Receipt number 9998-4989864

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MICHAEL CONWAY, in his capacity as Liquidator of COLORADO HEALTH INSURANCE COOPERATIVE, INC. Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 18-1623 C

COMPLAINT

Plaintiff Michael Conway, in his capacity as Liquidator of Colorado Health Insurance Cooperative, Inc. ("Colorado HealthOP" or "Plaintiff"), brings this action seeking damages and other relief based upon the United States Government's: (1) failure to make payments to Colorado HealthOP in violation of Section 1341 of the Patient Protection and Affordable Care Act (42 U.S.C. § 18061) and the regulation that implements Section 1341 (45 C.F.R. § 153.230); and (2) improper setoff in violation of Colorado insurance liquidation law.

NATURE OF ACTION

1. In March 2010, the Government enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010), 124 Stat. 119 and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, (March 30, 2010), 124 Stat. 1029 (collectively the "Affordable Care Act" or "ACA").

2. The ACA ushered in a host of market-wide reforms and requirements affecting the private health insurance industry. Among other things, it addressed the scope of covered services, availability of coverage, renewability of coverage, out-of-pocket costs for consumers,

pricing, and other coverage determinants. It limits health insurance product variation and restricts pricing and underwriting practices.

3. One of the hallmarks of the ACA is its establishment of health insurance exchanges, which are online marketplaces where individuals and small groups may purchase health insurance. Created by Title I, Subtitle D of the ACA, the health insurance exchanges "are designed to bring together buyers and sellers of insurance, with the goal of increasing access to coverage" offered in a competitive marketplace.

4. To further facilitate affordability and access to competitive health insurance through the exchanges (also referred to as "marketplaces"), Congress created the Consumer Operated and Oriented Plan ("CO-OP") program in ACA Section 1322. ACA Section 1322(a)(2) explicitly states that "the purpose of the CO-OP program [is] to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets . . . ." A qualified health plan ("QHP") is a health plan that meets certain standards established by the Centers for Medicare & Medicaid Services ("CMS") in order to be sold to consumers through the exchanges. Congress intended for CO-OP insurers to increase competition among health insurers and to provide consumers with a nonprofit option for high-quality care with integrated service delivery. The ACA requires CO-OP insurers to derive substantially all of their business from the individual and small-group markets—the markets served by the exchanges.

5. To minimize the risks to health insurers, the ACA established a number of programs. These included a permanent risk adjustment program, a transitional reinsurance (the "Reinsurance") program, and a temporary risk corridors program for each of the 2014, 2015, and

2016 benefit years (a "benefit year" is the calendar year for which a health plan provides coverage for health benefits).

6. The subject of this Complaint is the Government's failure to make payments under the Reinsurance program. The Reinsurance program, created by Section 1341 of the ACA, provided reinsurance as a means of mitigating risks associated with high-cost enrollees for insurers on the exchanges by obtaining mandatory collections ***from*** all insurers (on and off of the exchanges) and providing payments ***to*** those insurers who insured the most costly enrollees in a given year.

7. Under the Reinsurance program, the Department of Health and Human Services ("HHS") collected (during each of the years the program was in effect) Reinsurance contributions (a monthly per-enrollee fee established by regulation) from health insurance issuers and third-party administrators, and was then required to make Reinsurance payments to all eligible insurance issuers. Eligibility for payment was keyed to costs for individual enrollees: if an insurer's cost for any single enrollee was above a certain dollar threshold, called an "attachment point," it was entitled to a Reinsurance payment for that enrollee.

8. CMS set the attachment point for each of the three years the program was in effect. For the 2014 and 2015 benefit years, the attachment point was $45,000. CMS is required to reimburse insurers a proportion of costs above the attachment point, based on the "coinsurance rate" and subject to a "reinsurance cap" of $250,000 (above which costs are not subject to reimbursement).

9. As relevant here, Colorado HealthOP provided health insurance to its members in the Colorado marketplace in 2015. Pursuant to Section 1341 of the ACA and CMS' implementing regulation, Colorado HealthOP is entitled to receive a Reinsurance payment of

$38,664,334.67 for the 2015 benefit year. To date, however, Colorado HealthOP has been paid only $14,174,535 under the Reinsurance program for the 2015 benefit year. The remaining amount of $24,489,799.67 is presently due.

