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 Judge Nancy B. Firestone

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT
AND MEMORANDUM OF LAW IN SUPPORT

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Plaintiff, Michael Conway, as Liquidator of Colorado Health Insurance Cooperative, Inc. ("Colorado HealthOP"), respectfully submits this Memorandum In Support Of Its Motion for Summary Judgment against Defendant, the United States of America ("Government"), acting through the Centers for Medicare & Medicaid Services ("CMS") (and CMS' parent agency, the U.S. Department of Health and Human Services ("HHS")).

INTRODUCTION

Colorado HealthOP was a Colorado health care insurer. It is now in liquidation. It is the liquidator's responsibility to gather the assets of that insurer and distribute them to the company's insureds and other creditors in accordance with the priorities among creditors established by Colorado statute. For that reason, Plaintiff has filed this action. Plaintiff seeks to collect the money that Government owes Colorado HealthOP under Section 1341 of the Affordable Care Act ("ACA"), 42 U.S.C. § 18061 so that Plaintiff can ensure that it is distributed to Colorado HealthOP's insureds and other creditors.

The Government does not dispute it owes the amount claimed by Colorado HealthOP under Section 1341. Instead, the Government declines to pay on the theory that it has a preemptive right to "offset" from the money it owes Colorado HealthOP under Section 1341 certain sums that it says that Colorado HealthOP owes to the Government under a different provision of the ACA. The Government asserts that the claimed offset negates its obligation to pay under Section 1341, suggesting that the debt to the Government is entitled to a priority under federal law. The Government is wrong. The Government's failure to make the Section 1341 payments, which are mandatory under the ACA, violates both the ACA and Colorado statutory law applicable to Colorado HealthOP's liquidation. And, as declared by federal statute, Colorado law controls this issue.

The Government is not entitled to the claimed offset or any other form of priority under federal law. That is because this case involves the liquidation of an insurance company, and, under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, insurance regulation is a matter of state, not federal, law. Under McCarran-Ferguson, federal law does not "supersede" state law. In this case, federal law, and usual principles of federal preemption, bows to state law on the issues presented here.

The Supreme Court has specifically held that where a state has established rules of priority among creditors, designed to ensure that the liquidating insurer first meets its obligations to its insureds before the government and other creditors are paid, those state-law rules govern unless a federal statute *clearly states* that it preempts state law on this issue. Thus, state statutes determine how and to what extent debts owed to the liquidating insurer are assets of the estate, and how they must be distributed. The ACA, which creates the Government's debt to Plaintiff at issue in this case, not only does not state that it preempts conflicting state laws regulating the business of insurance, it says just the opposite: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d).

Colorado law thus controls. Under Colorado law, all collected assets of the liquidating insurer are to be collected and must be distributed according to the priorities established by the legislature. This is sound public policy. The funds owed by Colorado HealthOP's estate are critical to the creditors. And except as specifically authorized by Colorado statute, debts owed to the liquidating insurer are not subject to set-off for amounts purportedly owed by the liquidating insurer, because any impermissible offset would overturn the basic priority structure: the party claiming the offset would keep the entirety of sum owed for itself, rather than allow it to be

distributed to the insureds, and other creditors, ***according to the priorities set by the State***. The offset claimed here is not authorized under the Colorado offset statute. Therefore, the Government is not entitled to assert what is in effect, a super-priority—allowing it to retain, or claim an offset against, Section 1341 payments that are due.

STATEMENT OF THE ISSUE

Section 1341 of the ACA establishes a Reinsurance program. It requires that HHS make annual Reinsurance payments to health insurers who enroll high-cost enrollees once costs from the previous benefit year have been calculated and submitted to HHS. The Government does not dispute this obligation. For the 2014 benefit year, HHS owed Colorado HealthOP $19,571,825.50 under the Reinsurance program, and made full payment of this amount. However, after Colorado HealthOP encountered financial difficulties and entered liquidation, HHS made only a partial payment of $14,174,535 to Colorado HealthOP for benefit year 2015. That left a balance of $24,489,799 on the total amounts owed to Colorado HealthOP under Section 1341. HHS has declined to pay. It has done so based on a unilateral determination, without the approval of the Colorado court, that it need not pay the Section 1341 debt because it is entitled to offset against that debt owed to Colorado HealthOP certain money that Colorado HealthOP owes under the ACA's Risk Adjustment program. The Government has generally invoked the notion that it is entitled to a priority by virtue of federal law. In fact, as discussed below, federal law makes clear that state law controls this issue and that the Government's position in this case is wrong.

The questions presented are (i) whether the Government owes Colorado HealthOP full payment for benefit year 2015 under Section 1341 of the Act; and (ii) whether the Government's unilateral offset was improper. The answer to both questions is yes.

STATEMENT OF RELEVANT BACKGROUND

I. THE BASIC ISSUE

Colorado HealthOP is an insurer providing health care coverage in Colorado, subject to insurance regulation under Colorado law. After Colorado HealthOP encountered financial difficulties, the Denver County District Court ("Liquidation Court") placed Colorado HealthOP into liquidation proceedings on January 4, 2016. Those proceedings are governed by state law—namely, the Colorado Insurers' Rehabilitation and Liquidation Act, C.R.S. § 10-3-501, *et seq*. (the "Liquidation Act").

Under the Liquidation Act, the liquidator may collect all debts owed to the bankrupt entity. C.R.S. § 10-3-520(1)(h). All assets, including collected debts, are then distributed from the estate in accordance with a statutory priority framework. C.R.S. § 10-3-541. Under that framework, costs and expenses of administration of the liquidation, and all claims of insureds, are paid first, as Class 1 and Class 2 claims, respectively. Government claims are expressly subordinated to those claims as Class 3 claims. *Id.*

While in operation, Colorado HealthOP offered insurance on the Colorado exchanges created by the ACA.[1] As an issuer on the exchanges, Colorado HealthOP participated in a variety of ACA programs on the Colorado exchange. Most relevant to these proceedings is the temporary Reinsurance program created by Section 1341 of the ACA, 42 U.S.C. § 18061, "Transitional reinsurance program for individual market in each State." Under that program, money was collected from all insurers in the state, on and off of the exchanges. That money was

[1] The ACA is comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

in turn paid out to the subset of those insurers that insured the most costly enrollees during the relevant benefit year.

Colorado HealthOP provided health insurance on the Colorado exchange for benefit years 2014 and 2015. For benefit year 2015, it was a § 1341 net payee, meaning it was owed money under the Reinsurance program. CMS publicly confirmed in its "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year" that it owed Colorado HealthOP a Reinsurance payment of $38,664,334.67. To date, however, Colorado HealthOP has been paid only $14,174,535 under the Reinsurance program for the 2015 benefit year. CMS has refused to pay the remaining amount of $24,489,799. That balance is presently due.

