IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MICHAEL CONWAY, in his capacity as Liquidator of COLORADO HEALTH INSURANCE COOPERATIVE, INC.,	)	
Liquidator,	)	No. 18-1623C
v.	)	Judge Nancy B. Firestone
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

UNITED STATES' MOTION TO DISMISS AND
OPPOSITION TO LIQUIDATOR'S MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

After operating for just two years as a functioning health insurer, Colorado Health Insurance Cooperative, Inc. ("CHIC") defaulted on $72 million in loans provided to it by the United States Department of Health and Human Services ("HHS") under the Patient Protection and Affordable Care Act ("ACA") – loans that will almost certainly never be repaid. CHIC also owes HHS nearly $10 million related to its participation in various ACA programs – again, debts that will almost certainly never be paid.

Now, Plaintiff Michael Conway, in his capacity as liquidator of CHIC's estate (the "Liquidator"), demands $24 million in taxpayer funds, an amount allegedly due to CHIC for its 2015 participation in the ACA reinsurance program. Although the Liquidator asserts that HHS failed to make payment as required by the statute governing the reinsurance program, HHS unquestionably paid those funds to CHIC by offsetting them against debts owed by CHIC to HHS under another ACA program – risk adjustment. Offset is a form of payment, and HHS's offsets were authorized by federal law, and in this case, necessary for HHS's administration of the ACA. Thus, CHIC has received full payment of the amount it was owed under the reinsurance program.

Recognizing, as he must, that HHS made payment by offset, the Liquidator further alleges that HHS's offset violated Colorado state law, which supposedly prohibits HHS' offset. However, federal law preempts the state law.

In any event, the Liquidator's state law theories are incorrect. First, settled common law recognizes that debts owed between HHS and CHIC are mutual and subject to offset. Second, binding Federal Circuit precedent rejecting insurers' claims for additional risk corridors payments forecloses CHIC's theory that offset was unavailable because risk corridors payments remained due. Third, Colorado law does not limit offset to contractual debts as argued by the Liquidator.

Fourth, courts across the country have uniformly rejected the notion that offset is limited by a state priority distribution scheme. Finally, the Colorado state liquidation court cannot bar HHS's offset.

The Complaint should be dismissed in its entirety because it fails to state any claims upon which relief can be granted, and this Court lacks jurisdiction over the Liquidator's state law claim. Alternatively, the Court should deny the Liquidator's motion for summary judgment and grant summary judgment to the United States.

STATEMENT OF ISSUES

1. Whether the Liquidator's claims must be dismissed because CHIC was properly paid through offset.

2. Whether the Liquidator's state law claim should be dismissed for lack of jurisdiction.

BACKGROUND

I. Statutory and Regulatory Background

A. The ACA and Health Benefit Exchanges

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (collectively, hereinafter the "ACA"), in March 2010. The ACA adopted a series of measures designed to expand coverage in the individual health insurance market. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). First, the ACA provides billions of dollars of annual subsidies to help qualified individuals buy insurance. *Id.* at 2489. Second, the ACA generally requires individuals to maintain coverage or pay a penalty. *Id.* at 2486.[1] Third, the ACA bars

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

insurers from denying coverage or charging higher premiums based on an individual's health status. *Id.*

The ACA also created Health Benefit Exchanges ("Exchanges"), virtual marketplaces in each state where qualified individuals can purchase pre-certified health insurance coverage and obtain federal health insurance subsidies. 42 U.S.C. §§ 18031-18041; 26 U.S.C. § 36B. For qualified individuals, Exchanges are the only forums through which they can purchase coverage with the assistance of federal subsidies. For insurers, Exchanges provide marketplaces to compete for business in a centralized location, and are the only channels through which insurers can market their plans to the millions of individuals who receive federal subsidies. Plans offered through an Exchange generally must be Qualified Health Plans ("QHPs"), meaning that the plans provide "essential health benefits" and comply with other regulatory requirements, such as provider-network requirements, benefit-design rules, and cost-sharing limitations. 42 U.S.C. §§ 18021 and 18031; 45 C.F.R. parts 155 and 156.

The ACA also created several interrelated programs, the following of which are relevant to this case.

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

In an effort to mitigate the pricing risks and incentives for adverse selection, the ACA established three interrelated premium stabilization programs modeled on existing programs established under the Medicare program.[2] Informally known as the "3Rs," these ACA programs began with the 2014 calendar year and include the reinsurance, risk corridors, and risk adjustment programs.

