IN THE UNITED STATES COURT OF FEDERAL CLAIMS

RAYMOND G. FARMER, in his capacity as Liquidator of Consumers' Choice Health Insurance Company, et al.,	:	Case No. 18-1484C
	:	Judge Campbell-Smith
Plaintiffs,	:	
v.	:	
THE UNITED STATES OF AMERICA,	:	
Defendant.	:	

THE UNITED STATES' MOTION TO DISMISS THE COMPLAINT

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INTRODUCTION

Plaintiffs Raymond G. Farmer and Michael J. FitzGibbons (the "Liquidators") bring this case in their capacity as liquidators of the estate of Consumers' Choice Health Insurance Company ("Consumers' Choice"), a now-defunct health insurance company that issued health insurance plans for two years on the health insurance marketplaces created by the Patient Protection and Affordable Care Act ("ACA"). The Complaint—through ten separate causes of action—seeks judgment against the United States, alleging that the Department of Health and Human Services ("HHS") did not pay amounts that the Liquidators claim were owed to Consumers' Choice under an ACA program. However, the Complaint also recognizes that HHS offset the amounts in dispute against debts that the company owed to HHS under related ACA programs.[1] The sole dispute presented in this case concerns the propriety of HHS's exercise of offset. The offsets were proper, as it is well-settled 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).

The Liquidators' myriad of arguments to the contrary—*inter alia*, that the government was precluded from exercising its setoff rights and that a multi-million dollar loan of taxpayer funds to assist Consumers' Choice with start-up costs does not need to be repaid—are devoid of merit and find no support in federal laws, state laws, or the terms of any contract between Consumers' Choice

[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."

and HHS. Further, firmly established principles of sovereign immunity preclude enforcement of any state court orders purporting to vitiate the United States' setoff rights, and the Court lacks jurisdiction to entertain the Liquidators' state law claims. The Complaint should be dismissed in its entirety because it fails to state any claims upon which relief can be granted and because the Court lacks jurisdiction over the state-law claims.

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 United States' use of offset to collect mutual debts was proper.

3. Whether the Liquidators' state law claims should be dismissed for lack of jurisdiction.

BACKGROUND

I. Statutory and Regulatory 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). First, the ACA provides billions of dollars of annual subsidies to help individuals buy insurance. *Id.* at 2489. Second, the ACA generally required individuals to maintain 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.*

[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.

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 health insurance 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 forums through 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 are the only channels through which insurers can market their plans to the millions of individuals who receive federal subsidies. Plans offered through an Exchange generally must be Qualified Health Plans ("QHPs"), meaning that the plans 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]

To ensure that issuers operating on the Exchanges comply with these requirements, Congress required Exchanges to establish certification procedures consistent with guidelines

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[3] HHS administers the Federal-facilitated Exchanges in South Carolina. 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.

established by HHS. 42 U.S.C. § 18031(d)(4); 45 C.F.R. part 156. For Federally-facilitated Exchanges, 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" ("QHP Agreement"). In the QHP Agreements, issuers agree to adhere to privacy and information 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 several interrelated programs, the following of which are relevant to this case.

B. The CO-OP Program

The ACA established the Consumer Operated and Oriented Plan ("CO-OP") program to foster the creation of new consumer-governed, nonprofit health insurance issuers, referred to 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 state(s) 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 that established comprehensive governance and funding provisions. *Id.* § 18042(b)(2)(C)(i), (c)(5). Loan recipients who fail to make timely loan payments 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 Complaint as Exhibit A, Dkt. 1-2.

Consumers' Choice received a start-up loan and a solvency loan, which are subject to the provisions of the CO-OP statute and regulations and to the terms of the respective loan agreement (the "Loan Agreement"). *See* Complaint Exhibit A, Dkt. 1-2. HHS collected the bulk of the start-up loan via offsets performed in September 2016 and March 2017, after Consumers' Choice was declared insolvent and decertified from the CO-OP program. Complaint ¶ 89.[5] The Liquidators argue that the start-up loan is not subject to setoff under state insurance law (Count II) and the Loan Agreement (Count IV).[6]

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

In an effort to mitigate the pricing risks and incentives for adverse selection, the ACA established three interrelated premium-stabilization programs modeled on existing programs established under the Medicare program.[7] 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.

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[5] Consumers' Choice owes the United States an additional $314,000 under the start-up loan. Complaint ¶ 152.

[6] Although the Consumers' Choice has not repaid any of the $68.9 million solvency loan, collection of that loan is not at issue in this case.

[7] *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, based on a retrospective evaluation of the risk pool. 42 U.S.C. § 18061. The reinsurance program was designed to mitigate the losses that QHP issuers would incur as a result of insuring high-risk individuals who entered the insurance pool as a result of the ACA. *Id*. 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 (including, as relevant here, South Carolina) but one deferred to HHS to administer their reinsurance programs as set forth in the ACA's state flexibility provision, *id.* § 18041.[8] *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); *see also* Complaint ¶ 16 ("South Carolina . . . elected for HHS to operate the Reinsurance program.").

Here, the Liquidators seek to recover amounts owed to Consumers' Choice through the reinsurance program. They contend that the reinsurance payments should have been made to Consumers' Choice, rather than offset against the debts that the company owed to HHS under other programs.

[8] 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.

2. The Temporary Risk Corridors Program

The risk corridors program was created by section 1342 of the ACA and, like the reinsurance program, 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. § 18062.[9] 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).

