that would manifest an intent upon the part of Congress to contractually bind the government."). And HHS's rulemaking and guidance similarly contain no language that can plausibly be construed as an unambiguous offer. Thus, as this Court properly recognized in *Land of Lincoln*, "Section 1342 and the implementing regulations do not constitute an offer or invite acceptance by performance alone." *Land of Lincoln*, 129 Fed. Cl. at 113 (citation omitted). [29]

The Liquidators also do not and cannot allege, beyond a mere legal conclusion, that any HHS official enjoyed authority to bind the government in contract for risk corridors payments, as they must to avoid dismissal. *Trauma*, 104 F.3d at 1327 (the plaintiff "must allege facts sufficient to show that the Government representative who entered into its alleged implied-in-fact contract

[29] The Liquidators also allege that CoOportunity was "induced" by the government's promises of "full" risk corridors payments to participate in the health benefit exchanges and enter into the Loan Agreement. FAC ¶ 189. This Court already recognized that detrimental reliance is not an element of an implied-in-fact contract claim, and that the Court lacks jurisdiction over implied-in-law claims. *Land of Lincoln*, 129 Fed. Cl. at 111 n.29 (citations omitted).

was a contracting officer or had implied actual authority to bind the Government"); *McAfee v. United States*, 46 Fed. Cl. 428, 435 (2000) ("A government agent possesses express actual authority to bind the government in contract only when the Constitution, a statute, or a regulation grants it to that agent in unambiguous terms."). Nothing in section 1342 or the ACA authorizes *any* federal official to enter into a contract to make risk corridors payments. Absent that statutory authority, no federal official can form a binding contract. *See Schism v. United States*, 316 F.3d 1259, 1288 (Fed. Cir. 2002) (en banc) (holding that neither Secretaries of the Armed Forces nor the President had authority to contract with service members for free, lifetime healthcare). In these circumstances, an implied contract could not arise without the requisite "actual authority" on the part of the government's representative to bind the government. *Id* at 1278.

Finally, the Liquidators cannot establish that HHS breached a contractual obligation. *See Land of Lincoln*, 129 Fed. Cl. at 113; *BCBSNC*, 131 Fed Cl. at 480. For the Liquidators to recover on a breach of contract claim, they must establish both the existence of a valid contract with HHS and a breach of a duty created by that contract. *See Anderson v. United States*, 73 Fed. Cl. 199, 201 (2006). Because any contractual obligation here could extend no farther than what is required by statute and regulation, HHS cannot have breached such an agreement by making pro-rated risk corridors payments to the extent of risk corridors collections. Count II must be dismissed.[30]

III. The Offset Claims Alleged in Counts III and IV Fail as a Matter of Law And Should Be Dismissed

In Counts III and IV, the Liquidators make numerous arguments as to why the United States should have made risk corridors and reinsurance payments directly to CoOportunity, rather

[30] Because the Liquidators cannot establish a breach of any contract, the claim for breach of the implied duty of good faith and fair dealing necessarily fails. *Land of Lincoln*, 129 Fed. Cl. at 113-14.

than offsetting those amounts against the company's outstanding start-up loan and risk adjustment debts. Each of the Liquidators' theories fail as a matter of law.

A. Federal Law Authorizes HHS's Use of Offset

The United States' right to use offset to collect a mutual debt owed by an insolvent debtor is firmly established under the law. Federal courts have consistently recognized that "setoff (also called 'offset') allows entities that owe each other money to apply their mutual debts against each other, thereby avoiding 'the absurdity of making A pay B when B owes A.'" *Citizens Bank of Md. v. Strumpf*, 516 U.S. 16, 18 (1995) (quoting *Studley v. Boylston Nat. Bank*, 229 U.S. 523, 528 (1913)); *see also Munsey Trust Co. of Washington, D.C.*, 332 U.S. at 239; *Johnson v. All-State Construction, Inc.*, 329 F.3d 848 (Fed. Cir. 2003) ("This court and our predecessor court have repeatedly recognized the government's right of set-off.") (citation omitted); *United States v. DeQueen & E. R.R. Co.*, 271 F.2d 597, 599 (8th Cir. 1959) (acknowledging the government's right of "setoff, without limitation"); *United States v. Tafoya*, 803 F.2d 140, 141 (5th Cir. 1986) ("The right of setoff is 'inherent in the United States Government' . . . and exists independent of any statutory grant of authority to the executive branch.") (citations omitted).

Consistent with this longstanding recognition, HHS's regulations also authorize the use of offset to collect funds owed to the United States. In particular, 42 C.F.R. § 401.607(a)(2) provides that HHS "recovers amounts of claims due from debtors . . . by . . . [o]ffsets against monies owed to the debtor by the Federal government where possible." And the Netting Regulation specifically permits HHS to utilize netting—a form of offset—to collect amounts owed under the 3Rs and other ACA programs. 45 C.F.R. § 156.1215.

The Liquidators' contention that HHS lacked authority pursuant to federal law to exercise its right of offset, FAC ¶ 200-01, cannot be reconciled with this well-settled authority. Also

lacking merit is the allegation that HHS's offsets were "improper" because the United States' liability to CoOportunity exceeded its debts. FAC ¶ 202. If that were true, any balance would have been paid to CoOportunity's estate. The only amounts identified by the Liquidators to support their excess liability allegation are 2014 benefit year risk corridors amounts in excess of CoOportunity's pro-rata share, and the Federal Circuit has already determined that issuers, including CoOportunity, are not entitled to additional risk corridors payments. *See Moda*, 892 F.3d at 1331; *Land of Lincoln*, 892 F.3d at 1185.

B. Iowa Law Authorizes HHS's Use of Offset

Iowa law also allows—and in fact requires—offset of mutual debts. The Iowa Liquidation Act states that "mutual debts or mutual credits between the insurer and another person in connection with an action or proceeding under this chapter *shall be set off and the balance only shall be allowed or paid*." Iowa Code § 507C.30(1) (emphasis added); *see also Berger v. Cas' Feed Store, Inc.*, 543 N.W.2d 597, 599 (Iowa 1996) (recognizing that the "general right of setoff is well established").

1. HHS's Right of Offset Attaches Independent of Distribution Priority

Ignoring this body of authority, the Liquidators contend that HHS's use of offset violated the Iowa priority statute, Iowa Code § 507C.42, which governs the order in which an insolvent debtor's claims are paid. FAC ¶¶ 89, 109, 197-200. But courts have repeatedly rejected the assertion that the right of setoff is limited by a state priority scheme. *See, e.g.*, *In re Liquidation of Realex Grp. N.V.*, 210 A.D.2d 91, 94 (N.Y. App. Div. 1994) ("Although permitting offsets may conflict with the statutory purpose of providing for the pro rata distribution of the insolvent's estate to creditors, the Legislature has resolved the competing concerns and recognized offsets as a species of *lawful* preference. Indeed, *. . . it is 'only the balance, if any, after the set-off is deducted*

which can justly be held to form part of the assets of the insolvent'" (emphasis added; quoting *Scott v. Armstrong*, 146 U.S. 499, 510 (1892)); *Prudential Reinsurance Co. v. Superior Court*, 3 Cal. 4th 1118, 1124-25 (1992) (adopting position of "the majority of state and federal courts addressing the statutory right of setoff" and holding that the setoff provision "may not reasonably be construed as conditioning [a creditor's] right to set off on the insolvent insurer's ability to pay in full the claims of those in higher priority classes"); *see also In re Liquidation of Home Ins. Co.*, 972 A.2d 1019, 1022-23 (N.H. 2009) (noting that "setoff is an exception to the [priority framework] for discharging claims against an insolvent debtor"); *In re Agriprocessors, Inc.*, 547 B.R. 292, 325 (N.D. Iowa 2016) ("Setoffs are not 'transfers' . . . and, therefore, are not avoidable as preferences.").