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

The 3R programs distribute risks among issuers. Each of the 3R programs is funded by amounts that issuers and certain other entities pay into the program. *See* Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment 76 Fed. Reg. 41,930, 41,948 (July 5, 2011) ("The payments and receipts in risk adjustment, reinsurance, and risk corridors are financial transfers between insurers.").

1. The Reinsurance and Risk Adjustment Programs

The **reinsurance program** was created by section 1341 of the ACA. It was a temporary program for the 2014, 2015, and 2016 calendar years under which amounts collected from issuers and certain self-insured group health plans were used to fund payments to individual market issuers of eligible plans that cover high-cost individuals. 42 U.S.C. § 18061.

The **risk adjustment program** was created by section 1343 of the ACA. It is a permanent program under which amounts collected from insurers whose plans have healthier-than-average enrollees are used to fund payments to insurers whose plans have sicker-than-average enrollees. 42 U.S.C. § 18063.

The ACA contemplated states administering their own reinsurance and risk adjustment programs, with HHS responsible for operating the programs in states that fail to do so. 42 U.S.C. §§ 18061(b), 18063, 18041(a)-(c). In practice, the majority of the states deferred to HHS to administer their programs as set forth in the ACA's state flexibility provision, *id.* § 18041. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,759 (Feb. 27, 2015). HHS operated both of these programs in Colorado.

Here, CHIC received its 2015 reinsurance benefit of nearly $39 million through both direct payment and offset. The portion of that benefit the Liquidator demands here, nearly $24.5 million,

was offset by HHS crediting that amount against CHIC's 2015 risk adjustment debt owed to HHS. *See* Compl. ¶¶ 9, 53. HHS then distributed the funds made available by this offset to other issuers in Colorado, consistent with its administration of the risk adjustment program. While neither reinsurance nor risk adjustment are substantively at issue in this case, through Count I, the Liquidator argues that HHS violated ACA section 1341 by failing to pay 2015 reinsurance to CHIC. At Count II, the Liquidator challenges HHS's use of offset.

2. The Risk Corridors Program

The **risk corridors program** was created by section 1342 of the ACA and, like the reinsurance program, was a temporary program for the 2014, 2015, and 2016 calendar years, under which amounts collected from profitable insurance plans were used to fund payments to unprofitable plans. *See* 42 U.S.C. § 18062.[3] The risk corridors program mitigated risk for plans that underestimated their claims costs in the aggregate (including any required charges due to the government under the 3Rs programs). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (March 11, 2013).

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

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

The ACA did not appropriate any funding for risk corridors payments. Instead, Congress deferred the issue of funding to the annual appropriations process. And in subsequent legislation, Congress appropriated "payments in," but barred HHS from using other potential funding sources. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, 128 Stat. 2130, 2477; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624; Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135.[4] Congress thus locked HHS into its previously announced intention to operate the risk corridors program in a budget neutral manner. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787 (March 11, 2014); *see also* 160 Cong. Rec. H9307-1, H9838 (daily ed. Dec. 11, 2014) ("In 2014, HHS issued a regulation stating that the risk corridors program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect."). Throughout the risk corridors program's three-year life-span, the total amounts of "payments in" fell short of the total amount requested by issuers in "payments out." CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (November 2017).[5] Consistent with its three-year framework for administering the program, HHS issued prorated payments according to the extent of collections.

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

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

In a set of four recent decisions, the Federal Circuit gave effect to Congress's express restrictions on funding for risk corridors payments and held that HHS was not liable for full "payments out" to issuers. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1329 (Fed. Cir. 2018) (reversing trial court and rejecting the issuer's statutory and implied contract claims for additional risk corridors payments); *Land of Lincoln Mutual Health Ins. Co. v. United States*, 129 Fed. Cl. 81 (2016), *aff'd*, 892 F.3d 1184 (Fed. Cir. 2018) (affirming dismissal of statutory, express and implied contract, and Takings claims); *Maine Community Health Options v. United States*, 729 Fed. Appx. 939 (Fed. Cir. 2018) (affirming for reasons stated in *Moda*); *Blue Cross and Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457 (2017), *aff'd*, 729 Fed. Appx. 939 (Fed. Cir. 2018) (same). The issuers have now sought certiorari from the United States Supreme Court.