Under the risk corridors program, if a participating plan's premiums exceeded its costs by a certain amount (as determined by a statutory formula), the plan would pay a share of their profits to HHS—"payments in." 42 U.S.C. § 18062(b)(2). Conversely, if a participating plan's costs of providing coverage exceeded the premiums they received by a certain amount (according to the same formula), the plan would be paid a share of their excess costs by HHS—"payments out." *Id.* § 18062(b)(1).

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).[10] Consistent with its three-year framework for administering the program, HHS issued prorated payments according to the extent of collections. The ACA did not appropriate any funding for

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

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

risk corridors payments. Instead, Congress deferred the issue of funding to the annual appropriations process. And in subsequent legislation, Congress appropriated "payments in," but barred HHS from using other potential funding sources. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, 128 Stat. 2130, 2477; 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.[11] 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.").

In a set of four recent decisions, the Federal Circuit gave effect to Congress's express restrictions on funding for risk corridors payments and held that HHS was not liable for full "payments out" to issuers. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 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), *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*, 729 Fed. Appx. 939 (Fed. Cir. 2018) (affirming for reasons stated in *Moda*); *Blue Cross and Blue*

[11] 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.

Shield of North Carolina v. United States, 131 Fed. Cl. 457 (2017), *aff'd*, 729 Fed. Appx. 939 (Fed. Cir. 2018) (same) ("BCBSNC"). The issuers have now sought certiorari from the United States Supreme Court.[12]

The risk corridors program is not substantively at issue in this case, but the Liquidators argue that HHS's offsetting of reinsurance payables to Consumers' Choice against amounts owed to HHS under other ACA programs violated state and federal laws (Counts I, II, VII-X) and the QHP Agreement (Count III). In addition, the Liquidators' allegation that "Consumers' Choice is owed more than all of the claimed debts . . . subject to set-off," Complaint ¶ 91, may refer to risk corridors amounts that the Liquidators are seeking in a related action. *Farmer v. United States*, No. 17-363 (Ct. Fed. Cl.) (Campbell-Smith, J.); Complaint ¶ 14 n.1.

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 disproportionate numbers of healthy or sick individuals. 42 U.S.C. § 18063. The risk adjustment program mitigates the impact of adverse selection by 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. Health insurance issuers that offer coverage within the individual or small group markets within a

[12] Notwithstanding Congress's spending restriction and this binding precedent from the Federal Circuit, the Liquidators maintain that "the Government lacks statutory authority to pay anything less than 100% of the Risk Corridors payments due to Consumers' Choice, and is legally obligated to make full payment." Complaint ¶ 38.

state are subject to risk adjustment, with limited exceptions. *Id.* § 18063(c).[13] Like the risk corridors program, the risk adjustment program is not substantively at issue in this case.

D. Federal Consumer Subsidies

The ACA also created several temporary and permanent programs designed to facilitate and support the ACA's primary reforms. The most significant source of financial transfers between issuers and HHS under the ACA had been the monthly federal insurance subsidy of advance premium tax credit ("APTC") and cost-sharing reduction ("CSR") payments. In order to make insurance more affordable, the ACA subsidized many individuals' monthly health insurance premiums and their episodic cost sharing requirements (*i.e.*, deductibles, copays, and coinsurance). These subsidies were only available as part of individual QHPs obtained through an Exchange. 42 U.S.C. § 18071(f)(2). Rather than provide this assistance directly to eligible individuals after-the-fact or in advance to pay to their health insurers, the Department of Treasury paid these subsidies in advance to eligible individuals' insurers based on estimates derived from issuer-provided data. 42 U.S.C. § 18082. And, if these advance monthly payments wound up being too low (or too high), further payments (or collections) reconciled the difference. *See, e.g.*, 26 C.F.R. § 1.36B-4; 45 C.F.R. § 156.430.[14]

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[13] 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.

[14] In October 2017, in response to an inquiry from the Departments of Treasury and HHS, the Attorney General concluded that the permanent appropriation that had been funding CSR payments could not be used. Available at https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf. In response, HHS issued a memorandum explaining that CSR payments were prohibited unless and until such payments have a valid appropriation. *Id.*

Although these federal consumer subsidies are not substantively at issue in this case, the Liquidators argue that HHS's offsetting of the subsidies owed to and from Consumers' Choice against amounts owed to HHS under other ACA programs was unlawful. Complaint ¶¶ 88-90.

E. 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 allowing it to 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 from funds under the 3R programs. 78 Fed. Reg. at 72,370.

Here, the Liquidators argue that HHS's use of netting to administer the 3Rs violates federal and state laws (Counts I, II, VII-X) and the QHP Agreement (Count III).

II. Consumers' Choice's Participation in South Carolina's Exchange and Subsequent Liquidation

Consumers' Choice is a former CO-OP that issued health insurance plans sold on the Exchange in South Carolina from January 2014 until October 2015. Complaint ¶¶ 44-46, 51, 74-79. Under the CO-OP program, Consumers' Choice received a total of $87.6 million in taxpayer funds from HHS, comprised of an $18.7 million start-up loan and $68.9 million in solvency funds. *Id.* ¶ 47. During its short existence, Consumers' Choice also received the federal consumer subsidies, participated in the 3Rs programs for those benefit (and calendar) years, and was subject to HHS's monthly payment and collection cycle.

At Consumer Choice's inception, South Carolina insurance law required the solvency loan to be recognized as surplus and not as debt. Loan Agreement Appendix 10, Dkt. 1-2.[15] The South Carolina Department of Insurance issued a letter to that effect, *id*; no such acknowledgment was issued with respect to the start-up loan.