Because HHS's right of offset attaches by law independent of distribution priority, the Liquidators' theory lacks merit.

2. The Debts That HHS Offset Were Mutual

The Liquidators also wrongly allege that offset is impermissible under Iowa law because the debts between CoOportunity and HHS lack mutuality. FAC ¶¶ 87, 202. Mutuality exists when the debts are "in the same right and between the same parties standing in the same capacity[.]" *Meyer Med. Physicians Grp., Ltd. v. Health Care Serv. Corp.*, 385 F.3d 1039, 1041 (7th Cir. 2004) (citations omitted). "Capacity, for these purposes, means legal capacity (*e.g.*, principal, agent, trustee, beneficiary)." *In re Liquidation of Home Ins. Co.*, 953 A.2d 443, 447-48 (N.H. 2008) (citation and quotation marks omitted); *Matter of Midland Ins. Co.*, 590 N.E.2d 1186, 1192 (N.Y. 1992) (same). A defining feature of "capacity," and hence mutuality, is that the "parties have the right, in their own name, to collect against the others, in their own right." *In re Hanssen*, 203 B.R. 149, 150 (Bankr. E.D. Ark. 1996) (citations omitted). Mutuality is lacking, for example, where

one debt is owed in an individual debtor-creditor capacity while another is owed in a fiduciary capacity. *See, e.g.*, *Wiand v. Meeker*, 572 F. App'x 689, 691 (11th Cir. 2014); *In re Brittenum & Assocs., Inc.*, 868 F.2d 272, 275-76 (8th Cir. 1989).

Relying on the self-funded nature of the 3Rs programs and the ACA's state-flexibility provision, 42 U.S.C. § 18041(c), the Liquidators argue that HHS collects 3Rs charges on behalf of states and in an "intermediary/conduit" capacity, rather than as a creditor in its own right. FAC ¶¶ 27-30, 200, 230-235. As sovereign, the federal government's duties "are not defined by . . . common-law conception[s]" such as those defining the fiduciary capacities of private parties; rather, fiduciary duties *only* arise in the federal government "if it is plain from the relevant statutes or regulations that the government has accepted such a responsibility." *Grady v. United States*, No. 13-15C, 2013 WL 4957344, at *3 (Fed. Cl. July 31, 2013) (citation omitted), *aff'd*, 565 F. App'x 870 (Fed. Cir.), *cert. denied*, 135 S. Ct. 245 (2014); *see also Ashley v. U.S. Dep't of Interior*, 408 F.3d 997, 1002 (8th Cir. 2005). Neither the state-flexibility provision nor any other provision of the ACA makes "plain" or even suggests that the government has accepted a fiduciary responsibility with respect to 3Rs payments. *See* 42 U.S.C. § 18041(c). HHS administers the 3Rs programs, by, *inter alia*, collecting funds from certain issuers and making payments to others. *See* 42 U.S.C. §§ 18061(b), 18062(a), 18063(a). The Congressional Budget Office treats all such collections and payments as revenues and outlays. *See* Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, at 9, Congressional Budget Office (April 2014) ("CBO treats the [3Rs] payments as outlays and the collections as revenues").[31]

[31] Available at https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45231-ACA_Estimates_OneColumn.pdf.

Moreover, 3Rs debts are each owed either to or from CoOportunity and HHS. Issuers, like CoOportunity, do not owe funds to other issuers; rather, issuers owe money to HHS and HHS owes money to issuers, establishing a linear debtor/creditor relationship. *See* 42 U.S.C. § 18062(b) ("the Secretary shall pay to the plan [the risk corridors amount]" and "the plan shall pay to the Secretary [the risk corridors amount]"); *id.* § 18063(a) (HHS "shall assess a [risk adjustment] charge" on issuers and HHS "shall provide a [risk adjustment] payment") to issuers; 42 U.S.C. § 18061(b) ("health insurance issuers . . . are required to make payments to [HHS]. . . and . . . [HHS] . . . make[s] reinsurance payments to health insurance issuers"). If issuers fail to pay what they owe, HHS may sue in its own name to collect the funds; conversely, if HHS does not pay what issuers believe is owed, issuers may sue in their own name to collect. The more than 50 cases filed in this Court seeking payments under the risk corridors program demonstrates that an issuer's claim is against HHS. These circumstances remove any doubt that the 3Rs debts share mutuality with all other debts owed between the United States and CoOportunity.[32]

3. The Start-up Loan is Not a Capital Contribution Excepted from Iowa Law Requiring Offset

The Liquidators' theory that HHS's use of offset to collect the start-up loan violated Iowa law is based on the unfounded premise that the start-up loan was a capital contribution to CoOportunity. Iowa Code § 507C.30(5) (excepting capital contributions from offset). This theory is simply wrong. FAC ¶¶ 49, 88, 105, 202. The ACA is clear: start-up loans are "loans." 42 U.S.C. § 18042(b)(1)(A). The start-up loan bears all of the traditional indicia of a loan: it has a

[32] For purposes of mutuality, all agencies of the United States are treated as a single unit. *See Cherry Cotton Mills v. United States*, 327 U.S. 536, 539 (1946); *In re Turner*, 84 F.3d 1294, 1296 (10th Cir. 1996) ("[T]he United States is treated as a unitary creditor, and agencies of the United States government . . . may set off debts owed by one agency against claims that another agency has against a single debtor."). Therefore, all of CoOportunity's debts to the United States—whether owed to HHS under the 3Rs programs or to some other federal agency—are mutual.

fixed maturity date and repayment schedule, *id.* § 18042(b)(3), Loan Agreement § 4.4 (5 years), Dkt. 20-1; it bears interest upon default, 45 C.F.R. § 156.520(c)(1), Loan Agreement § 4.3 and Appendix 6 (0.90%); and a CO-OP's failure to pay its loan entitles HHS to use "any and all remedies available . . . to collect the debt," 45 C.F.R. § 156.520(d). Consistent with these characteristics, and unlike the solvency loan, the start-up loan is listed on a CO-OP's statutory balance sheet as debt. *Cf.* 45 C.F.R. § 156.520(a)(2).

Reinforcing the lack of merit to this theory is how the parties treated CoOportunity's solvency loan. Iowa and Nebraska regulators specifically requested that the solvency loan be treated as a capital contribution. Loan Agreement, Dkt. 20-1, at pages 73-74. No similar request was made for the start-up loan. Subsequently, the parties amended the Loan Agreement to clarify their intention that the solvency loan was to be treated as a surplus note for regulatory capital purposes. *See* Second Amendment to Loan Agreement, Dkt. 20-3, at page 2. No such amendment was executed as to the start-up loan. This contrasting treatment of the start-up and solvency loans confirm that the start-up loan was never considered a capital contribution.

C. The State Court Liquidation Order Did Not Negate HHS's Offset Rights

In the absence of any specific legal authority against setoff, the Liquidators rely heavily on the state court's Liquidation Order, from which they selectively quote to suggest the state court stripped HHS of its offset rights. FAC ¶¶ 84, 200. To be sure, the Liquidation Order purports to create a procedural hurdle to the federal government's exercise of offset. But the Liquidators' suggestion that the state court negated the United States' right of offset finds no support in the language of the order and should be rejected for its inconsistency with Iowa law requiring offset. *See* Iowa Code § 507C.30(1) ("mutual debts or mutual credits between the insurer and another person . . . *shall* be setoff and the *balance only* shall be allowed or paid") (emphasis added).