As is evident from communications between the parties, the Government takes the position that it is entitled to an offset against the balance of Reinsurance payments it owes Colorado HealthOP based on a balance that it claims Colorado HealthOP owes under ACA, Section 1342, 42 U.S.C. § 18063 (for the ACA's Risk Adjustment Program).

But the McCarran-Ferguson Act, and the principles laid down by the Supreme Court in applying McCarran-Ferguson to insurer liquidations, demonstrates that the right of offset is governed by state law. For reasons explained below, Colorado law permits offsets in only a narrow set of circumstances, which are not met in this case.

II. THE SECTION 1341 REINSURANCE PAYMENTS OWED TO COLORADO HEALTHOP.

To facilitate access to competitive health insurance through the exchanges, 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." Colorado HealthOP operated under the CO-OP program as an issuer of qualified health plans (QHPs) on the Colorado exchange.

To entice insurers to participate on the exchanges, and to help mitigate risk to insurers arising from many of the novel mandates of the ACA, Congress created a number of programs for the benefit of insurers participating in the exchanges.

The Reinsurance program created by § 1341 was one method the Government used to entice insurers such as Colorado HealthOP to participate on the ACA exchanges. It was established as a temporary program to operate for the first three benefit years of exchange operations, 2014-16. It offered a form of reinsurance as a means of mitigating risks associated with high-cost enrollees for insurers on the exchanges by obtaining mandatory collections from all insurers in the state (on and off of the exchanges) and, in turn, using that pool of collections to make payments to the subset of those insurers that insured the most costly enrollees in a given year.

Section 1341, establishing the Reinsurance program, states in relevant part:

> (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 were 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.

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.

Essentially, if an enrollee's total claims exceed a specified level (the "attachment point"), the insurer would be paid a proportion of claims costs ("coinsurance rate") beyond the attachment point until total claims costs reached a cap ("reinsurance cap").[2]

CMS set the attachment point for the 2014 and 2015 benefit years at $45,000. A proportion of costs above the attachment point is, therefore, required to be reimbursed, based on the "coinsurance rate" and subject to a "reinsurance cap" of $250,000 (above which costs are not subject to reimbursement).

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.[3] 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.

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.[4] Under the ACA and HHS' implementing regulations, and as specified in

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[2] HHS published the attachment point, 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.

[3] 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.

[4] 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-
(Continued...)

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. Despite publicly acknowledging the amount that the Government was required to pay to Colorado HealthOP, CMS has paid only $14,174,535 of this amount.

III. OTHER ACA PROGRAMS CITED IN CONNECTION WITH COLORADO HEALTHOP'S LIQUIDATION PROCEEDINGS.

In connection with the liquidation proceedings and the proofs of claims the Government submitted in those proceedings, the Government has cited and mentioned several other ACA programs and provisions. For the convenience of the Court, they are described here:

1. *The Federal Loans*

To help facilitate the CO-OP model, the ACA authorized two loan types "to persons applying to become qualified nonprofit health insurance issuers" under the CO-OP program: (1) Start-up loans "to provide assistance to such person in meeting its start-up costs;" and (2) Solvency loans "to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans." 42 U.S.C. § 18042(b)(1). CO-OPs received the Start-Up and Solvency Loans from CMS pursuant to 42 U.S.C. § 18042(b)(1)(A)-(B) and subject to terms set out in the loan agreements. The Government was the sole funder of the Start-Up and Solvency Loans.

Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf. 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.

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). On July 23, 2013, 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 a maximum Solvency Loan of $57,129,600.

The Loan Agreement is immaterial to the issues presented here. That is because the Loan Agreement *expressly* recognized that any HHS claim for repayment of the loan is subordinate to the claims of policyholders and other claimants. These loans are surplus notes and can only be paid after all other creditors have been satisfied. Pursuant to the Loan Agreements, the amounts due to the Government under the Surplus Notes "may not be offset or be subject to recoupment with respect to any liability or obligation . . . ." Compl. Ex. 3 at 17, 92.

2. *The Risk Corridors Program*

Section 1342 of the ACA, as codified at 42 U.S.C. § 18062, created the Risk Corridors program, or RCP. The RCP 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 operation. Under this program, CMS was required to pay a QHP issuer offering plans on the exchanges if the issuer's actual costs exceeded targeted costs under the formula in Section 1342, and a QHP issuer was required to pay CMS if its actual costs were less than its targeted costs.

The Government owes Colorado HealthOP $111,420,992 in Risk Corridors payments and Colorado HealthOP asserted a Risk Corridors claim as part of a certified class action. *See Health Republic Ins. Co. v. United States*, No. 16-259C, continuance of stay issued Jun. 29, 2018, ECF No. 69. In *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), the Federal Circuit held that certain appropriation riders, cutting off access to appropriations to pay the RCP

amounts from taxpayer funds, "suspended" but did not extinguish the Government's statutory obligation to make additional Risk Corridors payments to QHP issuers. *Id.* at 1323. Under the *Moda* ruling (which is still subject to a potential writ of certiorari), while the Risk Corridors money is still owed to Colorado HealthOP, the Government is not obligated to pay the amounts due unless and until Congress appropriates funds from which to make the payments.

3. *The Risk Adjustment Program*

Section 1342 of the ACA, codified at 42 U.S.C. § 18063, created the Risk Adjustment program. Risk Adjustment, unlike the temporary Risk Corridors and Reinsurance programs, is a permanent program. It is designed to transfer money from "low actuarial risk plans" to "high actuarial risk plans" within the same state. 42 U.S.C. § 18063. In administering this program, CMS determines the actuarial risk each insurer carries for a given policy year, collects the required payments from low actuarial risk plans, and then distributes those collections to redistribute the risk around the various markets in each state. *See* 42 U.S.C. § 18063; 45 C.F.R. § 153.310(a)(2). The Risk Adjustment program is administered as a closed pool: the actual proceeds received from low actuarial risk plans become part of the pool used to pay higher actuarial risk plans within the same market and state—*federal funds are not involved*.

IV. COLORADO HEALTHOP IS IN LIQUIDATION, AND THE GOVERNMENT HAS FAILED TO PAY THE BALANCE OWED COLORADO HEALTHOP UNDER SECTION 1341.

During 2014 and 2015, Colorado HealthOP experienced sustained financial difficulties, culminating with the Liquidation Court entering an order on January 4, 2016 (the "Liquidation Order") placing Colorado HealthOP into liquidation. The Liquidation Order authorized the Liquidator to institute legal proceedings and to collect all debts and monies due and claims belonging to Colorado HealthOP, in accordance with C.R.S. § 10-3-520. On March 23, 2016, Colorado HealthOP received a 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.