The risk corridors program is not substantively at issue in this case, but the Liquidator asserts in the Complaint that CHIC is "owed $111,420,992 in risk corridors payments." Compl. ¶ 39. While the Complaint does not further address CHIC's risk corridors claim, at Count II and in its MSJ, the Liquidator argues that the United States' offset is improper because it fails to account for CHIC's risk corridors claim. MSJ at 34-35.

C. Federal Consumer Subsidies

The ACA also created several temporary and permanent programs designed to facilitate and support the ACA's primary reforms. The most significant source of financial transfers between issuers and HHS under the ACA had been the monthly federal insurance subsidy of advance premium tax credit ("APTC") and cost-sharing reduction ("CSR") payments (collectively the "Federal Consumer Subsidies" or "Federal Consumer Subsidy programs"). In order to make insurance more affordable, the ACA subsidized many individuals' monthly health insurance premiums and their episodic cost-sharing requirements (*i.e.*, deductibles, copays, and coinsurance). These subsidies were only available to qualified individuals enrolled in a QHP

obtained through an Exchange. 42 U.S.C. § 18071(f)(2). Rather than provide this assistance directly to qualified individuals after-the-fact or in advance to pay to their health insurers, the Department of Treasury paid these subsidies in advance to qualified individuals' insurers based on estimates derived from issuer-provided data. 42 U.S.C. § 18082. And, if these advance payments wind up being too low (or too high) for the year, further payments (or collections) reconcile the difference. *E.g.*, 26 C.F.R. § 1.36B-4; 45 C.F.R. § 156.430.[6]

APTC and CSR payments are not at issue in this case though, as demonstrated below, CHIC continues to owe HHS for CSR reconciliation overpayments.

D. The CO-OP Program

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

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

CHIC received a $15 million start-up loan and $57 million in solvency funds.[7] Compl. ¶ 35, Ex. 3. CHIC has not made any payments to HHS on the loans.

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

Central to HHS's administration of the 3Rs and Federal Consumer Subsidy programs is its use of netting—a form of offset. To streamline its payment and collection process for the 3Rs and other enumerated ACA programs, HHS promulgated a regulation allowing it to net amounts owed by issuers against amounts HHS owes to the issuers under those programs. *See* 45 C.F.R. § 156.1215 (the "Netting Regulation"); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,322, 72,370-71 (Dec. 2, 2013) (explaining that netting will "permit HHS to calculate amounts owed each month, and pay or collect those amounts from issuers more efficiently"). As each of the 3R programs is funded by amounts that issuers and certain other entities pay into the program, HHS's use of netting in its monthly payments and collections cycle allows the agency to make timely payments to insurers that are due from funds under the 3R programs. 78 Fed. Reg. at 72,370.

The Netting Regulation is at the forefront of this case. Consistent with this practice, HHS netted nearly $24.5 million of the 2015 reinsurance payment due to CHIC against the 2015 risk adjustment charge due by CHIC. HHS then distributed these funds to other issuers in Colorado who were due risk adjustment payments. At Count II, the Liquidator challenges HHS's use of netting as contrary to Colorado law.

[7] The original amount of the start-up loan was $12,266,400. Compl. Ex. 3. The loan was amended on October 18, 2013 to increase the loan amount to $15,205,529. *Id.*

II. CHIC's Participation in Colorado's Exchange and Subsequent Liquidation

CHIC is a former CO-OP that issued health insurance plans sold on the Exchange in Colorado in 2014 and 2015. Complaint ¶ 9. As described above, under the CO-OP loan program, CHIC received a total of $72 million in taxpayer funds from HHS, comprised of a $15 million start-up loan and $57 million in solvency funds. *Id.* ¶ 35, Ex. 3.[8] During its short existence, CHIC also received payments under the Federal Consumer Subsidy programs, participated in the 3Rs programs for those benefit (or calendar) years, and was subject to HHS's monthly payment and collection cycle.

On February 15, 2015, CHIC came under Colorado state supervision. Compl. ¶ 47. On November 10, 2015, the Denver County District Court (the "State Court") ordered CHIC into rehabilitation. Compl. ¶ 48. On January 4, 2016, the court placed CHIC into liquidation. Compl. ¶ 49.