Even when properly construed, the Liquidator-Order-based theory fails at its threshold as Congress has not waived sovereign immunity such that a state court could enjoin HHS's operation of the 3Rs programs via netting. *See Cal. Ins. Gty. Ass'n v. Burwell*, 170 F. Supp. 3d 1270, 1274 (C.D. Cal. 2016) (holding that the United States has not waived sovereign immunity so as to be subject to the bar date of the state insurance insolvency statute); *see also TransAmerica Assurance Corp. v. Settlement Capital Corp.*, 489 F.3d 256, 260-63 (6th Cir. 2007) (state court order purporting to affect the rights of the United States was void as to the United States, having been entered without a waiver of sovereign immunity); *Twin City Fire Ins. Co. v. Adkins*, 400 F.3d 293, 299 (6th Cir. 2005) ("Where a federal court finds that a state-court decision was rendered in the absence of subject matter jurisdiction . . . it may declare the state court's judgment void *ab initio* and refuse to give the decision effect in the federal proceeding.") (citations omitted); *Settlement Funding, LLC v. Garcia*, 533 F. Supp. 2d 685, 690 (W.D. Tex. 2006) (holding state court order "not binding or enforceable against the United States"). Thus, although the state court has *in rem* jurisdiction over CoOportunity's assets, which allows it to administer claims and determine distributions, that jurisdiction does not empower the state court to enjoin or compel any action by the United States in the absence of a specific statutory waiver of sovereign immunity. *United States v. Nordic Vill. Inc.*, 503 U.S. 30, 38 (1992).[33]

[33] Sovereign immunity protects the United States from any compulsive state action, not simply suits in which the United States is a named defendant. *See United States v. Rural Elec. Convenience Co-op. Co.*, 922 F.2d 429, 433 (7th Cir. 1991) ("The general rule is that a suit is against the sovereign if the judgment would expend itself on the public treasury or domain, or interfere with public administration, . . . or if the effect of the judgment would be to restrain the Government from acting or compel it to act.") (citations and quotation marks omitted); *Scheckel v. I.R.S.*, No. C03-2045 LRR, 2004 WL 1771063, at *2 (N.D. Iowa June 18, 2004) ("an injunction to prevent the IRS from collecting federal taxes" implicated sovereign immunity even though United States not named as defendant).

Because Congress has not waived the United States' sovereign immunity for liquidation proceedings in state court, HHS was not required to request permission from the state court before administering the 3Rs programs via netting, as the Liquidators suggest, FAC ¶¶ 105, 198, 200. *See TransAmerica Assur. Corp.*, 489 F.3d at 262 ("compulsion itself is the vice that implicates federal sovereign immunity"). The Liquidation Order cannot render the United States' lawful exercise of setoff unlawful.

Contrary to the significance attached by the Liquidators, whether HHS's actions were in tension with the Liquidation Order ultimately has no bearing on the merits of the Liquidators' underlying claim to $30 million in risk corridors and reinsurance payments. This Court has jurisdiction to render judgment "upon any set-off or demand by the United States," and because CoOportunity is indebted to the United States, the Court can render judgment to that effect. 28 U.S.C. §§ 1503, 2508. The Amended Complaint challenges HHS's use of offset *per se*; it does not (and cannot) allege that the debts themselves were not owed to HHS. Whether the estate will be entitled to monetary relief hinges not, for example, on whether HHS should have obtained state court permission before operating the ACA's 3Rs programs via netting, but instead on whether CoOportunity was "a debtor to the United States in the amount of the offset," a circumstance not in dispute. *Lawrence v. United States*, 69 Fed. Cl. 550, 556-57 (2006); *see also* 28 U.S.C. §§ 2508, 1503. A defect in the use of offset, such as that complained of by the Liquidators, ultimately has no bearing on the success of CoOportunity's claim for risk corridors and reinsurance payments. *See, e.g.*, *Greene v. United States*, 124 Fed. Cl. 636 (2015) (finding no basis to infer that return of the offset funds is the remedy for failure to satisfy the notice requirements of a tax refund offset statute).

D. The Loan Agreement Permits Offset of the Start-Up Loan

At Count IV, the Liquidators contend HHS is bound by the Loan Agreement to forgo offset of the start-up loan. FAC ¶¶ 34, 38, 45-46, 207-216. This theory contradicts the plain language of the Loan Agreement, which clearly and unambiguously preserves HHS's right of offset:

> **Right of Set-Off**
>
> ***Notwithstanding any other provisions of this Agreement to the contrary***, in the event any Event of Default is not cured . . . within applicable notice and cure periods, Lender shall have at its disposal the full range of available rights, remedies and techniques to collect delinquent debts . . . ***including*** . . . ***administrative offset***[.]

Loan Agreement § 19.12, Dkt. 20-1 (emphasis added).

Relying on a different section of the Loan Agreement, section 4.4, the Liquidators contend that offset breached the Loan Agreement. According to the Liquidators, CoOportunity's obligation to repay the start-up loan was conditioned upon its ability to meet state reserve and solvency requirements. FAC ¶¶ 45-46, 210-12. But the Liquidators' theory ignores that the repayment provision, by its express terms, does not apply when the government "terminates this Agreement for cause," which indisputably occurred here. Loan Agreement §§ 4.4, 16.3, Dkt. 20-1. Moreover, section 4.4 plainly yields to section 19.12, which on its face preserves HHS's right of offset "[n]otwithstanding any other provision of this Agreement to the contrary." *Id.* § 19.12.

The Liquidators also contend that HHS's use of offset violates the subordination terms of the Loan Agreement. FAC ¶¶ 207-09. But the Loan Agreement's subordination provision only applies "while [CoOportunity] *is operating* as a CO-OP," which CoOportunity clearly was not when HHS collected the start-up loan by offset, having been decertified and placed in liquidation. Loan Agreement at § 3.4, Dkt. 20-1 (emphasis added). HHS's use of offset does not violate the Loan Agreement.

E. HHS's Offsets Are Wholly Unrelated to the QHP Agreement

Count IV also alleges that HHS's use of offset to administer the 3Rs programs breached the QHP Agreements, which the Liquidators wrongly construe to require "full and timely" payments of risk corridors and reinsurance amounts, yet prohibit collection of risk adjustment charges on mutuality grounds. FAC ¶¶ 217-41. This argument fails as a matter of law.

The Federal Circuit affirmed this Court's opinion holding that the QHP Agreements are unrelated to the risk corridors program and do not include a duty to make risk corridors payments. *See Land of Lincoln*, 892 F.3d at 1185; *see also Land of Lincoln*, 129 Fed. Cl. at 109 ("The plain language of the [QHP] agreements does not indicate any contractual commitment on behalf of HHS to make risk-corridors payments."). Instead, in the QHP agreements, CoOportunity agreed to adhere to privacy and security standards when handling consumer data and conducting electronic transactions on Exchanges using a federal platform. 45 C.F.R. § 155.260(b)(2); *Land of Lincoln*, 129 Fed. Cl. at 109. Because the QHP Agreements have nothing to do with administration of the 3Rs programs, the Liquidators' theory that HHS's offsets breached the QHP Agreements is meritless.

F. The Liquidators' Other Offset Arguments Are Also Meritless

Although federal law, Iowa law, and the Loan Agreement all authorize HHS's use of offset, the Liquidators still attempt to rely on out-of-context language from the Loan Agreement and various provisions of the ACA to argue that the United States is "bound" by Iowa law; that Iowa law prohibits HHS's use of offset; and that federal law must yield to Iowa law. FAC ¶¶ 91-103. As established above, any tension between Iowa and federal law is illusory. But to the extent a conflict exists, federal law controls.