On August 23, 2016, CMS provided certain documents to Colorado HealthOP under which it appears to have decided that, rather than pay the remainder of the Reinsurance amount due to Colorado HealthOP, it would unilaterally offset most of the $24,489,799 in Reinsurance payment amount still due to Colorado HealthOP. *See* Compl. Ex. 2. In particular, the Government appears to have unilaterally offset against the Reinsurance payment due to Colorado HealthOP more than $20 million that Colorado HealthOP purportedly owes CMS under the Risk Adjustment program.

In December 2016, the Government submitted its proofs of claims and supporting exhibits for amounts purportedly "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 obligations; and
> (4) $21,801,742.03 in claimed Risk Adjustment charges and $76,735.62 in Risk Adjustment user fees.

Compl. Ex. 3 at 1. In its proofs of claim, CMS claimed a right of priority citing "Federal Law and 508c.42(3)."[5] *Id.* Most of these proofs of claim do not appear relevant to the current question whether the Government is entitled to take an offset against the Reinsurance amounts owed *to* Colorado HealthOP. For example, Colorado HealthOP owes substantial sums to the Government under the Loan agreements, but (as described above), those Loan Agreements specifically declare that the repayment obligations are subordinate to other claims, and further, that they may not be used as an offset to bar repayment of amounts owed Colorado HealthOP.

[5] The Government's reference to "508c.42(3)" appears to be inadvertent. This is the form of citation used to cite Iowa statutes, which would be irrelevant to the issues here.

On April 17, 2017, the Liquidator wrote to CMS requesting that CMS provide additional information regarding CMS' unliquidated claims, the Start-Up and Solvency Loans, *offsets, and the Liquidator's priority determinations, and required a response by June 1, 2017.* Compl. Ex. 4 ("April 2017 Letter"). The Liquidator stated 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." Compl. Ex. 4 at 4.

CMS failed to timely respond to the Liquidator's April 2017 Letter, and requested an extension nearly a month after the deadline. The Liquidator granted an extension to August 14, 2017, and CMS again failed to respond. Compl. ¶¶ 59-62. On August 30, 2017, the Liquidator mailed to CMS a claims determination letter. Compl. Ex. 6 ("CMS Claims Determination").

In pertinent part, the Liquidator determined the following:

a) The claims based in the Affordable Care Act, other than the surplus note claims, would be classified in Class 3 under the priority statute, and the Government is not entitled to any "super priority";

b) 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;

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

Compl. Ex. 6 at 5-6. CMS never objected to the Liquidator's determination.

On December 11, 2017, the Liquidator filed a "Motion to Affirm Proof of Claim Determination, Priority Determination, and Partial Proof of Claim Denial" with the Liquidation Court, requesting that the Liquidation Court affirm: (1) Colorado HealthOP's CMS Claim Determination, including the priority of distribution set forth therein; and (2) the determination of CMS' POC. Compl. Ex. 7. The Liquidation Court granted the motion. Compl. Ex. 8.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. Colorado HealthOP was a corporation organized under the laws of Colorado which had its principal place of business in Greenwood Village, Colorado.

2. 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).

3. In 2014 and 2015, Colorado HealthOP provided health insurance in the Colorado marketplace.

4. Pub. L. No. 111-148, § 1341 (ACA Section 1341), 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.

5. HHS implemented the Reinsurance program through 45 C.F.R. §§ 153.200 *et seq.*

6. Congress also included a provision within the statute 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).

7. Accordingly, 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.

8. 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.

9. Under HHS's methodology, 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"). *See* Compl. ¶¶ 24-27.

10. HHS published the attachment point, coinsurance rate, and reinsurance cap—the Reinsurance payment parameters—in its annual payment notice. The payment parameters for plan years 2014, 2015, and 2016 were as follows:

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

11. On June 30, 2015, CMS published the amounts that issuers are owed 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.

12. 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. CMS made full payment of this amount.

13. On June 30, 2016, CMS published the amounts that issuers are owed 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 ("CMS 2015 Summary Report").

14. Under the ACA and HHS' implementing regulations, and as specified in CMS' report, Colorado HealthOP is owed $38,664,334.67 under the Reinsurance program for benefit year 2015. CMS has paid only $14,174,535 of this amount.

15. The ACA authorized two loan types for would-be QHP issuers under the CO-OP program, Start-Up Loans and Solvency Loans. *See* 42 U.S.C. § 18042(b)(1).

16. Pursuant to this statutory authority, Colorado HealthOP entered into the Loan Agreement with CMS to receive the Loans. *See* Compl. Ex. 3 at 24.

17. The Start-Up Loan was converted to Surplus Note on August 11, 2015, and pursuant to the Loan Agreement, the amounts due to the Government under the Surplus Note "may not be offset or be subject to recoupment with respect to any liability or obligation . . . ." Compl. Ex. 3 at 17, 92.

18. Section 1342 of the ACA created the RCP, under which 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. *See, e.g.*, 42 U.S.C. § 18062.

19. The RCP 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. As part of a certified class action, Colorado HealthOP has asserted a Risk Corridors claim in the amount of $111,420,992. *Health Republic Ins. Co. v. United States*, No. 16-259C, continuance of stay issued Jun. 29, 2018, ECF No. 69.

20. Section 1342 of the ACA created the Risk Adjustment program, a permanent program under which the Government acts as an intermediary in transferring funds from low actuarial risk plans to high actuarial risk plans within the same state. *See, e.g.*, 42 U.S.C. § 18063. CMS administers the Risk Adjustment program in a budget-neutral manner, with no involvement of federal funds.

21. On January 4, 2016, the Denver County District Court (the "Liquidation Court") entered an order placing Colorado HealthOP into liquidation pursuant to the Court's jurisdiction over the matter under C.R.S. §§ 10-3-504(2), (5). Compl. Ex. 1 (the "Liquidation

Order"). The Liquidation Order stated, among other things, that the Liquidator was authorized to institute legal proceedings and to collect all debts and monies due and claims belonging to Colorado HealthOP.

22. On March 23, 2016, Colorado HealthOP received a Reinsurance payment of $14,154,424 from CMS.

23. On March 31, 2016, Colorado HealthOP, through the Liquidator, provided a Notice of 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.

24. 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. Compl. Ex. 3 at 1.

25. CMS' POC claimed a right of priority, citing "Federal Law and 508c.42(3)." *Id.*

26. The Liquidator reviewed CMS' POC and, pursuant to C.R.S. § 10-3-535(3 on April 17, 2017 wrote to CMS, asking it to provide additional information regarding CMS' unliquidated claims, the Start-Up and Solvency Loans, offsets, and the Liquidator's priority determinations. Compl. Ex. 4. The letter explained 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." Compl. Ex. 4 at 4.

27. 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.

28. Despite the Liquidator's grant of an extension to respond, CMS never responded to the April 2017 Letter.

29. On August 30, 2017, the Liquidator sent a claims determination letter to CMS disallowing CMS' claim and requesting return of all offsets not authorized by the Liquidation Court. Compl. Ex. 6 ("CMS Claim Determination").