10. The Government does not contest the entire amount due, but asserts that it is not obligated to pay Colorado HealthOP the 2015 Reinsurance payment because, according to the Government, Colorado HealthOP owes a balance under the risk adjustment program (authorized by another provision of the ACA to reallocate risk amongst insurers).

11. The Government has no legal right to withhold the Reinsurance payment. To the contrary, the Government's actions are directly at odds with governing law.

12. By this lawsuit, Plaintiff seeks immediate full payment of the Reinsurance payment to which it is entitled from the Government under the ACA for benefit year 2015.

JURISDICTION

13. This Court has jurisdiction over the subject matter of this action pursuant to the Tucker Act, 28 U.S.C. § 1491. The statutory cause of action giving rise to this Court's Tucker Act jurisdiction is Section 1341, a money-mandating statute that requires payment from the federal government to issuers, like Colorado HealthOP, that satisfy certain criteria. Section 153.230 is a money-mandating regulation that implements Section 1341 and thus also obligates payment from the Government to issuers that satisfy certain criteria.

14. In the alternative, the Contract Disputes Act ("CDA"), 41 U.S.C. §§ 7101 *et seq.*, a money-mandating statute, provides Plaintiff a cause of action that gives rise to this Court's jurisdiction pursuant to the Tucker Act.

15. This controversy is ripe because CMS has failed to pay Colorado HealthOP the full amount it is owed for the 2015 benefit year as required by Section 1341 and Section

153.230.

PARTIES

16. Plaintiff Michael Conway is the Interim Commissioner of Insurance for the State of Colorado and is the Liquidator of Colorado HealthOP. Commissioner Conway brings this suit in his capacity as the Liquidator of Colorado HealthOP.[1]

17. Colorado HealthOP is a corporation organized under the laws of Colorado which had its principal place of business in Greenwood Village, Colorado. Colorado HealthOP is presently in liquidation proceedings administered under Colorado law.

18. Colorado HealthOP operated as a member-led QHP issuer on the exchange in Colorado. It was organized as a non-profit under the CO-OP program in ACA Section 1322 (described below) and offered comprehensive health insurance benefits to individuals, families, and businesses in Colorado.

19. In total, Colorado HealthOP provided insurance coverage to approximately 83,000 individuals on the exchange in Colorado through the individual and small-group markets.

20. The defendant is the Government, acting at times through CMS (or CMS' parent agency HHS). Unless otherwise noted, references in this Complaint to CMS include HHS where applicable.

[1] On January 4, 2016, the Denver County District Court appointed Marguerite Salazar, Commissioner of Insurance for the State of Colorado to serve as Liquidator of Colorado HealthOP. Commissioner Conway stepped into the role as the Liquidator once he was appointed as Interim Commissioner.

FACTUAL ALLEGATIONS

I. COLORADO HEALTHOP'S STATUTORY RIGHT TO REINSURANCE PAYMENTS

A. Establishment of CO-OPs

21. To facilitate affordability and access to competitive health insurance through the exchanges, Congress created the CO-OP program in ACA Section 1322. ACA Section 1322(a)(2) explicitly states that, "the purpose of the CO-OP program [is] to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets." The ACA requires CO-OP insurers to derive substantially all of their business from individual and small group markets.

B. The Reinsurance Program

22. Section 1341 of the Affordable Care Act, as codified at 42 U.S.C. § 18061, created the Reinsurance program. In relevant part that Section states:

> (1) IN GENERAL – In establishing the Federal standards under section 18041(a) of this title, the Secretary, in consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions that enable States to establish and maintain a program under which—
>
> > (A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable Reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and
> >
> > (B) the applicable Reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make Reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.
>
> (2) HIGH-RISK INDIVIDUAL; PAYMENT AMOUNTS – The Secretary shall include the following in the provisions under paragraph (1):
>
> > (A) Determination of high-risk individuals – The method by which individuals will be identified as high risk individuals for purposes of the

> Reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—
>
> > (i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or
> >
> > (ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

Pub. L. No. 111-148, § 1341(b)(1), (2). Section 1341 also includes a provision dealing with "required contributions," a method of determining the amount most non-group and group health plan issuers are required to contribute to the Reinsurance program for each plan year beginning January 1, 2014. *Id.* § 1341(b)(3). HHS established a methodology to collect a per-enrollee amount from most non-group and group health plan issuers and third-party administrators based on plan enrollment. 45 C.F.R. § 153.400.