The Supreme Court "has consistently held that federal law governs questions involving the rights of the United States arising under nationwide federal programs." *United States v. Kimbell Foods, Inc*., 440 U.S. 715, 726 (1979); s*ee also Boyle v. United Tech. Corp.*, 487 U.S. 500, 504-05 (1988). This well-settled principle is not vitiated by the choice of law provision in Section 19.12 of the Loan Agreement, FAC ¶ 90, as that provision expressly provides that state law only applies to the extent that it does "not conflict with applicable federal law." The Liquidators also rely on 42 U.S.C. § 18042, which directs HHS to promulgate regulations with respect to the CO-OP loans that are consistent with state solvency and reserve requirements. FAC ¶¶ 97-98. Nothing in section 18042 is even remotely related to HHS's collection of debt by offset, much less suggests that Iowa law should control HHS's administration of the 3Rs programs.

The Liquidators are on no firmer ground relying on a clause in the ACA's state flexibility provision (42 U.S.C. § 18041(d)) referring to "[n]o interference with State regulatory authority." FAC ¶ 96. According to the Liquidators, this clause, combined with the effect of the McCarran-Ferguson Act (15 U.S.C. § 1012), means state law takes priority over contrary federal statutes, including the ACA and its implementing regulations. FAC ¶ 102.[34] Rather than support the Liquidators' theory, section 18041(d) instead provides state insurance laws primacy *only* to the extent that they do not interfere with the application of the ACA's requirements. 42 U.S.C. § 18041(d); *see also St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) (holding that, pursuant to 42 U.S.C. § 18041(d), the ACA preempts any state law that hinders or impedes the implementation of the ACA). This circumstance removes any doubt that, even if a conflict

[34] The McCarran-Ferguson Act provides that, where generally applicable federal statutes with potentially preemptive effect "conflict with state law that was enacted 'for the purpose of regulating the business of insurance,'" the federal law will not have preemptive effect. *Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 42 (1996).

existed (and it does not), HHS's administration of the 3Rs programs would not yield to contrary state laws.

G. HHS's Temporary Administrative Hold is Moot Having Been Superseded by Offset

The Liquidators complain about HHS's temporary administrative hold of CoOportunity's payables to effectuate the agency's right of offset. FAC ¶¶ 105-11, 198-201. But as reflected in this Court's docket, HHS's temporary administrative hold ceased in 2016; HHS is not now "holding" any funds payable to CoOportunity. *See supra* n.25. As such, the operative legal dispute concerns not the temporary hold, but the propriety of HHS's use of offset. The hold, which the Liquidators acknowledge was to effectuate setoff, FAC ¶¶ 198-99, cannot be factually or analytically divorced from setoff. In any event, the legality of an administrative hold to preserve offset is well established. *See, e.g.*, *Strumpf,* (recognizing a creditor's right to temporarily refuse to pay a debt that is subject to setoff against a debt owed by the bankrupt entity); *Johnson v. All-State Construction, Inc.*, 329 F.3d 848 (Fed. Cir. 2003) (recognizing that the government's common law right of offset permits it to withhold payments).

H. *New Mexico Health Connections* Does Not Render HHS's Past Offsets Improper

Finally, appearing to rely on the February 2018 *New Mexico Health Connections* opinion, the Amended Complaint alleges HHS's prior use of offset to collect risk adjustment charges was improper because HHS's methodology was later determined arbitrary and capricious. FAC ¶¶ 156-158, 203, 239; *see supra* 14-16. But that opinion obviously did not exist when the challenged offsets were taken. The offsets were fully in accord with law.

In its October 19, 2018, opinion denying the government's motion for reconsideration, the New Mexico district court stated explicitly that it was not "issuing a nationwide injunction prohibiting enforcement of the rule" but was setting aside and vacating "the agency action as to

the statewide average premium rules and remanding to HHS." *New Mexico Health Connections*, 2018 WL 5112912, at *50 n.28. The district did not order HHS to net any current or future risk adjustment charges against amounts issuers paid in prior years. Nothing in *New Mexico Health Connections*, which, as noted above, reaches a conclusion contrary to that of the district court in *Minuteman*, suggests that even if the opinion were to stand after the parties have exhausted their judicial remedies, that CoOportunity would owe any less amount in risk adjustment charges than what it has previously been assessed.

IV. The Liquidators' Takings Claim Alleged in Count V is Foreclosed by Federal Circuit Precedent

Persisting in their disregard of binding Federal Circuit precedent, the Liquidators allege at Count V that CoOportunity has a property interest in 3Rs payments and that its property was "taken" by HHS's use of offset in violation of the Fifth Amendment's Takings clause. FAC ¶¶ 243-253. Like the Takings claim asserted in *Land of Lincoln* and *BCBSNC*, the Liquidators premise their claim on an alleged property interest in 3Rs payments—theories already considered and rejected by this Court and the Federal Circuit. *Land of Lincoln*, 892 F.3d at 1186; *BCBSNC*, 729 Fed. Appx. 939.

As the Federal Circuit explained, to the extent that the Liquidators purport to rely on a statutory entitlement to 3Rs payments, "no statutory obligation to pay money, even where unchallenged, can create a property interest within the meaning of the Takings Clause.'" *Land of Lincoln*, 892 F.3d at 1186 (citing *Adams v. United States*, 391 F.3d 1212, 1225 (Fed. Cir. 2004)). Because the Liquidators "cannot state a contract claim, its takings claim [also] fails to the extent it relies on the existence of a contract." *Id.* And because the Liquidators cannot "demonstrate the existence of a legally cognizable property interest, the court's task is at an end." *Am. Pelagic Fishing Co. v. United States*, 379 F.3d 1363, 1372 (Fed. Cir. 2004). Count V should be dismissed.

V. The APA Claims Alleged in Counts VI and VII Should Be Dismissed

Counts VI and VII allege that HHS's decisions regarding the risk adjustment program's methodology and participation requirements were arbitrary, capricious, and an abuse of discretion, and therefore invalid under the APA, 5 U.S.C. §§ 702-06 (hereinafter, the "APA Claims").[35] The APA is not a money-mandating statute and the Tucker Act does not provide jurisdiction for this Court to review the substantive validity of agency decision-making, notwithstanding the Liquidators' desire for monetary relief. As explained below, practical aspects of the risk adjustment program reinforce that the Liquidators' APA Claims cannot beget a money judgment.

A. Counts VI and VII Raise APA Challenges to the Risk Adjustment Program

In Count VI, the Liquidators seek damages allegedly caused when HHS collected risk adjustment charges due under the program on the theory that the governing rules were not the product of reasoned decision-making. Among their challenges, the Liquidators attack HHS's decisions regarding the adequacy of HCCs as a diagnostic tool; exclusion of prescription drug use as a predictive tool; and use of models that take into account purportedly "irrelevant" factors. FAC ¶¶ 162, 257, 148.[36] They also fault HHS's choices for how to attribute to a plan the risk of enrollees who are enrolled only for a portion of a year. *Id.* ¶¶ 159, 165, 257. Targeting the payment transfer formula, the Liquidators assert that HHS failed to adequately explain its decision to adopt a methodology that used the state-wide average premium as the cost-scaling measure to ensure that the methodology maintain budget neutrality for the applicable benefit year. *Id.* ¶¶ 150-156; 257.

[35] The APA authorizes courts to "hold unlawful and set aside agency actions, findings, and conclusions found to be arbitrary, capricious, [or] an abuse of discretion." 5 U.S.C. § 706(2)(A); FAC ¶ 256.

[36] Relatedly, the Amended Complaint alleges that HHS's decision to adopt concurrent rather than prospective models is arbitrary because this choice results in an enrollee's risk score not being carried over to subsequent benefit years. FAC ¶¶ 161, 163-64.

Count VI raises APA claims considered (and mostly rejected) by the district courts in *Minuteman* and *New Mexico Health Connections*.