In October 2015, the Liquidators requested that the start-up loan be reclassified as a surplus note, and "[HHS] advised that it would not approve the reclassification[.]" *See* Rehabilitation Order, *infra*, at ¶ 11. In financial statements submitted by the Liquidators to the State Court in March 2016, December 2016, June 2017, December 2017, and June 2018, the Liquidators represented to the State Court that the start-up loan is a "liability" and the solvency loan is "capital."[16]

On October 22, 2015, Consumers' Choice was placed into supervision. Complaint ¶ 74. The next day, the company agreed to wind down its operations. Complaint ¶ 75. On January 8, 2016, the Richland County Court of Common Pleas (the "State Court") entered an order for rehabilitation (the "Rehabilitation Order"), Complaint ¶ 77, and on March 28, 2016, entered an order for liquidation (the "Liquidation Order"), Complaint ¶ 79.[17]

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[15] Because the Liquidators failed to include Appendix 10 of the Loan Agreement, it is attached to this Motion. Appendix A1-A2.

[16] Available at http://www.cchpsc.org/liquidation-details. For the Court's convenience, copies are provided at Appendix A34-A58.

[17] Although the Liquidators cite to and quote from the Rehabilitation Order and Liquidation Order, Complaint ¶¶ 79-81, 90, 110, they did not attach copies to the Complaint. For the sake of completeness, copies are provided to the Court at Appendix A3-A25. The Rehabilitation Order and Liquidation Order are also publicly available. *See* www.cchpsc.org/wp-content/uploads/2016/08/Rehabilitation_Consent_Order_January_8_2015_CCHP.pdf; www.cchpsc.org/wp-content/uploads/2016/08/CCHIC_Order_of_Liquidation_March_28_2016.pdf.

Throughout this time, HHS continued to administer the 3Rs programs. In summer 2015, the agency determined that Consumers' Choice was entitled to receive reinsurance payments for the 2014 benefit year but owed HHS 2014 risk adjustment charges.[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 Consumers' Choice, including 2014 reinsurance payments.

Subsequently, on November 19, 2015, HHS announced that Consumers' Choice's risk corridors payment for the 2014 benefit year was calculated at $12.4 million, of which HHS would pay a prorated amount of $1.57 million in the forthcoming payment cycles. *See* Complaint ¶ 55; *see also* CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, at Table 41.[19] In March 2016, because Consumers' Choice was both insolvent and indebted to the United States, HHS placed an administrative hold on the company's accounts, with the result that payments to Consumers' Choice were not released to the estate but rather were held for offset to collect debts owed to the United States. Complaint ¶ 88.[20]

On June 30, 2016, HHS announced that Consumers' Choice owed risk adjustment charges and was entitled to receive reinsurance payments for the 2015 benefit year. *See* Complaint ¶¶ 20,

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[18] *See also* 2014 Reinsurance and Risk Adjustment Summary Report at 38 available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

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

[20] Although the March 8, 2016 letter is referenced in the Complaint, the Liquidators did not attach a copy. For the sake of completeness, a copy is provided to the Court at Appendix A26.

83; 2015 Reinsurance and Risk Adjustment Summary Report, at 46.[21] In the August 2016 payment cycle, HHS collected Consumers' Choice's 2015 risk adjustment charges, as well as CSR, APTC, and user fee charges, by netting approximately $21.7 million from 2015 reinsurance payments and other ACA program payments due to Consumers' Choice. *See* Complaint ¶ 89.[22] In the September 2016 payment cycle, HHS collected approximately $11 million of the start-up loan by offsetting it against Consumer Choice's 2015 reinsurance receivable. Complaint ¶ 89.[23] In the January 2017 payment cycle, HHS collected another $2.2 million of the start-up loan and other ACA debts through offset against Consumer Choice's 2015 receivables for reinsurance, risk corridors, and other ACA programs. Complaint ¶ 89.[24] In the March 2017 payment cycle, HHS collected another $2.3 million of the start-up loan[25] through offset against Consumer Choice's 2015 reinsurance receivable. Complaint ¶ 89.[26] By the Liquidators' estimation, HHS collected $37.2 million through netting. *Id.*

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[21] 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.

[22] Although the August 11, 2016 letter advising Consumers' Choice of the offsets is referenced in the Complaint, the Liquidators did not attach a copy. For the sake of completeness, a copy is provided to the Court at Appendix A27-A30.

[23] Although the September 29, 2016 letter advising Consumers' Choice of the offsets is referenced in the Complaint, the Liquidators did not attach a copy. For the sake of completeness, a copy is provided to the Court at Appendix A31.

[24] Although the January 19, 2017 letter advising Consumers' Choice of the offsets is referenced in the Complaint, the Liquidators did not attach a copy. For the sake of completeness, a copy is provided to the Court at Appendix A32.

[25] As noted above, Consumers' Choice owes the United States an additional $314,000 under the start-up loan. Complaint ¶ 152.

[26] Although the March 31, 2017 letter advising Consumers' Choice of the offsets is referenced in the Complaint, the Liquidators did not attach a copy. For the sake of completeness, a copy is provided to the Court at Appendix A33.

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 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 Complaint. As explained below, Counts VII, VIII and IX assert claims based on state law and therefore are beyond the jurisdiction provided by the Tucker Act and also should be dismissed under Rule 12(b)(1). In addition, and as argument in the alternative, all ten counts should be dismissed under Rule 12(b)(6) for failure to state claims upon which relief can be granted.