30. 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). CMS failed to file an objection to the CMS Claim Determination.

31. On December 11, 2017, the Liquidator Court entered an order affirming (1) HealthOP's CMS Claim Determination, including the priority of distribution set forth therein; and (2) the subsequent determination of CMS' POC. Compl. Ex. 8.

32. 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).

33. 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).

34. 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.

35. The Government claims an offset against *most* of the remaining balance of $24,489,799 to which Colorado HealthOP is entitled for 2015, purportedly because of Risk Adjustment payments the Government says Colorado HealthOP owes, but in any event has not paid *any* of the remaining balance.

JURISDICTION

This Court has Tucker Act jurisdiction because the ACA's Reinsurance program is an act of Congress that (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]" and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." 28 U.S.C. § 1491(a)(1); *see United States v. White Mountain Apache Tribe*, 537 U.S. 465, 466 (2003); *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (en banc in relevant part) (citations omitted).

Tucker Act jurisdiction is "limited to actual, presently due money damages from the United States." *See Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (citations and quotations omitted). Colorado HealthOP is entitled to presently due money damages because it has fulfilled all statutory requirements for payment. *See Doe v. United States*, 100

F.3d 1576, 1580, 1582 (Fed. Cir. 1996) (jurisdiction existed where plaintiff had fulfilled all statutory conditions for payment). Colorado HealthOP has submitted all required information to HHS demonstrating its entitlement to payment in specific amounts under the formula contained in Section 1341 of the ACA. HHS stated that for benefit year 2015, Colorado HealthOP was entitled to $38,664,334.67 under the Reinsurance program.

Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded." *Fisher*, 402 F.3d at 1173. Section 1341 is money-mandating, requires full and timely payment, sets forth statutory requirements for receipt of payment that Colorado HealthOP fulfilled, and requires payment the Government has not made. *See, e.g.*, Compl. ¶¶ 9-12, 29-31, 50-53, 86-88. Accordingly, this Court's jurisdiction is beyond dispute. *Me. Cmty. Health Options v. United States*, No. 16-967C (Fed. Cl. Mar. 9, 2017), ECF No. 30; *Moda Health Plan, Inc., v. United States*, 130 Fed. Cl. 436, 449-51 (2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 776 (2017).

SUMMARY OF ARGUMENT

Judgment in Colorado HealthOP's favor is appropriate because the Government has refused to pay Colorado HealthOP money that is mandated by the ACA.

1. *Statutory Mandate to Pay.* A QHP issuer's costs are to be calculated annually. If the costs incurred for individual enrollee was above a certain threshold (subject to a cap), the Government reimburses the issuer for those costs from a general fund comprised of mandatory collections from all insurers, thereby helping to mitigate the risks associated with high-cost enrollees. CMS has acknowledged that payment from this fund is owed to Colorado HealthOP for benefit year 2015, and its failure to make such payment violates the ACA and its implementing regulations, and federal law establishing that state law governs the distribution of

the assets of an insurer in liquidation to the extent the state law seeks to prioritize payments to the liquidating company's insureds.

2. *Improper Offset in Violation of Colorado Law.* The Government unilaterally "set off" money the Government claims Colorado HealthOP owes under the Risk Adjustment program against the amounts statutorily due to Colorado HealthOP under the Reinsurance program. In doing so, the Government violated Colorado law by improperly prioritizing itself over all other creditors of Colorado HealthOP. The Government's assertion that federal law entitles it to a priority for its claims is flatly wrong: The McCarran-Ferguson Act makes clear that for an insurer in liquidation, the relevant order of priority in the distribution of the liquidating insurer's assets is determined by state law – at least to the extent state law seeks to prioritize payment to the insureds and to the administrative expenses of liquidation. The offset taken by the Government is improper under Colorado law because: (1) there is no contract between Colorado HealthOP and the Government; (2) the debts are not mutual; (3) the Government is a net debtor; and (4) the Government defaulted by failing to continue to pursue its proof of claim in the Liquidation Court, with that court then properly determining the Government's claims against the Government.

SUMMARY JUDGMENT STANDARD

Because all material facts are undisputed, this case presents a clear question of statutory interpretation appropriate for summary disposition. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." RCFC 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-16 (2008). A fact is material if it "might affect the outcome of the suit under the

governing law," *Anderson v. Liberty Lobby*, *Inc.*, 477 U.S. 242, 248 (1986), and a dispute of material fact is genuine "if the evidence is such that a reasonable finder of fact could return a verdict for the nonmoving party." *Johnson*, 80 Fed. Cl. at 116 (citing *Liberty Lobby*, *Inc.*, 477 U.S. at 248). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Id.* (quoting *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002)).

ARGUMENT

I. THE GOVERNMENT IS LIABLE FOR NOT MAKING COMPLETE REINSURANCE PAYMENTS UNDER A MONEY-MANDATING STATUTE.

Based on the undisputed facts and as a matter of law, the Government owes Colorado HealthOP an unpaid balance of Reinsurance payments for benefit year 2015. This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and quotations omitted). The plain text of Section 1341 requires the Government to pay any eligible individual market plan issuer certain amounts, according to its regulatory formula. It directs that "the applicable Reinsurance entity collects payments [from all issuers and third-party administrators] and uses amounts so collected to make Reinsurance payments to health insurance issuers … that cover high risk individuals in the individual market …." Pub. L. No. 111-148, § 1341(b)(1)(B).

Eligibility for such payments is set out in the implementing regulations:

> A health insurance issuer of a reinsurance-eligible plan becomes eligible for reinsurance payments from contributions collected under the national contribution rate when its claims costs for an individual enrollee's covered benefits in a benefit year exceed the national attachment point.

45 C.F.R. § 153.230(a). Thus, for benefit year 2015, a health insurance issuer is eligible for Reinsurance payments if: (i) it issued individual market plans under the ACA during benefit

year 2015; and (ii) its claims costs for an insured's enrollment in benefit year 2015 exceed $45,000, the national attachment point for that year.[6]

Colorado HealthOP satisfies both eligibility requirements. First, Colorado HealthOP provided health insurance on the individual exchange in Colorado in 2015. Second, and as recognized by CMS in its published report for benefit year 2015, Colorado HealthOP's claims costs for individual enrollees' covered benefits exceeded the $45,000 national attachment point for benefit year 2015, entitling Colorado HealthOP to Reinsurance payments in the total amount of $38,664,334.67. *See* CMS 2015 Summary Report at 19.

The Government does not dispute that Colorado HealthOP is owed these funds under the Reinsurance program. The gravamen of this action, however, is the Government's unilateral determination to withhold $24,489,799 of the total $38,664,334.67 owed to Colorado HealthOP, purportedly on the basis that the federal government is entitled to an offset on account of money that Colorado HealthOP owes the United States under a different provision of the ACA. *See generally* Compl. Ex. 2.[7]

The Government's refusal to pay Colorado HealthOP the amounts that the Government itself recognizes are owed under the Reinsurance program is in direct contravention of Section

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[6] 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.