In Count VII, emphasizing the limited time CoOportunity offered plans in 2015, the Liquidators allege that HHS refused to exempt CoOportunity from the 2015 risk adjustment program and that this decision was invalid under the APA. FAC ¶¶ 260-62. The Liquidators cite to no authority that would permit HHS to deviate from the scope of risk adjustment established pursuant to section 1343 of the ACA and the implementing regulations at 45 C.F.R. part 153. Count VII also fails to identify the discrete agency action amounting to a "denial" of the Liquidators' exclusion request.

B. The Tucker Act Does Not Provide Jurisdiction Over Counts VI and VII

The Tucker Act, under which the Liquidators assert jurisdiction, FAC ¶ 4, "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976); 28 U.S.C. § 1491(a)(1). "[J]urisdiction under the Tucker Act requires the litigant to identify a substantive right for money damages against the United States separate from the Tucker Act itself." *Todd v. United States*, 386 F.3d 1091, 1094 (Fed. Cir. 2004) (citing *Testan*, 424 U.S. at 398). In meeting this burden, it is not enough for a plaintiff to point to a law requiring the payment of money in the abstract. Instead, the law must "fairly be interpreted as mandating compensation for damages sustained as a result of a breach of . . . duties [it] impose[s]." *United States v. Mitchell*, 463 U.S. 206, 219 (1983).

Counts VI and VII cannot satisfy these requirements. The APA does not provide the money-mandating predicate necessary for this Court's jurisdiction. *Martinez v. United States*, 333 F.3d 1295, 1313 (Fed. Cir. 2003) (en banc) (recognizing the APA is not a money mandating statute); *Johnson v. United States*, 105 Fed. Cl. 85, 91-92 (2012) (Lettow, J.) (same).

As a basis for monetary relief, the Liquidators contend HHS failed to consider important factors in establishing the 2014 and 2015 risk adjustment methodology (Count VI) and the federal regulation establishing the scope of the risk adjustment program (Count VII), thereby demonstrating their desire for this Court to review the quality of HHS's decision-making. But the Tucker Act is not co-terminus with the so-called "federal question" statute, 28 U.S.C. § 1331, which provides district courts with jurisdiction to review agency action under the APA. *Chrysler Corp. v. Brown*, 441 U.S. 281, 317 n.47 (1979) ("Jurisdiction to review agency action under the APA is found in 28 U.S.C. § 1331"); *Crocker v. United States*, 125 F.3d 1475, 1476 (Fed. Cir. 1997) (the Claims Court "lacks the general federal question jurisdiction of the district courts, which would allow it to review the agency's actions and to grant relief pursuant to the [APA]"); *Reunion, Inc. v. United State*s, 90 Fed. Cl. 576, 583 (2009) (Lettow, J.) (same) citing and quoting *Lion Raisins Inc. v. United States*, 416 F.3d 1356, 1370 n.11 (Fed. Cir. 2005) ("Of course, no APA review is available in the Court of Federal Claims"). In light of these blackletter jurisdictional constraints, it is well established that this Court lacks jurisdiction over claims, such as those pled at Counts VI and VII, "challenging the substantive validity or reasonableness of the government's actions." *Roberts v. United States*, 745 F.3d 1158, 1167 (Fed. Cir. 2014).

The Liquidators do not (and cannot) allege that HHS's application of the risk adjustment methodology to CoOportunity violated the risk adjustment statute or rules or that CoOportunity failed to receive the treatment provided for under the 2014 and 2015 program. Instead, the premise of both counts is that the rules themselves are invalid because they are not supported by reasoned decision-making. Counts VI and VII present APA claims over which this Court lacks jurisdiction. *See, e.g., Hearts Bluff Game Ranch, Inc. v. United States*, 669 F.3d 1326, 1332-33 (Fed. Cir. 2012) (the court lacks jurisdiction over claim that agency's denial of an application was arbitrary and

capricious; in order to challenge the legality of the agency's denial decision, plaintiff would have had to sue in a district court); *Carroll v. United States*, 67 Fed. Cl. 82, 86 (2005) ("[t]o the extent that plaintiffs' real argument is that it was an abuse of discretion on the part of the Secretary to implement differing pay scales within the same pay grade, that claim would [] be outside the court's jurisdiction. We have no general federal question jurisdiction, *see* 28 U.S.C. § 1331, nor the right generally to review final agency action under the [APA]").

C. The APA Claims Do Not Beget Money Damages

Counts VI and VII are premised on the incorrect assumption that this Court can award monetary relief to redress an APA claim. But "the APA does not authorize an award of money damages at all." *Johnson v. United States*, 105 Fed. Cl. 85, 91-92 (2012) (Lettow, J.). Rather remand, and not monetary relief, is the remedy available for APA claims of this nature, as is evident from the circumstances of the risk adjustment program.

Congress entrusted HHS to establish the criteria and methods for carrying out risk adjustment activities and directed the agency to operate risk adjustment on behalf of non-electing states. 42 U.S.C. §§ 18041(c), 18063(b). In light of this delegation of policy-making authority, to the extent a court determines that HHS's criteria for risk adjustment (*e.g.*, rules as to methodology and scope) were not the product of reasoned decision-making, the function of the reviewing court ends and the parameters for risk adjustment are once again before HHS to reassess. *See, e.g., I.N.S. v. Orlando Ventura*, 537 U.S. 12, 16 (2002) ("a court of appeals should remand a case to an agency for decision of a matter that statutes place primarily in agency hands"); *Oil, Chem. & Atomic Workers Int'l Union, AFL-CIO v. N.L.R.B.*, 46 F.3d 82, 92-93 (D.C. Cir. 1995) (emphasizing that remand "vindicates" the administrative process, as well as the agency's "primary authority and responsibility for making federal [] policy").

The unavailability of a damages remedy to redress the APA Claims is underscored by the inherently relative nature of the risk adjustment program, which requires calculation of the relative actuarial risk of *all* enrollees attributed to *all* insurers in a state market risk pool in order to calculate the charge or payment for any *one* insurer in that market. Consistent with ACA section 1343, whether CoOportunity is provided a risk adjustment payment or assessed a charge depends entirely on how CoOportunity's risk score compares to the average actuarial risk of other plans in the Iowa and Nebraska markets. 42 U.S.C. § 18063(a). If CoOportunity's relative actuarial risk is less than the market average, it would owe a charge; correlatively, if CoOportunity's risk score is higher than the average, it would be provided a payment. *Id.* Neither the market average nor CoOportunity's relationship to that average, however, can be derived absent industry-wide application of revised rules, a circumstance that has not occurred.

Under the Liquidators' mistaken theory, success on the APA Claims would entitle CoOportunity's estate to an immediate money judgment. But at least since *United States v. Testan*, a plaintiff enjoys no entitlement to money absent violation of some statute or regulation mandating it. 424 U.S. at 402. The Amended Complaint does not allege that HHS violated the risk adjustment rules in any manner. Nor does the Amended Complaint assert that CoOportunity failed to receive the treatment provided for under the rules. Instead, the Liquidators' claims are based on a theory of how the risk adjustment program *should* have been operated, seeking payment of monies CoOportunity would have received had the program's methodology and scope been designed as the Liquidators prefer. The Liquidators do not state a proper claim in this Court. *Testan*, 424 U.S. at 402 (recognizing "[t]he established rule [] that one is not entitled to the benefit of a position until he has been duly appointed to it"). Counts VI and VII should be dismissed.

CONCLUSION

For the foregoing reasons, the Amended Complaint should be dismissed.

Dated: October 26, 2018

Respectfully submitted,

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APPENDIX

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coOportunity HEALTH® In Liquidation

May 24, 2016

VIA EMAIL and U.S. MAIL

Mr. Kevin Counihan
Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201
Kevin.Counihan@cms.hhs.gov

Re: CoOportunity Health, Inc.
2015 Risk Adjustment

Dear Mr. Counihan:

I am the Special Deputy Liquidator of CoOportunity Health, Inc., which operated as a Consumer Operated and Oriented Plan ("CO-OP") in Iowa and Nebraska until it was liquidated by the Iowa District Court effective February 28, 2015.