ARGUMENT

Although the Liquidators assert ten separate causes of action, the crux of the Complaint and underlying each theory is the assertion that HHS's offsets were improper. As explained below,

each of the Liquidators' theories—whether grounded in statute, contract, or the Constitution—fails to state a claim upon which relief can be granted. Accordingly, each claim should be dismissed.

I. The Offset Claims Fail as a Matter of Law

In Counts I and II, the Liquidators assert numerous statutory and regulatory theories as to why the United States should have made reinsurance payments directly to Consumers' Choice, rather than offsetting those amounts against the company's outstanding debts to HHS under other ACA programs. Each of the Liquidators' theories fails 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, 852 (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, Complaint ¶ 90, cannot be reconciled with this authority.

Also lacking merit is the allegation that HHS's offsets were "improper" because the United States' liability to Consumers' Choice exceeded Consumer's Choice's debts. Complaint ¶ 91. If that were true, any balance would have been paid to Consumers' Choice's estate. Further, the only amounts identified by the Liquidators to support their excess liability allegation are risk corridors amounts in excess of Consumers' Choice's pro rata share, Complaint ¶ 38, and the Federal Circuit has already determined that issuers, including Consumers' Choice, are not entitled to additional risk corridors payments beyond their pro rata shares. *See Moda*, 892 F.3d at 1331; *Land of Lincoln*, 892 F.3d at 1185.[27] The Liquidators fail to identify any amounts owed to Consumers' Choice in excess of the amounts setoff by HHS.

B. South Carolina Law Authorizes HHS's Use of Offset

South Carolina law not only allows mutual debts to be setoff, but *requires* it. The South Carolina Rehabilitation and Liquidation Act (the "Liquidation Act") provides: "Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding

[27] The Liquidators also complain about HHS's temporary administrative hold of Consumers' Choice's payables to effectuate the agency's offset rights. Complaint ¶¶ 109(e), 110. But the operative legal dispute concerns not the temporary hold, but the propriety of HHS's use of offset. The hold 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).

under this chapter ***must*** be set off and the balance only may be allowed or paid[.]" S.C. Code § 38-27-490(a) (emphasis added).[28] South Carolina's equitable and common law is in accord, permitting offset without regard to a party's solvency. *Carwile v. Metropolitan Life Ins. Co.*, 134 S.E. 285, 291 (S.C. 1926) ("the very fact of insolvency of a creditor against whom a set-off is claimed creates an equity permitting the set-off"); *W.M. Kirkland, Inc. v. Providence Washington Ins. Co.*, 264 S.C. 573, 581 (1975) ("the insolvency of a party against whom set-off is claimed is sufficient ground for equitable interference"). Therefore, the Liquidators' assertion that offset is contrary to South Carolina law, Complaint ¶ 90, ignores the content of that very law.

C. Distribution Priority Does Not Hinder HHS's Right of Offset

Notwithstanding the Liquidation Act's mandate that mutual debts be setoff, S.C. Code. § 38-27-490(a), the Liquidators contend that HHS's use of offset violated another provision of the Liquidation Act, S.C. Code § 38-27-610, which governs the order in which an insolvent debtor's claims are paid. Complaint ¶¶ 71, 89, 109(c), 110, 180-83. 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

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[28] As established here and also addressed below, the Liquidators' assertions that HHS's offsets violate "state law," Complaint ¶ 90, and the Liquidation Act, Complaint ¶¶ 96, 97, 109(b), (c), (d), and Counts VII, VIII, and IX, cannot be squared with the plain language of this provision of the Liquidation Act.

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 the distribution priority enunciated in § 38-27-610 does not hinder HHS's right of offset, the Liquidators' theory lacks merit.

D. The Start-Up Loan Is a Loan, Not a Capital Contribution

The Liquidators' theory that "Start-up and Solvency Loans . . . are, in effect, capital contributions rather than loans," Complaint ¶ 95, is belied by the record. The ACA is clear: start-up loans are "loans." 42 U.S.C. § 18042(b)(1)(A). Consumers' Choice's start-up loan bears all of the traditional indicia of a loan: it has a fixed maturity date and repayment schedule, *id.* § 18042(b)(3), Loan Agreement § 4.4 (5 years), Dkt. 1-2; 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).

If there were any doubt, the Liquidators' treatment of the start-up loan confirms that it was never considered a capital contribution. In October 2015, the Liquidators requested that the start-up loan be reclassified as a surplus note, and "[HHS] advised that it would not approve the reclassification[.]" *See* Rehabilitation Order at ¶ 11. Subsequently, in all four financial statements submitted by the Liquidators to the State Court, the Liquidators represented to the State Court that

the start-up loan was a "liability" and that the solvency loan was "capital." *See* Appendix A34-A58.

Further, South Carolina regulators required that the solvency loan be treated as a capital contribution, Loan Agreement, at Appendix 10, attached as Appendix A1-A2, but made no similar requirement for the start-up loan. *See also* 45 C.F.R. § 156.520(a)(2) (requiring that the solvency loan be structured in a manner that it is recognized as capital rather than debt). The start-up loan is a loan (not a capital contribution) and the Liquidators allege no other plausible inference.