Throughout this time, HHS continued to administer the 3Rs programs. CHIC was entitled to a reinsurance payment of nearly $39 million for the 2015 benefit year. Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year (December 6, 2016) ("HHS Report on Reinsurance and Risk Adjustment for 2015") at 7; Compl. ¶ 31.[9] CHIC also owed risk adjustment payments of just over $42 million for the 2015 benefit year. HHS Report on Reinsurance and Risk Adjustment for 2015

[8] At CHIC's inception, the solvency loan was classified as a surplus note. Compl. Ex. 3A (Dkt. 1-2 at 30). In August 2015, HHS agreed to amend the start-up loan and classify it too as a surplus note. Compl. Ex. 3A (Dkt. 1-2 at 25). Because both loans are treated as surplus, HHS has not setoff any of the over $72 million provided to CHIC that has not been paid back to the United States. Thus, these loans are not at issue in this litigation.

[9] Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

at 7. In sum, CHIC owed more to HHS in risk adjustment charges than HHS owed to it in reinsurance payments, such that after netting, no amounts were due to CHIC.

HHS makes payments on a rolling basis, netting payments owed against payments due, and HHS made an initial payment of the 2015 reinsurance benefit, approximately $14.2 million, to CHIC in March 2016. Compl. ¶ 31. Subsequent to that March payment, the remainder of the nearly $39 million reinsurance payment due to CHIC for 2015, approximately $24.5 million, was netted in the August 2016 and February, March and December 2017 payment cycles against the risk adjustment charges for 2015 owed by CHIC to HHS. Compl. ¶ 53.[10]

Following the netting of the reinsurance payment, CHIC owed and currently owes HHS the following debts totaling nearly $82 million:

- Start-up loan $15,205,529
- Solvency loan $57,129,600
- Additional 2015 risk adjustment charges $6,613,796
- 2015 Cost-sharing Reduction Reconciliation Charges $2,180,837
- Cost-sharing Reduction Reconciliation Interest $52,476
- 2015 risk adjustment user fees $76,735
- Reinsurance contributions $771,298

STANDARD OF REVIEW

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

[10] The Complaint quotes from letters and reports confirming netting and offsets between the Parties but fails to attach any of the documents on which it relies. For completeness, attached at Appendix A1-A3 is a netting report ("Netting Report") setting forth the history of financial transfers between the Parties, and attached at Appendix A4-A11 are HHS's letters advising CHIC of the offsets.

lacks jurisdiction over the subject matter, it must dismiss the claim." *Matthews v. United States*, 72 Fed. Cl. 274, 278 (2006) (citations omitted).

To avoid dismissal under Rule 12(b)(6) for failure to state a claim, a Liquidator must "provide the grounds of [its] entitle[ment] to relief" in more than mere "labels and conclusions." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation and quotation marks omitted); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A "formulaic recitation of the elements of a cause of action" is insufficient. *Twombly*, 550 U.S. at 555. Rather, the complaint must "plead factual allegations that support a facially 'plausible' claim to relief." *Cambridge v. United States*, 558 F.3d 1331, 1335 (Fed. Cir. 2009). The Court must dismiss a claim "when the facts asserted by the claimant do not entitle [it] to a legal remedy." *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002).

"Summary judgment is proper 'if the movant shows that there is no genuine dispute as to any material fact and that the movant is entitled to judgment as a matter of law.' *Butler v. United States*, 139 Fed. Cl. 617, 625 (2018) (quoting RCFC 56(a)). "A genuine dispute is one that could permit a reasonable jury to enter a verdict in the non-moving party's favor, and a material fact is one that could affect the outcome of the lawsuit." *Id.* (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). "Cases involving only questions of law are particularly appropriate for summary judgment." *Id.* (citing *Dana Corp. v. United States*, 174 F.3d 1344, 1347 (Fed. Cir. 1999)).

ARGUMENT

The Liquidator seeks to recover ACA reinsurance program payments that CHIC has already received through offset against CHIC's ACA debts. As demonstrated below, Count I fails because the amounts sought have been paid. Count II, which serves as the basis for the Liquidator's attack upon the exercise of offset, also fails as a matter of law.

I. Count I Fails as Matter of Law Because the Amount Claimed was Properly Paid Through Offset

In Count I, the Liquidator alleges solely that CHIC has not been paid reinsurance for benefit year 2015 in violation of ACA § 1341, 42 U.S.C. § 18061, and its implementing regulations. Yet, in paragraph 53 of the Complaint, the Liquidator acknowledges that HHS offset the payable against outstanding debts. The Liquidator alleges that "[t]he Government has no legal right to withhold the Reinsurance payment." Compl. ¶ 11. But HHS did not "withhold" payment – HHS made payment by offset, and HHS had every legal right to do so. Because Count I does not itself dispute the propriety of offset, it fails as a matter of law.