On May 2, 2016, health insurers sent data to HHS/CMS that will be used for calculation of charges and payments due under the Affordable Care Act's Risk Adjustment program for the 2015 benefit year. We expect that HHS/CMS will release final payments and charges under the 2015 Risk Adjustment program by June 30, 2016.

During the weeks leading up to the May 2 data transmission deadline, we raised concerns with HHS/CMS about preliminary projections for CoOportunity, particularly very high anticipated Risk Adjustment charges that amount to roughly fifty percent of all premium collected for CoOportunity's plans in 2015. HHS/CMS officials confirmed that the anticipated data results and charges indeed appeared anomalous. We discussed possible solutions (e.g., omit CoOportunity from the calculation of charges and payments), but did not reach a resolution before the May 2 data transmission deadline. To avoid risk of penalty or a default risk adjustment charge, CoOportunity sent its data to HHS/CMS on May 2.

We continue to be very concerned about the anticipated Risk Adjustment charges, and ask that HHS/CMS take action to avoid unfair Risk Adjustment charges on the CoOportunity Estate before the June 30, 2016, deadline for HHS/CMS to release notice of payments and charges.

1. The Anticipated Risk Adjustment Charges Raise Red Flags About HHS/CMS's Methodology and, if Enforced, Would be Unfair, Arbitrary, Capricious, and Unlawful.

CoOportunity had qualified health plans in effect for only the first two months of 2015. CoOportunity received $42 million in premium for those two months. Incurred claims during that period totaled $46 million, producing a medical loss ratio exceeding 100%. The MLR suggests CoOportunity had a number of high risk enrollees, but CoOportunity's risk scores for this short period in 2015 are much lower than the scores for the immediate preceding year, despite the fact that the enrollees were largely the same in both years. Preliminary reports project that CoOportunity will be assessed Risk Adjustment charges totaling approximately $21 million, or 50% of its 2015 premium.

CoOportunity's situation is unprecedented and its data set off obvious red flags of anomalous results. The purpose of Risk Adjustment is to even the playing field for insurers, and to counter against the risks of insurers attracting high risk enrollees with corresponding high claims costs. 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). A plan's actuarial risk is determined on enrollees' risk scores, which are based on provider coding for enrollees' diagnoses and conditions during each year of the program.

CoOportunity faces an extreme Risk Adjustment charge because it had QHPs for only the first two months of 2015. The anticipated charges are wholly unconnected to the actual risk profile of CoOportunity enrollees whose risk scores at the end of 2014 were substantially higher. If the anticipated charges are enforced, this would be unfair, arbitrary, capricious, and unlawful because it violates the statutory mandate for Risk Adjustment funds to be transferred from low actuarial risk plans to high actuarial risk plans. The actual actuarial risk of CoOportunity's enrollees cannot be determined in only the first two months of 2015.

2. CoOportunity's Demise in Early 2015 Created an Extraordinary Situation.

On December 23, 2014, the Iowa District Court entered an Order of Rehabilitation for CoOportunity and ended new enrollment effective December 15, 2015. By the date of the Rehabilitation Order, state and federal regulators recognized that the company needed to be liquidated, and that obtaining an order of liquidation was simply a matter of timing.

The Rehabilitator and his representatives worked closely with HHS/CMS regarding the timing of the anticipated liquidation order. HHS/CMS specifically requested that the effective date of liquidation and plan terminations be at 11:59 p.m. on February 28, 2015 to accommodate CMS's systems and accounting needs for a month-end termination date and to facilitate notice to enrollees about moving to other coverage. A December 31 liquidation order and termination of coverage would have caused severe disruption to enrollees who had no time to get new coverage in place by January 1. A January 31 liquidation order and coverage termination date was too early to accommodate HHS/CMS's considerations discussed above.

Based on these factors, we agreed to HHS/CMS's request regarding the timing of the liquidation order, and the Iowa District Court entered a Liquidation Order effective on February 28, 2015. Thus, CoOportunity plans were in effect for only for the first two months of 2015.

CoOportunity's enrollment during January and February of 2015 consisted mainly of individuals who were CoOportunity enrollees during the 2014 policy period. Enrollment in Nebraska in early 2015 was roughly equal compared to 2014. In Iowa, enrollment dropped by roughly 50% in early 2015. Based on this, the actual risk of CoOportunity's enrollment should not deviate substantially from the risk in 2014. But the 2015 risk scores do not reflect this because the Risk Adjustment Methodology does not provide scores reflecting the actual risk of enrollees when they had coverage for only the first 17% of a calendar year.

CoOportunity enrollees were seeking new coverage in early 2015–at CMS's and CoOportunity's urging–due to the impending liquidation and plan terminations. Many enrollees were trying 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 caused a decline in provider visits during early 2015.

Despite the decline in provider visits, enrollees continued to fill drug prescriptions for high-risk conditions, some of them very expensive. Overall claims costs continued at a rate similar to that in late 2014.

3. The HHS/CMS Risk Adjustment Methodology Does Not Contemplate or Fairly Address CoOportunity's Experience in 2015.

CoOportunity's average risk scores for the 2015 benefit year are significantly and artificially lower than the scores for largely the same enrollees at year-end 2014 due to the dearth of HCC coding in early 2015. HHS/CMS's Risk Adjustment methodology does not account for CoOportunity's extraordinary situation in 2015.

HHS/CMS has acknowledged CoOportunity's anomalous results for 2015. In particular, after review of CoOportunity's EDGE Server data as of February 1, 2016, CMS conducted a data quality evaluation in preparation for release of interim Risk Adjustment reports and found that CoOportunity had "data outliers" in at least three metrics: Medical Claims per Enrollee Ratio, Average Number of Conditions per Enrollee with at Least One Claim, and Percent of All Enrollees with at Least One Hierarchical Condition Category ("HCC"). After concluding the data was anomalous, CMS asked CoOportunity to confirm if the EDGE Server data was correct. In response, CoOportunity confirmed that its data was correct and complete. Thus, CMS has known for some time that CoOportunity's situation and data for 2015 were extraordinary and anomalous.

Enrollees' Risk Scores Do Not Transfer From Year to Year. Under HHS/CMS's methodology, an individual enrollee's HCCs and risk score do not transfer over from year to year, nor is the prior year's risk score factored into calculations for the present year. Rather, enrollees' risk scores are calculated anew after the end of each policy year, when enrollees have a full year for provider visits and resulting entries of a diagnosis codes for that enrollee.

This means that even though CoOportunity continued to cover many enrollees with established high-risk conditions during 2014, their risk score did not carry over into 2015, and the same HCCs present 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 identifying these HCCs.

For just a couple of examples, the same Iowa enrollees with End Stage Renal Disease who had an average risk score of 62.80 at the end of 2014, had an average risk score of 19.65 in early 2015; and the same Iowa enrollees with HIV/AIDS in 2014 who had an average risk score of 7.13 averaged only 2.20 in early 2015.

Since HHS's methodology does not account for diagnosis coding established during 2014, but "resets" at the beginning of 2015, the extremely limited coverage period caused CoOportunity's 2015 risk scores to be inaccurate, artificially deflated and not reflective of the actual risk.

HHS/CMS's Methodology Does Not Allow for Risk Scoring Based on Prescription Drug Costs. As explained above, risk coding typically occurs only upon a provider claim, and HHS's methodology does not factor prescription drugs into its risk scoring methodology and calculations. In CoOportunity's case, enrollees with high-risk conditions continued to have coverage for the same conditions and to refill prescriptions (some of which are extremely expensive), but did not have a physician claim with HCC information in its 2015 data, the result being artificially low risk scores for enrollees who had much higher risk scores just a month or two earlier at the end of 2014.