23. Following the statute's mandate that HHS determine how high-risk enrollees are identified,[2] HHS determined that Reinsurance payments would be made to individual market plans with high-cost enrollees. HHS, "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, Proposed Rule." 76 Fed. Reg. 41930 (July 16, 2012).

24. HHS implemented the Reinsurance program in the Code of Federal Regulations at 45 C.F.R. §§ 153.200 *et seq*. In relevant part, Section 153.230 states:

> (a) General requirement. A health insurance issuer of a non-grandfathered individual market plan becomes eligible for Reinsurance payments when its claims costs for an individual enrollee's covered benefits in a benefit year exceed the attachment point.

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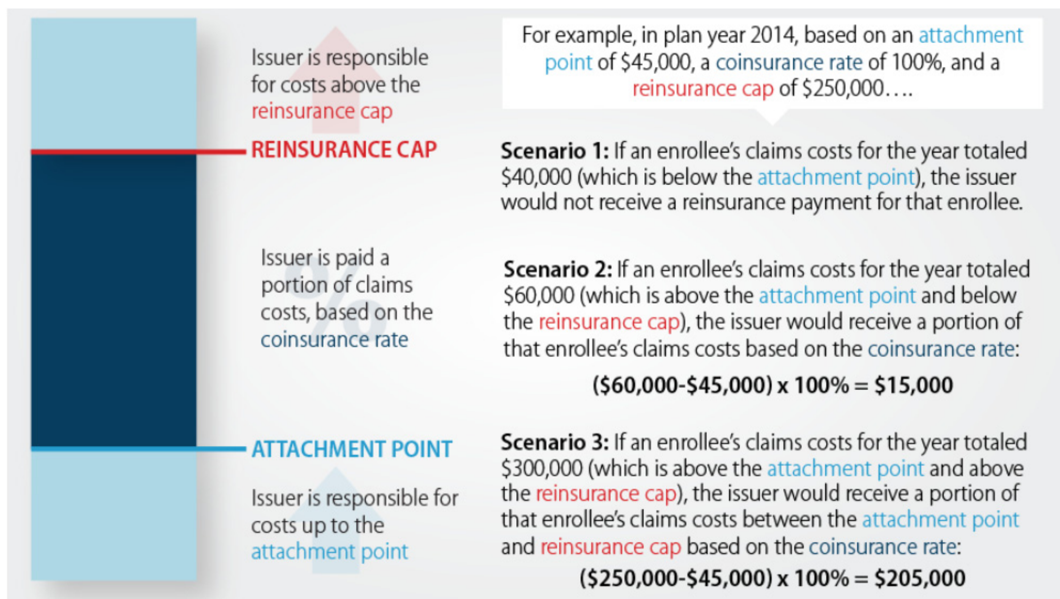
[2] 42 U.S.C. § 18061(b)(2)(A).

Essentially, if an enrollee's total claims exceed a specified level (the "attachment point"), the insurer would be paid a proportion of claims costs (the "coinsurance rate") beyond the attachment point until total claims costs reached a cap (the "reinsurance cap").

25. The Reinsurance program's payment parameters are illustrated below:



Uberoi, K. Namrata and Edward C. Liu, Congressional Research Serv., "The Patient Protection and Affordable Care Act's (ACA's) Transitional Reinsurance Program" (Nov. 16, 2016).

26. HHS published the attachment point, coinsurance rate, and reinsurance cap—the payment parameters of the Reinsurance program—in the annual payment notice. CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F) Regulatory Impact Analysis," (March 2012), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf.

27. The specific payment parameters for plan years 2014, 2015, and 2016 were:

Year	Attachment Point	Coinsurance Rate	Reinsurance Cap
2014	$45,000	100%	$250,000
2015	$45,000	55.1%	$250,000
2016	$90,000	50%	$250,000

C. The Government Owes Reinsurance Payments to Colorado HealthOP

28. On June 30, 2015, CMS published the amounts owed to issuers under the Reinsurance program, as well as the amount of required Reinsurance contributions collected from issuers, for benefit year 2014. CMS, "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year" (June 30, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf.

29. Under the ACA and HHS' implementing regulations, and as specified in CMS' report, Colorado HealthOP was owed $19,571,825.50 under the Reinsurance program as a result of its high-cost enrollees in benefit year 2014, and CMS made full payment of this amount.