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

The Liquidators also rely on selective passages from the State Court's Rehabilitation Order and Liquidation Order to suggest the State Court stripped HHS of its offset rights. Complaint ¶¶ 79-81, 90, 110. But the Liquidators' suggestion that the State Court negated the United States' right of offset finds no support in the language of the orders, and should be rejected for its inconsistency with the Liquidation Act. *See* S.C. Code § 38-27-490(a) ("Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter *must* be set off and the balance only may be allowed or paid[.]") (emphasis added).

As an initial matter, nothing in the State Court orders prohibits setoff. The Liquidators baldly allege a prohibition on setoff, without reference to or citation of any contents of the orders. *See* Complaint ¶¶ 90, 110. Rather, the Liquidators appear to rely on S.C. Code § 38-27-70 of the Liquidation Act, Complaint ¶¶ 77, 81-82, which allows injunctive relief to prevent eleven particular actions.[29] But offsets are not prohibited by this section. That is no surprise because, as

[29] The Liquidators cite to subsections "(a)(4) and (11)" of S.C. Code § 38-27-70. Those subsections do not exist, but the Complaint appears intended to reference subsections (a)(1)(d) and (a)(1)(k) and has been treated as such.

discussed previously, South Carolina law requires that mutual debts be setoff. *See* S.C. Code § 38-27-490(a).

In any event, the State Court orders could not bind the United States because Congress has not waived sovereign immunity such that the State Court could enjoin HHS's use of netting in administering the 3Rs. *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 Consumers' Choice'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).[30] The State Court's orders could not have hindered the United States' lawful exercise of setoff.

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[30] 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

F. The Executive Order Did Not Create Any Enforceable Rights

The Liquidators also cite to Executive Order No. 13765 (2017) and assert that the United States' actions "violate" the order. Complaint pg. 2 and ¶ 111. But the order expressly "is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States[.]" *Id.* at § 6(c). There simply "is no private right of action to enforce obligations imposed on executive branch officials by executive orders." *Facchiano Const. Co. v. U.S. Dep't of Labor*, 987 F.2d 206, 210 (3d Cir. 1993). Counts I and II should be dismissed.

II. The Liquidators' Contract Claims (Counts III-VI) Fail

In Counts III, IV, V, and VI, the Liquidators assert express and implied contract claims seeking "full" reinsurance payments, contending that the United States breached the QHP Agreements, the Loan Agreement, an implied-in-fact contract, and the covenant of good faith and fair dealing, respectively. But as discussed above, the Liquidators do not actually dispute that Consumers' Choice received its full reinsurance payment. Instead, they contend that the reinsurance payment should have been paid to Consumers' Choice, rather than being offset against the company's debts to HHS stemming from other ACA programs. Because HHS's offsets did not breach any contractual obligations, the Liquidators' various contract theories fail.

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).

A. Count III Fails Because the QHP Agreements Are Wholly Unrelated to the Reinsurance Program

In Count III, the Liquidators rehash the same contract theories that the Federal Circuit rejected already, contending that the United States breached the QHP Agreements by not making reinsurance payments directly to Consumers' Choice, and instead offsetting those amounts against the company's ACA debts. Complaint ¶¶ 116-27. Like the insurers in *Land of Lincoln* and *Moda*, who contended that the QHP Agreements created a contractual right to risk corridors payments, the Liquidators premise Count III on the "systems and processes" language in the QHP Agreements, Complaint ¶ 118, and general choice of law provisions, Complaint ¶¶ 121-22.

The Court must begin its analysis with the plain language of the QHP Agreements. *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1038 (Fed. Cir. 2003) (en banc). Even a cursory reading of the QHP Agreements reveals that they have nothing to do with reinsurance. "The [QHP] agreements . . . 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, *aff'd,* 892 F.3d 1184 (Fed. Cir. 2018) (citation omitted). As the Court observed, HHS's obligation "to implement systems and processes" must be read in its proper context within the QHP agreements; that context concerns the QHP's handling of consumer data and its use of HHS's "Data Services Hub Web Services." *Id.* Given this context, "systems and processes" relates to the electronic system that HHS and the QHP issuer will be using, and the processes that support this electronic system." *Id.* The "systems and processes" language does not give rise to any reinsurance obligation. *Id.* ("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, *aff'd,* 729 Fed. Appx. 939 (Fed. Cir. 2018) ("[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.").

Nor do the QHP Agreements' general references to federal law and regulations incorporate the reinsurance provisions. *Land of Lincoln*, 129 Fed. Cl. at 109. ("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. *See Land of Lincoln*, 129 Fed. Cl. at 110; *Moda*, 892 F.3d at 1330-31 (rejecting the claim that the government breached a contract to make risk corridors payments). Because HHS has not breached any of its obligations under the QHP Agreements, Count III should be dismissed.

B. Count IV Fails Because the Loan Agreement Permits Offset of the Start-Up Loan

At Count IV, the Liquidators contend that HHS is bound by the Loan Agreement to forgo offset of the start-up loan. Complaint ¶¶ 129-36. This theory contradicts the plain language of the Loan Agreement, which 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. 1-2 (emphasis added).

Relying on a different section of the Loan Agreement (Section 3.4), the Liquidators contend that HHS's use of offset violates the subordination terms of the Loan Agreement. Complaint ¶¶ 131, 134. But the Loan Agreement's subordination provision only applies "while [Consumers' Choice] *is operating* as a CO-OP," which Consumers' Choice clearly was not when HHS collected the start-up loan by offset, having been decertified and placed in liquidation. Loan Agreement § 3.4, Dkt. 1-2 (emphasis added).