HHS's Methodology Does Not Account for the Extremely Short Period of CoOportunity's Plans. HHS/CMS's methodology assumes a full twelve-month 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 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.

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 average 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.

4. Conclusion and Requested Relief.

This situation is a result of limitations in HHS's Risk Adjustment methodology, which does not properly account for enrollment and dearth of HCC coding when coverage is terminated very early in a calendar year due to an insolvency. Risk scores calculated for enrollees covered for only the first two months of the year do not represent the actual risk of those enrollees. The timing of the Liquidation Order was set at February 28 to accommodate HHS's data systems and to allow enrollees to switch carriers with minimum disruption.

Including CoOportunity's early 2015 enrollment and very limited diagnoses coding in Risk Adjustment calculations for all of 2015 enrollment and diagnoses of other carriers would result in an extremely unfair and unwarranted penalty to CoOportunity. The severely skewed and inaccurate risk profile for CoOportunity's 2015 partial year plans does not reflect the actual risk of its enrollees and should not be measured against the scores of many of those same enrollees whose scores increased significantly over the remaining ten months of 2015 when covered by other carriers that stand to unfairly reap an unintended windfall. The Risk Adjustment formula to calculate these payments does not produce fair or intended results when one of the plans is not in operation for the last 83% of a calendar year due to a liquidation.

It does not appear that there is any administrative appeal process through which we may raise with HHS/CMS the issues outlined in this letter. *See, e.g.,* 45 C.F.R. § 156.1220 (addressing administrative appeals, but only relating to a claimed "processing error," "incorrect application of the relevant methodology," or "mathematical error" for Risk Adjustment and other ACA programs). If HHS/CMS believes that 45 C.F.R. § 156.1220 or any other regulation provides an administrative appeal through which we may raise any of these issues, please let me know right away.

We object to HHS's Risk Adjustment regulations, methodology, and formula as applied to CoOportunity for its extremely short 2015 policy period because the anticipated risk scores and Risk Adjustment charges are arbitrary and capricious and unfairly penalize CoOportunity. Such a result is contrary to the mandate in the ACA for "low actuarial risk plans" in certain markets to pay "high actuarial risk plans." The actuarial risk of CoOportunity's enrollees cannot be accurately calculated with claim data from only the first two months of 2015.

If CoOportunity is included in calculation of 2015 Risk Adjustment payments and charges, other issuers in Iowa and Nebraska with ten to twelve months of enrollee medical claims will have a significantly higher calculated actuarial risk for no other reason than they have a five to six times longer exposure period that is being evaluated than CoOportunity's limited exposure period. And, as a result, those carriers, with CMS' assistance, would reap an untended and unwarranted windfall from an insolvent company.

Consider an enrollee of CoOportunity diagnosed with a high-risk condition like HIV/AIDS in 2014, but for which no HCC was assigned for CoOportunity for 2015 due to its very condensed plan period. Once the member moves to a plan for the remaining ten months, that receiving plan would have the benefit of receiving the HCC for the high risk condition. Under HHS/CMS's methodology, the net effect is that CoOportunity, which ended business February 28, would have a risk adjustment charge payable to the receiving plan for coverage in the final ten months of the year when CoOportunity was out of business. Both carriers covered the exact same member, but CoOportunity is exposed to liability for periods when it could no longer cover that enrollee. Same enrollee, same risk, but an anomalous risk score result and unfair penalty to CoOportunity. This illustration is representative of the larger impact on CoOportunity under HHS/CMS's Risk Adjustment methodology.

For all of these reasons, we request that HHS/CMS exclude CoOportunity's data from HHS's calculations under the Risk Adjustment program for the 2015 policy year; that HHS/CMS

refrain from assessing Risk Adjustment charges to CoOportunity for other carriers for the 2015 benefit year; and that HHS/CMS grant all other relief necessary and appropriate to avoid an unfair Risk Adjustment assessment or charge to CoOportunity for the 2015 policy year.

We have been communicating with HHS/CMS for the past few months on the now well-documented anomalies related to the Risk Adjustment formula as applied to CoOportunity for its limited 2015 plans. We ask that HHS/CMS please review and resolve this issue promptly, and certainly no later than the anticipated June 30 publication of Risk Adjustment charges and payments.

Thank you for your time and attention to this very important subject.

Sincerely,

Daniel L. Watkins
Special Deputy Liquidator of CoOportunity Health

DJS/sm

cc: Nick Gerhart, Liquidator of CoOportunity Health
Douglas J. Schmidt

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United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 113th CONGRESS, SECOND SESSION

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House of Representatives

EXPLANATORY STATEMENT SUBMITTED BY MR. ROGERS OF KENTUCKY, CHAIRMAN OF THE HOUSE COMMITTEE ON APPROPRIATIONS REGARDING THE HOUSE AMENDMENT TO THE SENATE AMENDMENT ON H.R. 83

The following is an explanation of the Consolidated and Further Continuing Appropriations Act, 2015.

This Act includes eleven regular appropriations bills for fiscal year 2015, as well as further continuing appropriations for the Department of Homeland Security Appropriations Act. The divisions contained in the Act are as follows:

- Division A—Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2015;
- Division B—Commerce, Justice, Science, and Related Agencies Appropriations Act, 2015;
- Division C—Department of Defense Appropriations Act, 2015;
- Division D—Energy and Water Development and Related Agencies Appropriations Act, 2015;
- Division E—Financial Services and General Government Appropriations Act, 2015;
- Division F—Department of the Interior, Environment, and Related Agencies Appropriations Act, 2015;
- Division G—Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2015;
- Division H—Legislative Branch Appropriations Act, 2015;
- Division I—Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2015;
- Division J—Department of State, Foreign Operations, and Related Programs Appropriations Act, 2015;
- Division K—Transportation, Housing and Urban Development, and Related Agencies Appropriations Act, 2015;
- Division L—Further Continuing Appropriations, 2015;
- Division M—Expatriate Health Coverage Clarification Act of 2014; and
- Division N—Other Matters.

NOTICE

If the 113th Congress, 2nd Session, adjourns sine die on or before December 24, 2014, a final issue of the *Congressional Record* for the 113th Congress, 2nd Session, will be published on Wednesday, December 31, 2014, to permit Members to insert statements.

All material for insertion must be signed by the Member and delivered to the respective offices of the Official Reporters of Debates (Room HT–59 or S–123 of the Capitol), Monday through Friday, between the hours of 10:00 a.m. and 3:00 p.m. through Tuesday, December 30. The final issue will be dated Wednesday, December 31, 2014, and will be delivered on Monday, January 5, 2015.

None of the material printed in the final issue of the *Congressional Record* may contain subject matter, or relate to any event, that occurred after the sine die date.

Senators' statements should also be formatted according to the instructions at http://webster/secretary/cong_record.pdf, and submitted electronically, either on a disk to accompany the signed statement, or by e-mail to the Official Reporters of Debates at "Record@Sec.Senate.gov".

Members of the House of Representatives' statements may also be submitted electronically by e-mail, to accompany the signed statement, and formatted according to the instructions for the Extensions of Remarks template at https://housenet.house.gov/legislative/research-and-reference/transcripts-and-records/electronic-congressional-record-inserts. The Official Reporters will transmit to GPO the template formatted electronic file only after receipt of, and authentication with, the hard copy, and signed manuscript. Deliver statements to the Official Reporters in Room HT–59.

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By order of the Joint Committee on Printing.

CHARLES E. SCHUMER, *Chairman.*

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

H9307

Printed on recycled paper.