30. Similarly, on June 30, 2016, CMS published the amounts owed to issuers under the Reinsurance program, as well as the amount of required Reinsurance contributions collected from issuers, for benefit year 2015. CMS, "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year" (June 30, 2016), *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.[3]

31. Under the ACA and HHS' implementing regulations, and as specified in CMS' report, Colorado HealthOP was owed $38,664,334.67 under the Reinsurance program as a result of its high-cost enrollees in benefit year 2015. CMS has paid only $14,174,535 of this amount. The remainder is due and owing.

II. OTHER ACA PROGRAMS THAT HAVE GIVEN RISE TO CLAIMS OR HAVE BEEN THE SUBJECT OF FEDERAL GOVERNMENT PROOFS OF CLAIM IN THE LIQUIDATION PROCEEDINGS: FEDERAL LOANS, THE RISK CORRIDORS PROGRAM, AND THE RISK ADJUSTMENT PROGRAM

32. Several other ACA programs and provisions have been cited and mentioned in connection with the liquidation of Colorado HealthOP, and the respective claims of Colorado HealthOP and the Government in connection with the liquidation. These include the following:

A. The Federal Loans

33. The ACA authorized two loans, the Start-up Loan and the Solvency Loan, under the CO-OP program. 42 U.S.C. § 18042(b)(1).

34. Colorado HealthOP applied for federal funding to operate as a CO-OP, and in early 2012, CMS approved Colorado HealthOP's business plan and application to operate as a QHP issuer, and authorized federal funding to Colorado HealthOP to operate as a CO-OP as defined in 42 U.S.C. § 18042(a)(1)-(2).

35. On July 23, 2012, CMS and Colorado HealthOP executed a Loan Agreement under which Colorado HealthOP was to receive a maximum Start-Up Loan of $12,266,400 and

[3] This initial report indicated that CMS owes Colorado HealthOP $38,644,223.02, but this number was revised to $38,664,334.67 in the amendment to the report. *See* CMS, "Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year" (December 6, 2016) ("2015 Payment Report"), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

a maximum Solvency Loan of $57,129,600. The Loan Agreement expressly recognized that any HHS claim for repayment of the loan amounts is subordinate to the claims of policyholders and other claimants. In fact, the Start-Up and Solvency Loans were converted to Surplus Notes on August 11, 2015.[4]

B. The Risk Corridors Program

36. Section 1342 of the ACA, as codified at 42 U.S.C. § 18062, created the risk corridors program.

37. The risk corridors program was designed to help cabin risks to issuers by limiting the amounts of money that issuers could lose or gain through the exchanges during the first three years of the exchanges.

38. Under this program, CMS was required to make payments to a QHP issuer offering plans in the exchanges if the issuer's actual costs exceeded targeted costs under the formula in Section 1342, and a QHP issuer was required to make payments to CMS if its actual costs were less than its targeted costs.

39. Colorado HealthOP is owed $111,420,992 in risk corridors payments from the Government.

40. The risk corridors program is currently the subject of numerous lawsuits at the Court of Federal Claims, some of which have been appealed to the Court of Appeals for the Federal Circuit. Colorado HealthOP's risk corridors claim is asserted as part of the certified class action. *Health Republic Ins. Co. v. United States*, No. 16-259C, continuance of stay issued Jun. 29, 2018, ECF No. 69.

[4] Based on the conversion of the Start-Up and Solvency Loans to Surplus Notes, the Government cannot argue the right to set off the reinsurance amounts against these notes.

41. In *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), the Federal Circuit held that certain appropriation riders "suspended" the Government's statutory obligation to pay risk corridors amounts to QHP issuers.

C. The Risk Adjustment Program

42. Section 1343 of the ACA, as codified at 42 U.S.C. § 18063, created the risk adjustment program.

43. Risk adjustment, unlike the temporary Reinsurance program, is a permanent program. Using the Government as conduit/intermediary administrator, the risk adjustment program transfers funds from "low actuarial risk plans" to "high actuarial risk plans" within the same state. 42 U.S.C. § 18063.

44. Serving as a conduit, CMS determines the actuarial risk each insurer carries for a given policy year, collects the required payments from low actuarial risk plans, then distributes them to spread risk around the various markets in each state. *See* 42 U.S.C. § 18063; 45 C.F.R. § 153.310(a)(2).

45. CMS administered the risk adjustment program in a budget neutral manner such that actual proceeds received from low actuarial risk plans are used to pay higher actuarial risk plans within the same market and state, with no involvement of federal funds.