Moreover, Section 3.4 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. HHS's use of offset therefore does not violate the Loan Agreement, and Count IV should be dismissed.

C. Count V Fails Because No Implied-In-Fact Contract Existed or Was Breached

In Count V, the Liquidators assert that section 1341 of the ACA, 45 C.F.R. § 153.210, and HHS's "representations" indicate an intent to contract for, and an offer of, "full" reinsurance payments, and that Consumers' Choice accepted the offer. The Liquidators further allege that this implied contract is evidenced by "the execution by the parties of the QHP Agreement." Complaint ¶ 144. This theory fails for four reasons: (1) the United States had no intent to contract; (2) no HHS official had authority to bind the United States in contract; (3) the United States did not breach any duty; and (4) any breach-of-implied-in-fact contract claim premised on the QHP Agreements is duplicative of the Liquidators' claims for breach of those express contracts.

1. The United States Had No Intent to 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). But as the Federal Circuit has already held with regard to the risk corridors program, "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."). 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.").

Moreover, an unambiguous offer and acceptance cannot be inferred from the language or circumstances of the reinsurance program. Just as "Section 1342 and the implementing regulations make no explicit reference to an offer or contract," *Land of Lincoln*, 129 Fed. Cl. at 112 (citations omitted), section 1341 and its implementing regulation make no reference to an offer or contract.

See 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."). Similarly, HHS's rulemaking and guidance regarding the reinsurance program contain no language that can plausibly be construed as an unambiguous offer. Because section 1341 and the implementing regulations do not constitute an offer or invite acceptance by performance, no intent to contract can be divined, and no implied-in-fact contract was formed.

2. HHS Officials Lacked Authority to Bind The United States

The Liquidators do not and cannot allege, beyond a mere legal conclusion, that any HHS official enjoyed authority to bind the government in contract for "full" reinsurance 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 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 the ACA, much less section 1341, authorizes any federal official to enter into a contract to make reinsurance 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.

3. If an Implied-in-Fact Contract Existed, The United States Did Not Breach It by Setting Off Mutual Debts

Nor can the Liquidators establish that HHS breached a contractual obligation. For the Liquidators to recover on a breach of contract claim, they must establish both the existence of a valid contract with HHS and the breach of a duty created by that contract. *See Anderson v. United States*, 73 Fed. Cl. 199, 201 (2006). Any contractual obligation here could extend no farther than what is required by the relevant statutes and regulations. The statute and regulations do not preclude offsets, and, moreover, HHS promulgated a regulation allowing netting, which is a form of offset. 45 C.F.R. § 156.1215. HHS thus cannot have breached any implied contract by lawfully exercising its offset rights.

4. The Implied-in-Fact Contract Claim Duplicates the Relief Sought in the Express Contract Claims

Finally, the contention that an implied contract is evidenced by the QHP Agreements fails because an implied contract cannot be grounded in an express contract. *Durant v. United States*, 16 Cl. Ct. 447, 452 (1998) ("Because plaintiffs' implied-in-fact contract argument is grounded on the same facts as the express contract, the existence of the express contract precludes the court from finding an implied in fact contract"); *accord Bank of Guam v. United States*, 578 F.3d 1318, 1329 (Fed. Cir. 2009) (collecting cases). The QHP Agreements established the relevant contractual parameters of Consumers' Choice's offering of QHPs on an Exchange, and those parameters required only that Consumers' Choice meet certain data transmission and security requirements before it could participate on an Exchange. The Liquidators cannot now inject additional contractual obligations (or prohibitions) by recourse to an implied contract theory.

For each of the foregoing reasons, Count V should be dismissed.

D. Count VI Fails Because the Liquidators Fail to Allege That HHS Breached Any Duty Contained in Any Contract

The Liquidators allege in Count VI that the United States breached the implied covenant of good faith and fair dealing by offsetting Consumers' Choice's reinsurance payment against other ACA debts owed to HHS, rather than paying the reinsurance amount to Consumer's Choice. Compl. ¶¶ 158-59. This claim fails because HHS did not undermine any promise of any contract.

A party breaches the implied duty of good faith and fair dealing when it interferes with the other party's performance or destroys the reasonable expectations of the other party regarding the fruits of the contract. *Dobyns v. United States*, 915 F.3d 733, 739 (Fed. Cir. 2019) (quoting *Centex Corp. v. United States*, 395 F.3d 1283, 1304 (Fed. Cir. 2005)). "But the implied duty of good faith and fair dealing cannot expand a party's contractual duties beyond those in the express contract or create duties inconsistent with the contract's provisions. Instead, any breach of that duty has to be connected, though it is not limited, to the bargain struck in the contract." *Id.* (internal quotation marks and citations omitted). While "a breach of the *implied* duty of good faith and fair dealing does not require a violation of an *express* provision in the contract," *Metcalf Constr. Co. v. United States*, 742 F.3d 984, 994 (Fed. Cir. 2014) (emphasis in original), "a specific promise must be undermined for the implied duty to be violated," *Dobyns*, 915 F.3d at 739.

Here, the Liquidators fail to identify any promise by the United States that was undermined by HHS's use of offset or any contractual obligation of the United States that suggests HHS would not exercise its setoff rights. Nor do they allege that the United States interfered with Consumers' Choice's performance under any contract. Because the Liquidators have failed to identify any specific contractual promise that was undermined by HHS's use of netting, Claim VI should be dismissed.