Risk Corridor Program.—In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments.

Ventricular Assist Devices.—The agreement is concerned with the Medicare National Coverage Analysis for Ventricular Assist Devices for Bridge-to-Transplant and Destination Therapy (CAG–00432R), Decision Memo dated October 30, 2013. CMS is encouraged to review the decision, and upon receipt of appropriate new evidence, to consider whether to cover ventricular assist devices for 1) individuals who are undergoing an evaluation to determine candidacy for heart transplantation; and 2) individuals who would be potential heart transplant candidates, but are not eligible because of a contraindication that may be favorably modified by the use of a ventricular assist device.

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT

The agreement includes $672,000,000, to be transferred from the Medicare trust funds, for Health Care Fraud and Abuse Control activities. This includes a base amount of $311,000,000 and an additional $361,000,000 through a budget cap adjustment authorized by section 251(b) of the Balanced Budget and Emergency Deficit Control Act of 1985.

ADMINISTRATION FOR CHILDREN AND FAMILIES

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

Technical assistance, training, and monitoring.—The director of the Office of Community Services should ensure that funds provided for training and technical assistance are provided to organizations with significant expertise working with State, tribal, and local home energy assistance programs.

REFUGEE AND ENTRANT ASSISTANCE

Refugee Social Services.—In allocating social services funding to States, the director of Office of Refugee Resettlement should account for secondary migration of refugees to ensure, to the greatest extent practicable, that funding is allocated based on the total need for such services in the State, and the total number of eligible refugees living in that State. The director should work with national resettlement agencies, State refugee coordinators, and other organizations to determine ways to improve data collection on secondary migration, and the mental and physical health care and housing needs of refugees. Finally, the director should also provide guidance to national resettlement agencies and State refugee coordinators on how to best consult with local stakeholders in the refugee resettlement process.

PAYMENTS TO STATES FOR THE CHILD CARE AND DEVELOPMENT BLOCK GRANT

State plan requirements.—In submitting plans under section 658E of the Child Care and Development Block Grant (CCDBG) Act, States shall include an assurance that CCDBG Act funds received by the State will not be used to develop or implement an assessment for children that will be the primary or sole basis for a child care provider being determined to be ineligible to participate in the program.

CHILDREN AND FAMILIES SERVICES

Head Start Designation Renewal System.—The agreement continues to encourage HHS to consider the unique challenges faced by Head Start providers in remote and frontier areas when reviewing grantees as part of the Designation Renewal System.

Child Abuse Discretionary Activities.—The agreement includes funding to continue the Quality Improvement Center for Research-Based Infant-Toddler Court Teams program. These funds support efforts that bring together the court system, child welfare agencies, health professionals, and community leaders to improve current practices in the child welfare system and make better informed decisions on behalf of the child.

Child Welfare Research, Training and Demonstration.—The agreement includes funding within this program to resume the National Survey of Child and Adolescent Well-Being.

The Administration for Children and Families is encouraged to continue to work with the Department of Housing and Urban Development to improve the availability and coordination of housing, child welfare, and foster care services for older youth in or aging out of the child welfare and foster care systems.

Community Services Block Grant (CSBG).—The Office of Community Services (OCS) is commended for developing additional assessment measures of the CSBG program and management performance at the State, federal and local levels in collaboration with grantees and community action agencies. In addition, the agreement encourages OCS to renew support for implementing a standard of excellence initiative for community action agencies.

The director of OCS should ensure CSBG funding is released to grantees in a timely manner, and instruct grantees to allocate funds to sub-grantees as quickly as reasonably possible. Delays in awarding and distributing these funds can cause unnecessary hardships on both State and local agencies administering these funds and the individuals they serve.

ADMINISTRATION FOR COMMUNITY LIVING

AGING AND DISABILITY SERVICES PROGRAMS

The agreement includes a new general provision that supports implementation of section 491 of the WIOA and the transfer of the National Institute on Disability and Rehabilitation Research, independent living programs under chapter 1 of title VII of the Rehabilitation Act, and programs under the Assistive Technology Act from the Department of Education to the Department of Health and Human Services.

Home- and Community-Based Supportive Services.—ACL is directed to work with States to prioritize innovative service models, like naturally occurring retirement communities, which help older Americans remain independent as they age.

Elder Rights Support Activities.—The agreement includes $7,874,000 for Elder Rights Support Activities, of which $4,000,000 is included for a new Elder Justice Initiative to provide competitive grants to States to test and evaluate innovative approaches to preventing and responding to elder abuse.

Aging Network Support Activities.—The agreement provides $9,961,000 for Aging Network Support Activities. The agreement includes $2,500,000 to help provide supportive services for aging Holocaust survivors living in the United States.

Limb Loss.— Funding and administrative responsibility for the Limb Loss Program is transferred from CDC to ACL in fiscal year 2015 because the program is better aligned with the ACL mission of increasing the independence and well-being of people with disabilities. ACL is directed to work with CDC on a smooth transition of the program, which ensures that support for current grantees is continued in fiscal year 2015.

University Centers for Excellence in Developmental Disabilities (UCEDD).—Within the amount appropriated for UCEDD, the agreement provides no less than the fiscal year 2014 level for technical assistance for the UCEDD network.

Human Services Transportation.—The agreement includes $1,000,000 for a competitive grant or contract for the purpose of providing generally available technical assistance to local government and nonprofit transportation providers. This assistance should focus on the most cost-effective ways to provide transportation assistance to all persons of any age with disabilities.

OFFICE OF THE SECRETARY

GENERAL DEPARTMENTAL MANAGEMENT

Overhead Costs.—The Department is directed to include in its annual budget justification for fiscal year 2016, the amount of administrative and overhead costs spent by the Department for every major budget line. Beginning in fiscal year 2017, and each year thereafter, the agreement directs the Department to include the amount and percentage of administrative and overhead costs spent by the Department for every program, project and activity.

Office of Women's Health.—The agreement includes $3,100,000 to continue the State partnership initiative to reduce violence against women, which provides funding to state-level public and private health programs to improve healthcare providers' ability to help victims of violence and improve prevention programs.

Sports-Related Injuries.—The agreement encourages the Department to investigate the development of new and better standards for testing sports equipment that is supported through independent research, governance, and industrial independence. These standards should actually replicate on-field impacts and produce testing data for ''worst-practical-impact'' conditions. Such standards will lead to research and development of new safety equipment to ensure that athletes have state-of-the-art gear that significantly reduces injuries.

Lupus.—The agreement includes $2,000,000 to continue the national health education program on lupus for healthcare providers, with the goal of improving diagnosis for those with lupus and reducing health disparities. The agreement reflects strong support for this program, which is intended to engage healthcare providers, educators, and schools of health professions in working together to improve lupus diagnosis and treatment through education.

Tribal Lease Agreements.—The agreement encourages the Secretary to work with tribal governments in recognizing the unique circumstances of Native Americans while maximizing their full participation in Federal programs. Specifically, the Secretary should review issues relating to real property lease agreements when such agreements are ''less-than-arm's-length'' as defined under the Office of Management and Budget's Circular A–87. The Secretary should work with tribes in resolving such issues in the future.

Transparency in Health Plans.—The agreement directs the Secretary to provide additional clarification to qualified health plans, based upon relevant and related GAO findings, to ensure greater consistency and full transparency of coverage options included in health insurance plans prior to plan purchase in the marketplace enrollment process. The agreement requests a timeline for such clarifying guidance to be submitted to the House and Senate Committees on Appropriations within 30 days after enactment of this act.

Seafood Sustainability.—The agreement prohibits the Department from using or recommending third party, nongovernmental certification for seafood sustainability.

Healthcare Provider Complaints.—Legislation appropriating funding for the Department of Health and Human Services has carried a general provision relating to health