III. THE GOVERNMENT IMPROPERLY WITHHELD REINSURANCE PAYMENTS OWED TO COLORADO HEALTHOP

A. Colorado HealthOP Enters Liquidation

46. During 2014 and 2015, Colorado HealthOP experienced severe and sustained financial difficulties.

47. On February 15, 2015, the Commissioner of Insurance approved a stipulated agreement between the Division of Insurance and Colorado HealthOP, ordering Colorado

HealthOP under confidential supervisions pursuant to C.R.S. §§ 10-3-401, *et seq.*

48. On November 10, 2015, the Denver County District Court (the "Liquidation Court") entered an order placing Colorado HealthOP into rehabilitation. The subsequent efforts of Plaintiff to rehabilitate Colorado HealthOP proved futile, and ultimately a petition was filed in the Liquidation Court seeking an order of liquidation.

49. On January 4, 2016, the Liquidation Court placed Colorado HealthOP into liquidation, pursuant to the Court's sole and exclusive jurisdiction over the matter under C.R.S. §§ 10-3-504(2), (5). Ex. 1 (the "Liquidation Order"). The Liquidation Order stated, among other things, that the Liquidator was authorized, in accordance with C.R.S. § 10-3-520, to institute legal proceedings and to collect all debts and monies due and claims belonging to Colorado HealthOP.

B. The Government Improperly Set Off Risk Adjustment Payments Ostensibly Due From Colorado HealthOP Against the Reinsurance Payment Due to Colorado HealthOP

50. On March 23, 2016, Colorado HealthOP received an early reinsurance payment of $14,154,424 from CMS, leaving a balance of $24,489,799 still due for Colorado HealthOP's participation in the Reinsurance program for benefit year 2015.

51. On March 31, 2016, Colorado HealthOP, through the Liquidator, provided a Notice and a Proof of Claim ("POC") form to all policyholders, general creditors, medical providers, insurance producers, and other persons having any claim or demand of any kind against Colorado HealthOP, and direction on how to file such a claim.

52. The POC form required each claimant to complete the form and respond to Colorado HealthOP by January 2, 2017, the "claims bar" date.

53. On August 23, 2016, CMS provided certain documentation under which it

appears to have decided that, rather than pay amounts claimed by Colorado HealthOP, it would unilaterally offset $20,255,084 of the $24,489,799 in Reinsurance payment amount still due to Colorado HealthOP. *See* Ex. 2. In particular, it appears to have set off against the Reinsurance payment due to Colorado HealthOP on the theory that Colorado HealthOP owes CMS $21,775,432 under the risk adjustment program.

54. On December 30, 2016, CMS submitted a POC to Colorado HealthOP. Ex. 3.

55. CMS' POC claimed over $97,715,924.32 for "[a]mounts owed by Debtor [Colorado HealthOP] under the Affordable Care Act and federal law," which includes: (1) Start-Up Loan and the Solvency Loan amounts, (2) $2,180,837.60 in cost-sharing reduction reconciliation obligation; (3) $771,298 in Reinsurance obligation; and (4) $21,801,742.03 in claimed risk adjustment charges and $76,735.62 in risk adjustment user fees. Ex. 3 at 1.

56. CMS' POC claimed a right of priority, citing "Federal Law and 508c.42(3)." Ex. 3 at 1.

57. The Liquidator reviewed CMS' POC and, pursuant to C.R.S. § 10-3-535(3), mailed a letter to CMS on April 17, 2017, requesting that CMS provide additional information regarding CMS' unliquidated claims, the Start-Up and Solvency Loans, offsets, and the Liquidator's priority determinations. Ex. 4 ("April 2017 Letter").

58. The April 2017 Letter required that CMS respond by June 1, 2017, and provided that if CMS "fail(s) to respond as to a particular matter, or fail(s) to provide requested documentation, then the Liquidator reserves the right to consider that the information does not support the proof of claim, and deem the omitted information not to support your position in this matter." Ex. 4 at 4.

59. Under C.R.S. § 10-3-535 and case law, a claimant must include a certain set of

required information, and the liquidator may "at any time, request the claimant to present information or evidence supplementary to [the required information]" in order to determine whether a claim should be allowed or disallowed.

60. CMS failed to provide a response to the April 2017 Letter by June 1, 2017.

61. On June 27, 2017, the Department of Justice contacted the Liquidator's claims handler and requested an extension to respond to the April 2017 Letter. Ex. 5.