[7] Specifically, on August 23, 2016, CMS provided Colorado HealthOP a CMS Reconsideration Spreadsheet reflecting the fact that, rather than pay amounts owed by Colorado HealthOP, it would unilaterally offset $20,255,084 of the $24,489,799 in Reinsurance payments still due to Colorado HealthOP on the theory that Colorado HealthOP owes CMS over $20 million under the separate Risk Adjustment program. Compl. Ex. 2. Regardless, CMS has failed to pay even the amount of the difference between what it owes Colorado HealthOP and what it says Colorado HealthOP owes it. *See id.*

1341 of the ACA and its implementing regulations. Accordingly, the Government is liable to Colorado HealthOP for of $24,489,799 as required by statute.

II. THE GOVERNMENT HAS IMPROPERLY TAKEN AN OFFSET IN VIOLATION OF BOTH FEDERAL AND COLORADO LAW.

The Government violated Colorado law through its improper, unilateral act of attempting to set off amounts purportedly due from Colorado HealthOP under the Risk Adjustment program against the Section 1341 Reinsurance payments owed to Colorado HealthOP.

A. Under McCarran-Ferguson, the Controlling Issues of Priority and Offset Are Subject to Colorado, Not Federal, Law.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, gives States the primary authority to regulate the business of insurance. It specifically provides that "Act[s] of Congress" not expressly purporting to regulate the "business of insurance" do not "invalidate, impair, or supersede" state laws regulating the business of insurance. *Id.* at § 1012(a) & (b). Stated simply, McCarran-Ferguson reverses the ordinary principles of federal preemption. State laws governing insurance are controlling unless Congress, by statute, expressly and clearly states otherwise. Absent a "clear statement" in a conflicting federal statute that "specifically requires otherwise," "state laws enacted 'for the purpose of regulating the business of insurance' do not yield to conflicting federal statutes." *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 507 (1993).

Colorado law establishes a priority structure for the distribution of assets to a liquidating insurers' creditors. That structure gives the highest priority to paying the insureds and the expenses of liquidation. The Supreme Court squarely has held that the liquidation of insurance companies under state statutes designed for that purpose, specifically including a priority structure that places insureds in a position of priority relative to other creditors, including the federal government, is part of the "business of insurance" subject to the control of the States

under McCarran-Ferguson. *See id. at* 509. That is because the "purpose of a [state] statute that distributes the insolvent insurer's assets to policyholders in preference to other creditors is identical to the primary purpose of the insurance company itself: the payment of claims made against policies." *Id.* at 505-06. Consequently, a State may enact laws that assign a higher priority to payments owed to insureds, and to the costs of administering the liquidation, than it assigns to a federal creditor. Those laws will be respected notwithstanding any provisions of federal law purporting to afford super-priority to federal debts. *See id.* at 502.

In sum, because McCarran-Ferguson reverses ordinary federal preemption principles, federal law itself guarantees Colorado the right to grant a higher priority for the use of Colorado HealthOP's funds to pay the administrative expenses of liquidation, and ensure that the insurer fulfills its obligations to its insureds, rather than pay or credit amounts owed the federal government.

The fundamental principle set forth in *Fabe* applies directly to federal agency efforts to avoid the state priority framework by claiming offsets in an effort to limit the payment of federal debts owed to the liquidating insurer. The issue whether a creditor can take an offset in connection with an insurance litigation is every bit as much part of the business of insurance as is the setting of priorities in the first instance, at issue in *Fabe*. That is because, under Colorado law, a creditor's assertion of an impermissible offset fundamentally overturns the rules of priority that would be applied to the distribution of the debt among the creditors. *See Bluewater Ins. Ltd. v. Balzano*, 823 P.2d 1365, 1374 (Colo. 1992) (reinsurers' offset of amounts due to insolvent insurer was improper because it "would be contrary to the order of distribution provided in the liquidation act").

Under ordinary liquidation principles, any and all money owed to the liquidating insurer

is treated as an asset of the liquidating insurer, to be divided and paid out among and between all creditors according to the priority system set forth by statute. In insurance liquidations, this requires that obligations to the insureds (and the costs of administration) are paid first.

The taking of an offset against a debt owed to the liquidating insurer changes all that. Rather than pay the money to the liquidator for distribution to all creditors according to the statutory priority scheme, a claim of offset violates the structure of the priority scheme. In other words, an offset takes an asset (debt) of the company intended for distribution to all creditors, and seizes it for the benefit of only one creditor, here the Government. Through their respective laws, certain states permit this activity in the liquidation of its insurers, and certain states do not. As discussed in *Fabe*, this state-specific determination—ensuring the priority distribution of insurer assets in liquidation—is part of the business of insurance. Thus, there is no question that Colorado law, not federal law, provides the relevant rule in determining whether the Government's claimed offset is permissible. And Colorado law does not permit the Government's action here. The Government violated Colorado insurance liquidation law by offsetting Reinsurance payment amounts due to the Colorado HealthOP against Risk Adjustment obligations owed by Colorado HealthOP.

The ACA itself confirms the primacy of state law under a clause titled "No interference with States regulator authority." 42 U.S.C. § 18031(d). Although axiomatic, the language is worth quoting here: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."[8] Accordingly, under the McCarran-

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

Ferguson Act, the Government is bound by applicable law as it relates to the liquidation of Colorado HealthOP, including priorities and offset.

B. The Government's Unilateral Offset Was Impermissible Under Colorado Law.

The Government's unauthorized, unilateral offset of money ostensibly owed by Colorado HealthOP to CMS under the Risk Adjustment program, in order to avoid the payment of the Government's debt under the Reinsurance program, is impermissible under Colorado law. Under Colorado law, when an insurer is placed into liquidation, the liquidator may collect all debts owed to the bankrupt insurer.[9] C.R.S. § 10-3-520(1)(h). The collected debts are then paid out from the bankrupt entity in accordance with the statutorily mandated order set forth in C.R.S. § 10-3-541(1).

Here, the Liquidator determined, consistent with the Liquidation Act, that the Government's claims based on the ACA would be classified as Class 3 of the distribution scheme, which encompasses "[c]laims of the federal government." C.R.S. § 10-3-541(1)(c).[10] Class 3 claims are preceded by Class 1 ("the costs and expenses of administration during rehabilitation and liquidation") and, importantly, Class 2 ("[a]ll claims under policies," defined

[9] Colorado HealthOP is an insurance company organized under the laws of Colorado, has its principal place of business in Colorado, and served approximately 83,000 individuals on the Colorado exchange. Compl. ¶¶ 17-19. Colorado HealthOP has been ordered into liquidation by the Colorado courts, the proceedings for which are governed by Colorado law. *See* C.R.S. § 10-3-504(2) ("The district court in and for the city and county of Denver shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this part 5."). Indeed, the Colorado Liquidation Act was enacted specifically to govern the rehabilitation and liquidation of its insurance companies: "The purpose of this [Act] is to protect the interests of insureds, claimants, creditors, and the public generally[.]" C.R.S. § 10-3-501(3).