III. The State Law Claims (Counts VII, VIII, and IX) Should Be Dismissed

In Counts VII, VIII, and IX, the Liquidators assert that HHS's offsets violated three provisions of the Liquidation Act. Complaint ¶¶ 169-89. As an initial matter, the Tucker Act does not provide jurisdiction in this Court for state law claims. Regardless, none of the three cited provisions address setoff, much less suggest that offset is improper. And even if those state law provisions were determined to prohibit setoff, the provisions would be preempted by the ACA. The state law claims fail as a matter of law.

A. The Tucker Act Does Not Provide Jurisdiction Over the State Law Claims

The Tucker Act, under which the Liquidators assert jurisdiction, Complaint ¶ 4, waives sovereign immunity for certain non-tort claims against the United States founded upon the Constitution, a federal statute or regulation, or a contract. 28 U.S.C. § 1491(a)(1). The Tucker Act "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). "Thus, jurisdiction 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).

"Claims founded on state law are . . . outside the scope of the limited jurisdiction of the Court of Federal Claims." *Souders v. South Carolina Pub. Serv. Auth.*, 497 F.3d 1303, 1307 (Fed. Cir. 2007) (citations omitted). Even if a plaintiff "avers that he is entitled to compensation under [state law] . . . the Court of Federal Claims does not have jurisdiction over claims founded on state law." *Cabral v. United States*, 317 Fed. Appx. 979, 981-82 (Fed. Cir. 2008) (citation omitted).

Nor can the Court hear state law claims based on supplemental jurisdiction. Under 28 U.S.C. § 1367, only district courts are authorized to exercise supplemental jurisdiction. *See Hall v. United States*, 69 Fed. Cl. 51, 57 (2005); *Waltner v. United States*, 98 Fed. Cl. 737, 765 (2011), aff'd, 679 F.3d 1329 (Fed. Cir. 2012); *Trek Leasing, Inc. v. United States*, 62 Fed. Cl. 673, 678 (2004).

Here, Counts VII, VIII, and IX assert only state law claims. Because the Court lacks jurisdiction over those claims, they should be dismissed under Rule 12(b)(1).

B. The State Law Claims Also Fail to State Claims Upon Which Relief Can be Granted

1. The Sections of the Liquidation Act Relied Upon by the Liquidators Do Not Prohibit Offset

The Liquidators' assertions that HHS's offsets violated three provisions of the Liquidation Act fail at the threshold because those provisions do not prohibit setoff. In fact, none of the cited provisions, S.C. Code §§ 38-27-510, -610, and -470, so much as mentions offsets. Section -510 deals with reinsurers; section -610 deals with the priority of distributions from the insurer's estate; and section -470 deals with voidable transfers of property by a liquidating insurance company. But another section of the Liquidation Act directly addresses offsets, and requires that mutual debts be set off. S.C. Code § 38-27-490(a).

Here, the Liquidators' theories in Counts VII, VIII, and IX require the Court to ignore a provision expressly requiring offset, S.C. Code § 38-27-490(a), while reading a prohibition against setoff into other provisions that have nothing to do with offset, S.C. Code §§ 38-27-510, -610, and -470. For this reason alone, the Court should dismiss Counts VII, VIII, and IX.

2. The ACA Preempts State Laws That Conflict With ACA Programs

The Liquidators' claims for violations of the Liquidation Act also fail because those provisions are preempted by the ACA to the extent that they would interfere with HHS's administration of the ACA via offset. 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) (citation omitted); *see also Blair v. United States*, 515 F.3d 1323, 1329 (Fed. Cir. 2008) ("As the Supreme Court has explained, 'state law is naturally preempted to the extent of any conflict with a federal statute.'"); *United States v. Rhode Island Ins. Insolvency Fund*, 80 F.3d 616, 619-23 (1st Cir. 1996) (holding that the federal Medicare Secondary-Payer Act, rather than state law, governed the United States' rights in insurance insolvency); *Geston v. Anderson*, 729 F.3d 1077, 1079 (8th Cir. 2013) (affirming district court holding that federal Medicaid Act preempted state insurance law regarding treatment of annuity payments); *Gunter v. Farmers Ins. Co.,* 736 F.3d 768, 772 (8th Cir. 2013) (holding that National Flood Insurance Act and related regulations preempted state insurance law).

Consistent with this jurisprudence, Congress made clear that the ACA preempts any state law that "'hinder[s] or impede[s]' the implementation of the ACA[.]" *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) (citing 42 U.S.C. § 18041(d)). And consistent with the ACA's preemption provision, the Loan Agreement between HHS and Consumers' Choice provided that the Agreement would "be governed by the laws and common law of the United States, including without limitation such regulations as may be promulgated from time to time by HHS . . . and by the laws of the State of South Carolina *to the extent the same do not conflict with applicable Federal law*." Loan Agreement § 19.2 (emphasis added); *see also id.* § 6.3 ("In the event any payment due under this Agreement is delinquent for more than 180 days . . . Lender

shall refer the matter to the United States Department of Justice for processing and other Federal action, *in accordance with the terms of applicable Federal law*.") (emphasis added).[31]

Here, the Liquidators seek to use provisions of the Liquidation Act to prohibit HHS from netting, which would impede HHS's administration of the ACA. HHS relies on netting to facilitate its monthly payments and collections cycle, which is necessary for HHS to make timely payments to insurers that are due funds under the 3R programs. 78 Fed. Reg. at 72,370. Application of the Liquidation Act, as suggested by the Liquidators, would impede that crucial system to the detriment of the ACA programs. Accordingly, if the Court concludes it has jurisdiction over the claims arising under the Liquidation Act, the claims should be dismissed as the state law is preempted by federal law.