62. The Liquidator extended CMS' response date to August 14, 2017. Despite this extension, CMS again failed to file its response.

63. Under C.R.S. § 10-3-535(2), when a claimant fails to provide information requested by the liquidator, the liquidator may determine not to consider the POC as allowable.

64. On August 30, 2017, the Liquidator mailed a claims determination letter to CMS. Ex. 6 ("CMS Claim Determination").

65. The CMS Claim Determination stated, in pertinent part, the following:

a) The subordinated claims under the Solvency Loan and the Start-Up Loan are disallowed due to not being liabilities given the lack of surplus by the terms of the associated loans and surplus notes and the failure to meet other conditions precedent to payment of the loans;

b) Even if assets were to unexpectedly be collected which allowed the funding of claims below Class Two, the Start-Up Loan and Solvency Loan would be classified as Class 9 claims[5];

c) The claims based in the Affordable Care Act, other than the surplus note claims, would be classified in Class 3 under the priority statute, if they were not disallowed due to offsets being available;

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[5] The CMS Claim Determination letter inadvertently stated that the Start-Up Loan and the Solvency Loan would be classified as "Class Nine claims," when in fact the two loans are classified as Class 7 claims.

d) Request is made for ***return of all unauthorized offsets,*** since offsets were taken when the United States is a net debtor and not a net creditor, and ***each offset was taken without court authorization***;

e) The principal amount of the Class 3 claims eligible for potential approval is limited to the principal amount claimed. The Liquidator reserves the right to adjust the figures if the Liquidator determines that any of the sums claimed are interest or late charges. Since no net Class 3 claim is allowed in light of the full offset, the Liquidator reserves the right to audit and adjust any approved amount based upon any further documentation; and

f) The United States is ***deemed to have waived any argument against disallowance of its claim through full offset in light of its non-response***.

66. The CMS Claim Determination also advised CMS of its right to object pursuant to C.R.S. § 10-3-538(1).

67. C.R.S. § 10-3-538(1) states:

> When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or the claimant's attorney by first class mail at the address shown in the proof of claim. Within sixty days after the mailing of the notice, the claimant may file objections with the liquidator. ***If no such filing is made, the claimant may not further object to the determination.***

(Emphasis added.)

68. CMS failed to file an objection to the CMS Claim Determination.

69. Due to CMS' failure to file an objection, the requirement under C.R.S. § 10-3-538(2) for the Liquidator to request a hearing to adjudicate any objection, was not triggered.

70. On December 11, 2017, the Liquidator filed its "Motion to Affirm Proof of Claim Determination, Priority Determination, and Partial Proof of Claim Denial" ("Motion") with the Liquidation Court, requesting that the Liquidation Court affirm: (1) HealthOP's CMS Claim Determination, including the priority of distribution set forth therein; and (2) the subsequent determination of CMS' POC. Ex. 7. The Liquidation Court granted the Motion the

next day. Ex. 8.

71. On September 4, 2018, the Liquidator moved to substitute Michael Conway for Marguerite Salazar as Liquidator for Colorado HealthOP. The Liquidation Court granted the motion the same day.

IV. THE SETOFF OF RISK ADJUSTMENT PAYMENTS OSTENSIBLY OWED BY COLORADO HEALTHOP TO CMS, AGAINST THE REINSURANCE PAYMENT DUE TO COLORADO HEALTHOP, VIOLATES COLORADO LAW AND THE LIQUIDATOR'S DETERMINATION

72. Under Colorado law, the Denver County District Court has jurisdiction over the liquidation of Colorado HealthOP, C.R.S. § 10-3-504(1), and the Court has affirmed the Liquidator's determination as set forth above that, *inter alia*, CMS' ACA claims against Colorado HealthOP—including the risk adjustment payments—are ***disallowed and all offsets are to be returned***.

73. The McCarran-Ferguson Act gives States the primary authority to regulate the business of insurance and to provide that in an insurance liquidation, a higher priority may be given to payments owed to the insureds and the costs of administering the estate, than to a federal creditor, notwithstanding other provisions of federal law. *See* 15 U.S.C. § 1012; *Dep't of Treasury v. Fabe*, 508 U.S. 491, 502 (1993).