[10] As discussed *infra*, § II.C, the Liquidator nonetheless determined that the Government's Class 3 claims were disallowed.

as including "those insurance company products that are authorized under the laws of the state . . . ."). *See* C.R.S. § 10-3-541(1). Under the law, each predecessor class must first have their claims satisfied in full prior to the Government receiving any distribution on its claims. *See id.* ("Every claim in each class shall be paid in full, or adequate funds shall be retained for such payment, before the members of the next class receive any payment."). If the Government withholds funds owed to the liquidating insurer, it thereby fails to allow those funds to be distributed among all creditors according to the priority system established by statute. It thereby grants itself a super-priority in those funds, superseding the claims of all other creditors.

To illustrate: Assume the Government owes $100.00 to the Co-Op in Reinsurance payments. In the ordinary course, those dollars would be paid to the liquidator and distributed to, and divided among, the Priority 1 creditors and Priority 2 creditors, which include the insureds. Any Government claim for money that the Government is purportedly owed under the Risk Adjustment program would be classified by Colorado statute as Priority 3, and would be paid ***only if*** and when all Priority 1 and Priority 2 creditors have been paid in full. If the Government is permitted to offset Risk Adjustment payments owed to it against the Reinsurance payments it owes the liquidating insurer, it will effectively "jump the line" and deprive Priority 1 and 2 creditors of funds that would have otherwise been available for distribution to them. Indeed, by taking all of the debt for itself, the Government would, in essence, be granting itself a priority over *all* other claimants who would otherwise be distributed a portion of the Reinsurance payment funds.

By unilaterally effectuating an improper offset, the Government not only leap-frogged over Class 1 and 2 creditors, it disregarded the statutory distribution scheme in whole and took "super priority" over *all* other claimants. Such a misuse of offset is impermissible under

Colorado law. *See Bluewater*, 823 P.2d at 1374 (reinsurers' offset of amounts towed insolvent insurer was improper because it "would be contrary to the order of distribution provided in the liquidation act").

In *Bluewater*, the Colorado Supreme Court held that the taking of an impermissible offset is contrary to public policy and fundamentally overturns the statutory system of priorities for the distribution of the assets of a liquidating insurer. 823 P.2d at 1376. It further held that there is no general or common law right of offset recognized under Colorado law for insurance liquidations. *See id.* at 1375-76 (distinguishing New York and Illinois precedent that common law offsets are allowed, noting that Colorado's insurance code contains no similar provision providing that certain mutual debts could be offset, and that Colorado has "a different view of what is in the best interests of policyholders and the public."). In Colorado, a right to offset against a debt in liquidation must be specially authorized by law, regulation or contract.

Following *Bluewater*, the Colorado legislature did enact legislation allowing offsets in certain defined circumstances. Under Colorado statute, offsets are permitted 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, shall be set off, and ***the balance only shall be allowed or paid*** . . . ." C.R.S. § 10-3-529(1) (emphases added).

The Government's claimed offset here fails to meet to any of these statutory requirements: (1) the relevant debts and credits do not arise out of any *contract* between Colorado HealthOP and the Government; (2) the relevant debts and credits are not mutual; and (3) should any offset be allowed, the balance must be paid to Colorado HealthOP only, since the Government is a net debtor. Further, the Government has defaulted on any right to claim an offset by declining to present the relevant information to the Colorado courts for determination

following its submission of proofs of claim. The Government, as the party seeking offset, has the burden of establishing that it is entitled to such offset. *See*, *e.g.*, *In re Balducci Oil Co., Inc.*, 33 B.R. 847, 850-51 (Bankr. D. Colo. 1983) ("the burden of proof is on the creditor asserting the setoff right"). The Government cannot carry its burden.

1. *The Relevant Debts and Credits Do Not Arise Out of a Contract.*

To set off against a debt in an insurance liquidation under Colorado law, that debt must "aris[e] out of one or more ***contracts***" between the parties. C.R.S. § 10-3-529(1) (emphasis added). Here, no such contracts exist between Colorado HealthOP and the Government with respect to either the Reinsurance or Risk Adjustment programs. The Government's obligation to make the Reinsurance payments to Colorado HealthOP arises from Section 1341 of the ACA, which created the Reinsurance program, and its implementing regulations. Similarly, any purported obligation of Colorado HealthOP to make Risk Adjustment payments to the Government arises from Section 1342 of the ACA, which created the Risk Adjustment program.

"[T]he presumption is 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." *Brooks v. Dunlop Mfg.*, 702 F.3d 624, 630 (Fed. Cir. 2012) (quoting *National R.R. Passenger Corp. v. Atchison, Topeka & Santa Fe Ry.*, 470 U.S. 451, 465-66 (1985)). This presumption rests on the basic premise that Congress's function is to pass laws that set national policy, not to make contracts. *See Brooks*, 702 F.3d at 630 (quoting *Atchison*, 470 U.S. at 466)). Here, this well-settled presumption cannot be overcome. Reinsurance and Risk Adjustment are distinct ***statutory*** programs that help to implement the ACA's policy by mitigating risk for insurers—not contracts. *See Baker v. United States*, 50 Fed. Cl. 483, 489 (2001) ("[T]he United States cannot be contractually bound merely by invoking the cited statute and regulation."). Accordingly, because neither Colorado HealthOP's claimed debt under the Section 1341 Reinsurance program

nor the Government's claimed debt under the Risk Adjustment program "aris[e] out of one or more contracts," C.R.S. § 10-3-529(1), the Government's unauthorized, unilateral offset violated Colorado law.

2. *No Mutuality Exists Between the Relevant Debts and Credits.*

In any event, even where a contract exists, only "***mutual*** debts or ***mutual*** credits" can be set off. C.R.S. § 10-3-529(1) (emphases added). Here, there is no mutuality between the Reinsurance payment owed to Colorado HealthOP on the one hand, and the Risk Adjustment payment owed under the Risk Adjustment program, on the other. That is because the two programs operate completely independently, with independent resources and pools of money to distribute. Money taken in, or paid out, in one program simply cannot be used in the other program. Indeed, a company that participates in one program has no claim to any money paid into the other program. And the Government itself is a financial stakeholder only in the Reinsurance program—paying itself with the funds it takes in—but not in the Risk Adjustment program. Money claimed under one program cannot be used as an offset against money owed under another. Therefore, there is no mutuality here.