[31] The Liquidators' position may be based on the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), under which state law is not preempted by federal law if: (1) the federal law at issue does not specifically relate to the business of insurance; (2) the state law at issue was enacted for the purpose of regulating the business of insurance; and (3) application of the federal law would "invalidate, impair or supersede" the state law. *See, e.g.*, *Rhode Island Ins. Insolvency Fund*, 80 F.3d at 619 (citation omitted). The Supreme Court has held that, as a result of the McCarran-Ferguson Act, state law may, under certain circumstances, apply the rule of decision for determining the federal government's priority in an insurance insolvency. *See generally United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993). But *Fabe* held only that the McCarran-Ferguson Act causes state insolvency laws to take precedence over the Federal Priority Statute, 31 U.S.C. § 3713, to the extent such laws prioritize policyholder and administrative expense claims. The Court specifically noted that state law would not apply to the extent it prioritized "other categories of claims" over those of the United States. 508 U.S. at 493-94. Furthermore, *Fabe* concerned the United States' commercial interests as obligee on various surety bonds and not its sovereign interests as administrator of a federal program. Therefore, *Fabe* did not consider the interplay between the McCarran-Ferguson Act and federal lending programs, and does not apply to this case. And the ACA *does* specifically relate to the business of insurance, so the McCarran-Ferguson Act is irrelevant. "[W]hen Congress enacts a law specifically relating to the business of insurance, that law controls." *Humana Inc. v. Forsyth*, 525 U.S. 299, 306 (1999).

3. Count VII (Violation of S.C. Code § 38-27-510) Fails Because the United States Is Not a "Reinsurer"

In Count VII, the Liquidators assert that the United States, in administering section 1341 "is acting as a reinsurer" and violated S.C. Code § 38-27-510, which provides that amounts recoverable from "reinsurers" may not be reduced as a result of delinquency proceedings. This argument fails on its face. South Carolina law defines a "reinsurer" as "a person, a firm, an association, or a corporation licensed in [South Carolina] . . . as an insurer with the authority to assume reinsurance." S.C. Code § 38-46-20. The United States is a sovereign nation administrating a nationwide program, not an insurance company assuming reinsurance. Because the United States clearly is not a "reinsurer," Count VII should be dismissed.

4. Count VIII (Violation of S.C. Code 38-27-610) Fails Because Offsets Do Not Affect the Priority of Distributions

In Count VIII, the Liquidators assert that the United States' use of administrative hold violated South Carolina's priority statute. S.C. Code § 38-27-610. But as explained above, HHS's right to set off mutual debts attaches independent of distribution priority. *See* supra at 18-19. Moreover, South Carolina law requires offset of mutual debts. *Id.* at 17-18. Count VIII should be dismissed.

5. Count IX (Violation of S.C. Code 38-27-470) Fails Because HHS's Offsets Are Not Voidable Preferences

In Count IX, the Liquidators assert that HHS's offsets were a voidable transfer in violation of S.C. Code § 38-27-470, which allows liquidators to avoid certain transfers of a liquidating insurers' property. Section 38-27-470(a)(1) defines a "preference" as "a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt . . . the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive." The statute goes on to define a set of

preferences that are voidable at a liquidator's discretion, and permits the liquidator to recover the property (or its value) if the liquidator voids the preference. *Id.* § 38-27-470(a)(2)-(3). But again, nothing in this provision of the Liquidation Act suggests that an offset constitutes a "preference," especially because another provision of the Liquidation Act expressly requires that mutual debts be set off. S.C. Code § 38-27-490(a). Because the offset of mutual debts does not constitute a voidable preference, Count IX should be dismissed.

IV. The Takings Claim (Count X) Fails to State a Claim Upon Which Relief Can Be Granted

The Liquidators allege at Count X that Consumers' Choice had a property interest in reinsurance payments and that its property was "taken" by HHS's use of offset, in violation of the Fifth Amendment's Takings clause. Complaint ¶¶ 191-95. Courts use a two-part test to evaluate whether governmental action constitutes a taking under the Fifth Amendment. "First, the court determines whether the claimant has identified a cognizable Fifth Amendment property interest that is asserted to be the subject of the taking. Second, if the court concludes that a cognizable property interest exists, it determines whether that property interest was 'taken.'" *Acceptance Insurance Cos., Inc. v. United States*, 583 F.3d 849, 854 (Fed. Cir. 2009) (collecting Federal Circuit cases). "If the claimant fails to 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). Here, Count X fails at the threshold.

The Liquidators' purported reliance on a statutory entitlement to reinsurance payments fails because "no statutory obligation to pay money, even where unchallenged, can create a property interest within the meaning of the Takings clause. *Land of Lincoln Mutual Health Ins. Co. v. United States*, 892 F.3d 1184, 1186 (Fed. Cir. 2018) (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.* The Liquidators' failure to "demonstrate the existence of a legally cognizable property interest" means "the court's task is at an end." *Am. Pelagic Fishing Co. v. United States*, 379 F.3d 1363, 1372 (Fed. Cir. 2004).

In any event, by the Liquidators' own admission, Consumers' Choice received its reinsurance payment. The fact that HHS lawfully exercise its setoff rights does not mean that the United States has "taken" Consumers' Choice's property. Count X should be dismissed.

CONCLUSION

For the foregoing reasons, the Complaint should be dismissed.

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