74. The ACA does not contradict Colorado law regarding the business of insurance, but rather expressly acknowledges the applicability of state law under a clause titled "No interference with State regulatory authority." 42 U.S.C. § 18041(d) ("Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.").

75. HHS also published proposed regulations implementing the ACA, noting that

solvency and financial health of insurers is a "State-regulated function." 76 Fed. Reg. 43,237, 43,244 (July 20, 2011).

76. Accordingly, under the McCarran-Ferguson Act, the Government is bound by applicable Colorado law as it relates to the liquidation of Colorado HealthOP.

77. Under the Colorado statute regulating liquidation and rehabilitation of insurance companies, the Government's claims, including the risk adjustment payment due from Colorado HealthOP, fall under Class 3, "Claims of the federal government." C.R.S. § 10-3-541(1)(c).

78. This priority of distribution scheme requires that "distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full . . . before the members of the next class receive any payment." C.R.S. § 10-3-541(1).

79. Neither Class 1, the "costs and expenses of administration during rehabilitation and liquidation," nor Class 2, "[a]ll claims under policies" have been paid in full.

80. The Government, by setting off the Reinsurance payment amount due to Colorado HealthOP by the risk adjustment payment amount ostensibly due from Colorado HealthOP, has essentially jumped priority over Class 1 and Class 2 priority creditors of the Colorado HealthOP estate in violation of Colorado's statutory priority scheme protecting higher priority creditors. *See Fabe*, 508 U.S. at 506.

81. Under the Colorado statute regulating the liquidation and rehabilitation of insurance companies, setoffs are allowed only for "mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this part 5." C.R.S. § 10-3-529(1).

82. The Government's offset of Reinsurance payments owed to Colorado HealthOP,

by the risk adjustments payments owed to the Government from Colorado HealthOP, is not a permissible offset under C.R.S. § 10-3-529(1).

83. The Government's offset is thus prohibited by Colorado law and the full amount of the Government must pay the full amount of the Reinsurance payment owed into the liquidation estate of Colorado HealthOP.

* * * * *

84. Colorado HealthOP seeks the immediate payment in full of Reinsurance receivable for the 2015 benefit year.

CLAIM FOR RELIEF

COUNT I

(Violation of Statutory and Regulatory Mandate to Make Payments)

85. Plaintiff re-alleges and incorporates the above Paragraphs 1-84 as if fully set forth herein.

86. As part of its obligations under Section 1341 of the ACA and its obligations under 45 C.F.R. § 153.230, the Government is required to pay any individual market plan issuer certain amounts according to its regulatory formula.

87. The Government has failed to fulfill its obligations under Section 1341 of the ACA and 45 C.F.R. § 153.230.

88. The Government's failure to provide timely payments to Colorado HealthOP is a violation of Section 1341 of the ACA and 45 C.F.R. § 153.230, and Colorado HealthOP (and its estate in liquidation) has been harmed in the amount of $24,489,799 by this failure.

COUNT II

(Improper Setoff in Violation of Colorado Law)

89. Plaintiff re-alleges and incorporates the above Paragraphs 1-88 as if fully set forth herein.

90. The Government unilaterally set off Reinsurance payments due to Colorado HealthOP.

91. For the reasons set forth by the Liquidator, the Government's claim, including the offset of Reinsurance payments due to Colorado, was disallowed and is impermissible, the Government has failed properly to challenge that determination, and the District Court, City and County of Denver, upheld such determination.

92. The Government improperly has declined to make Reinsurance payments due and owing to Colorado HealthOP by improperly and unlawfully claiming a setoff against payments owed.

93. This unilateral setoff violated applicable Colorado laws and the Order Affirming the CMS Claim Determination.

PRAYER FOR RELIEF

Plaintiff requests the following relief:

A. That the Court award Plaintiff monetary relief in the amount to which Plaintiff is entitled under Section 1341 of the ACA and 45 C.F.R. § 153.230 and that has been improperly withheld by the Government: $24,489,799.

B. That the Court award pre-judgment and post-judgment interest at the maximum rate permitted under the law;

C. That the Court award such court costs, litigation expenses, and attorneys' fees as are available under applicable law; and

D. That the Court award such other and further relief as the Court deems proper and just.

Dated: October 19, 2018

Respectfully submitted,

/s/ Stephen McBrady
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CERTIFICATE OF SERVICE

I certify that on October 19, 2018, a copy of the forgoing complaint was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

/s/ Stephen McBrady

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