The Colorado liquidation statute does not define "mutual," but courts throughout the country have interpreted that term in similar contexts to mean that the debts involved must be "between the same parties ***acting in the same capacity***." *E.g.*, *In re Adamic,* 291 B.R. 175, 181 (Bankr. D. Colo. 2003) (emphasis added) (quoting *Davidovich v. Welton*, 901 F.2d 1533, 1537 (10th Cir. 1990)); *Ario v. Am. Patriot Ins. Agency, Inc.*, No. 05 C 1049, 2007 WL 2743204, at *12 (N.D. Ill. Sept. 7, 2007) ("[m]utuality requires that the debts be both contemporaneous in time and ***owed in the same capacity***") (emphasis added). Federal courts have construed this strict mutuality requirement to mean that if either or both parties have no right to the funds in question, then there is no mutuality and no right to offset. *In re Fernandez Super Markets, Inc.*,

1 B.R. 299, 302 (Bankr. D. Mass. 1979); *see also In re Cullen*, 329 B.R. 52, 57 (Bankr. N.D. Iowa 2005). Similarly, when a creditor acts in reality as a "mere conduit" of funds rather than as a true creditor, there is no mutuality. *See, e.g.*, *In re James River Coal Co.*, 534 B.R. 666, 672 (Bankr. E.D. Va. July 16, 2015) (a creditor had no right to offset tax refund sums it was holding because those sums were deemed to be held in trust for the ultimate benefit of the state); *In re Winstar Commc'ns*, 315 B.R. 660 (D. Del. 2004) (holding a creditor could not hold and offset tax refunds because the creditor was acting in an agency capacity rather than in its individual capacity).

To illustrate with two simple examples: Where Company X is a reinsurer and owes reinsurance payments to the liquidating insurer, but the liquidating insurer owes Company X premiums that it has failed to pay, then Company X may take the unpaid premium as offset against the amount of reinsurance that it will pay to the liquidating insurer. Company X has a right to the premiums for its own benefit and use as a reinsurer; the money it owes, it owes as a reinsurer. Both parties are operating within the reinsurer-reinsured relationship.

In contrast, if Company X owes money to the liquidating insurer as a reinsurer, and Company X also happens to be acting as agent for a trust (or perhaps a different reinsurer) that has a claim *against* the insurer, Company X cannot use that claim as a set-off to avoid paying its own debt. In that setting, the money it claims as a creditor is not being claimed for its own benefit, but rather for the benefit of the trust beneficiaries or the company it represents.

Here, the debt owed to Colorado HealthOP, and the debt claimed from Colorado HealthOP, are not mutual. Reinsurance and Risk Adjustment are two distinct programs under the ACA with different stakeholders involved: (1) The two programs involve two separate, and entirely distinct, pools of money; (2) the participants and the beneficiaries under each program

are different; and (3) the Government itself acts in a different capacity under one program as compared to the other.

First, the Reinsurance and the Risk Adjustment programs each utilize their own distinct pool of money to fund only that specific program. Under the Reinsurance program, the Government collects payment contributions from all health insurance issuers based on a per-capita basis, and uses that payment pool to reimburse individual market plan issuers that cover high-cost enrollees, based on the Reinsurance payment methodology in 45 C.F.R. § 153.400. Any surplus that remains in the payment pool is simply rolled forward to the next benefit year. 45 C.F.R. 153.235(b). It does not flow into the general treasury and it cannot be used for other purposes. For example, $1.7 billion in surplus Reinsurance funds collected for the 2014 benefit year were rolled forward to the 2015 benefit year. None of the Reinsurance funds are used toward the Risk Adjustment (or any other) ACA program.

Under the Risk Adjustment program, the Government collects payments from plans that cover relatively low risk enrollees, and redistributes that pool of payments to plans that cover relatively high risk enrollees. 42 U.S.C. § 18063. Transfers within a given state net to zero, and none of the Risk Adjustment funds are used toward Reinsurance or any other ACA programs.

As such, the two pools of money are independent and not interchangeable. Colorado HealthOP's Risk Adjustment debt collectible by the Government is not owed in the same capacity as the Reinsurance debt collectible by Colorado HealthOP, and therefore there is no mutuality between the two debts.

Second, the participants and beneficiaries under the Reinsurance program are different from those under the Risk Adjustment program. As described above, participation in the Reinsurance program encompasses all insurers—including all individual, small group, and large

group market issuers of fully-insured major medical products, as well as self-funded plans. All such insurers were required to make payment contributions that were used to pay individual market plan issuers that cover high-cost enrollees—the beneficiaries of the program. In contrast, the Risk Adjustment program only involves non-grandfathered[11] individual and small group market plan issuers, both inside and outside of the exchanges. The beneficiaries of the program are those plan issuers with relatively high-cost enrollees. Since the insurers involved in the Reinsurance program—both the contributors and the beneficiaries—are different from the ones involved in the Risk Adjustment program, the debts owed under the Reinsurance program are not owed in the same capacity as the debts owed under the Risk Adjustment program.

Third, and finally, the Government's own role with respect to the two different programs and pools of money is different. Under the Risk Adjustment program, the Government acts only as a conduit, a manager that accepts money in and redistributes it out. 45 C.F.R. 153.310. The Risk Adjustment program does not involve any appropriated funds from the U.S. Treasury. Rather, it is established a closed system in which money is paid in, and then reallocated according to a specified formula. The Government itself has no direct financial stake in the program. As such, any Risk Adjustment payments purportedly owed by Colorado HealthOP under this program would be distributed to other insurers under the program, and not to the Government.

In contrast, the Government collects payments from participating insurers under the Reinsurance program not only to pay certain other insurers, but also to pay itself for the costs of the early retiree reinsurance program which it had operated prior to the inception of the ACA.

[11] Plans in existence at the time the ACA was enacted in March 2010 were grandfathered into the program and are subject to fewer requirements.

See 42 U.S.C. § 18061(3)(B)(iv). Those funds collected under the Reinsurance program are paid directly into the Treasury under the program and the statute requires that those funds be used solely for the benefit of the Government. 42 U.S.C. § 18061(b)(4)(B). As such, the Government is not a mere conduit, but also a beneficiary and stakeholder, with the amount collected from the participating insurers flowing into the Treasury for the benefit of the United States.

In sum, there is no "mutual debt or mutual credit" at issue here. The two programs and their participants are distinct. And the sums owed to Colorado HealthOP under the Section 1341 Reinsurance program are to be paid by the Government in a different capacity than is owed to the Government under the Risk Adjustment program. *See Fernandez Super Markets, Inc.*, 1 B.R. 299 at 302; *James River Coal Co.*, 534 B.R. 666 at 672.

3. *The Government Is a Net Debtor, Not a Net Creditor*

The Government's offset is improper for an additional reason, too: as the Liquidator found and the Liquidation Court ordered, the Government is a net ***debtor***, not a net ***creditor***. As the Liquidator articulated in the CMS Claims Determination, the Government is a net debtor because the $111,420,992 the Government owes Colorado HealthOP under the Risk Corridors program is more than sufficient to cover all of the Government's claims in its POC—which includes the Risk Adjustment amount Colorado HealthOP allegedly owes the Government.

The Government is likely to rely on the Federal Circuit decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), to argue that it is not obligated to pay the Risk Corridors amount and, therefore, there is no basis for it to be included in determining who owes how much to whom in connection with this liquidation. The Government would be wrong. *Moda* held that the "shall pay" language of Section 1342 ***unambiguously created a payment obligation*** . *Id.* at 1320. It then held that certain subsequent enactments, in the form of appropriation riders, barred the use of Treasury funds for that purpose and thus "suspended" the

obligation to pay. *Id.* at 1325. Instead, the obligation could only be paid from certain money paid into the Risk Corridors program—which would and could be paid out as the money became available. *Id.* at 1328.

As the Federal Circuit perceived it, these enactments did not *cancel* the underlying obligation itself, but merely *suspended* payment for the relevant years in which the debts accrued. *See id.* at 1330-31. As the Government argued in *Moda*, and as the Federal Circuit credited, the debt would remain outstanding and payable to the extent funds were made available (as from money taken in from other insurers under that program). *Id.* at 1328; *see also* Br. for Appellant at 66, *Moda* (No. 17-1994), ECF No. 17 (noting that unpaid obligations could still be paid if funded by Congress). Thus, the Government continues to owe Colorado HealthOP $111,420,992 in Risk Corridors debt. Under *Moda*, the Government is simply not required to pay that sum to Colorado HealthOP unless an appropriation is made. But the issue here does not involve the making of any risk corridor payments where no Treasury funds have been appropriated for that purpose—the *Moda* question. All that is involved here is a computation of who owes what to whom. And even assuming arguendo that all of these programs involved contracts, and the debts and credits were mutual, the fact would still remain that the Government owes more than it is owed; it is a net debtor.[12]

The Colorado liquidation statute is clear that offsets account for "***all*** mutual debts and credits," and that "***the balance only*** shall be allowed or paid." C.R.S. § 10-3-529(1) (emphases added). Thus, when computing who owes what to whom—a balance sheet matter—the Government here clearly ends up as a net debtor, not a net creditor.

[12] As noted above, the loan amounts owed by Colorado HealthOP are not relevant for these purposes because there are explicitly not eligible for offset and subordinated to all other obligations.

C. The Government Has Defaulted on Its Claim.

Apart from the inapplicability of the Colorado offset statute discussed above, Government's offset is also precluded under Colorado law, as the Colorado court has determined that the Government has defaulted on its claims against Colorado HealthOP—another reason why the Government's claimed offset cannot be sustained.

The Government subjected itself to the Denver County District Court's jurisdiction with respect to Colorado HealthOP's liquidation when it submitted its POC. *See* C.R.S. § 10-3-504(2) ("The district court in and for the city and county of Denver shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this part 5."). The Government then failed to support the claimed debts owed by Colorado HealthOP or to support any federal defense. The consequence was that the Liquidator and the Liquidating Court rejected those claims, including as a basis for offset.

Pursuant to its jurisdictional authority, the District Court for the City and County of Denver issued its Liquidation Order on January 4, 2016, wherein it authorized the Liquidator to, among other things:

> take such steps ***as are necessary and authorized by the laws of Colorado*** to liquidate the affairs and business of Respondent, and the Liquidator is granted all the powers of the CO-OP's directors, officers, shareholders and managers, whose authority shall be suspended by this Order except insofar as they are delegated by the Liquidator.

Compl. Ex. 1 ¶ 15 (emphasis added). Moreover, it stated that the Liquidator "has the authority to collect all debts and moneys due and claims belonging to the CO-OP." Compl. Ex. 1 at 6.

Pursuant to the Liquidation Order, on March 31, 2016, Colorado HealthOP, through the Liquidator, provided a Notice and a 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. The POC form was due by January 2, 2017. On December 30, 2016, CMS submitted the Government's proof of claim and supporting exhibits, claiming over $97,715,924.32 for "[a]mounts owed by Debtor [Colorado HealthOP] under the Affordable Care Act and federal law," which includes, among others, $21,801,742.03 in Risk Adjustment charges. Compl. Ex. 3 at 1. Notably, CMS claimed a right of priority citing "Federal Law and 508c.42(3)." *Id.*

Pursuant to C.R.S. § 10-3-535(3), the Liquidator mailed the April 2017 Letter to CMS, asking CMS to provide additional information regarding CMS' unliquidated claims, the Start-Up and Solvency Loans, offsets, and the Liquidator's priority determinations, and required a response by June 1, 2017. Compl. Ex. 4. The Liquidator expressly stated that, consistent with C.R.S. § 10-3-535(2), 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." *Id.* at 4.

Even after the Liquidator granted an extension for CMS to respond to the April 2017 Letter, CMS failed to provide any response whatsoever. Compl. ¶¶ 59-62. On August 30, 2017, the Liquidator mailed to CMS the CMS Claims Determination denying CMS's POC in its entirety. Compl. Ex. 6. CMS never objected to the Liquidator's determination, and is therefore barred from now objecting to the determination under C.R.S. § 10-3-538(1) ("[i]f no [response to Liquidator's determination] is made, the claimant may not further object to the determination.").

On December 11, 2017, the Liquidator filed its "Motion to Affirm Proof of Claim Determination, Priority Determination, and Partial Proof of Claim Denial" 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. Compl. Ex. 7. The Liquidation Court granted the motion. Compl. Ex. 8.

The Government received the benefit of an extension to provide the information requested by the Liquidator pursuant to the Liquidation Order, but twice declined to respond to the Liquidator's questions. The Government received the benefit of 60 days to object to the Liquidator's determination of CMS' claim but, again, the Government declined to do so. As a result, CMS cannot further object to the Liquidator's determination of CMS' claim, C.R.S. § 10-3-538, and the Liquidation Court granted the Liquidator's motion to affirm its determination of the CMS' claim. Yet, the Government still has not complied with the Liquidator's determination that it must return its unauthorized, unilateral offset and pay Colorado HealthOP what it is owed under the Reinsurance program. In so doing, the Government has deprived Colorado HealthOP's creditors of the payments to which they are entitled under Colorado law. The Government must therefore be compelled to make the required payments to prevent further harm to creditors of Colorado HealthOP's estate.

CONCLUSION

Colorado HealthOP respectfully requests that its motion for summary judgment be granted and judgment entered for Colorado HealthOP and against the Government in the amount of $24,489,799.

Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

Dated: December 8, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on December 8, 2018 a copy of the forgoing motion for summary judgment 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.

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