The right of the United States to use offset to collect debts is firmly established. "[S]etoff (also called 'offset') allows entities that owe each other money to apply their mutual debts against each other, thereby avoiding 'the absurdity of making A pay B when B owes A.'" *Citizens Bank of Md. v. Strumpf*, 516 U.S. 16, 18 (1995) (quoting *Studley v. Boylston Nat. Bank*, 229 U.S. 523, 528 (1913)); *see also United States v. Munsey Trust Co. of Washington, D.C.*, 332 U.S. 234, 239 (1947); *Johnson v. All-State Constr., Inc.*, 329 F.3d 848, 852 (Fed. Cir. 2003) ("This court and our predecessor court have repeatedly recognized the government's right of set-off.") (citation omitted); *United States v. DeQueen & E. R.R. Co.*, 271 F.2d 597, 599 (8th Cir. 1959) (acknowledging the government's right of "setoff, without limitation"); *United States v. Tafoya*, 803 F.2d 140, 141 (5th Cir. 1986) ("The right of setoff is 'inherent in the United States Government' . . . and exists independent of any statutory grant of authority to the executive branch.") (citations omitted).

HHS regulations also prescribe the use of offset to collect funds owed to the United States. In particular, 42 C.F.R. § 401.607(a)(2) provides that HHS "recovers amounts of claims due from debtors . . . by . . . [o]ffsets against monies owed to the debtor by the Federal government where

possible." And the ACA Netting Regulation specifically permits HHS to utilize netting—a form of offset—in administering the payments and charges arising under the premium stabilization and other ACA programs. 45 C.F.R. § 156.1215.

The Federal Circuit has recognized that offset is a form of payment. *Brazos Elec. Power Co-op., Inc. v. United States*, 144 F.3d 784, 787-88 (Fed. Cir. 1998) ("[c]ancellation of debt owed to the federal government under such circumstances is just as much a form of monetary damages for purposes of the Tucker Act as the direct payment by the federal government of conventional money damages"); *see also Gonzales & Gonzales Bonds & Ins. Agency, Inc. v. Dep't of Homeland Sec.*, 490 F.3d 940, 945 (Fed. Cir. 2007) ("offset of other debt is a form of monetary relief"); *Beloit Corp. v. C3 Datatec, Inc.*, No. 95-3309, 1996 WL 102436, at *1 (7th Cir. March 1, 1996) ("Usually payment occurs by check or cash, but payment may occur by cancellation of offsetting accounts."). The Liquidator's preference for direct payment, rather than payment in the form of debt cancellation, is not sufficient to state a claim for violation of section 1341.

II. Count II Should Be Dismissed; HHS's Offset was Proper

Notwithstanding HHS's well-established right of offset, at Count II, the Liquidator contends that state law rather than federal law should govern the federal government's rights to offset and that Colorado law forbids offset in the event of insolvency. These arguments are demonstrably incorrect.

A. Federal Law Governs HHS's Use of Offset

Congress enacted the ACA and conferred responsibilities on HHS with respect to the 3Rs programs. 42 U.S.C. §§ 18041, 18061, 18062, 18063. The unique federal interests in this case arises directly from HHS's operation of these premium stabilization programs. 42 U.S.C. §§ 18041, 18061, 18062, 18063(b), Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410 (March 11, 2013); 45 C.F.R. §

156.1215. Central to HHS's administration of these programs is the Netting Regulation, which directly and explicitly authorizes HHS's offsets, as it allows HHS, "[a]s part of its payment and collections process," to "net payments owed to issuers . . . against amounts due to the Federal or State governments from the issuers . . . for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, payment of any fees for State-based Exchanges utilizing the Federal platform, and risk adjustment, reinsurance, and risk corridors payments and charges." 45 C.F.R. § 156.1215(b).[11] Consistent with its operation of these federal programs, HHS offset reinsurance payments owed to CHIC against risk adjustment charges due to the federal government.

In circumstances such as these, the Supreme Court "has consistently held that federal law governs questions involving the rights of the United States arising under nationwide federal programs." *United States v. Kimbell Foods, Inc*., 440 U.S. 715, 726 (1979); s*ee also Boyle v. United Tech. Corp.*, 487 U.S. 500, 504-05 (1988). This well-settled principle confirms that HHS's use of offset in administering the 3Rs programs is governed by federal law.

B. The McCarran-Ferguson Act Is Inapplicable

The Liquidator apparently asserts that federal law, specifically, the McCarran-Ferguson Act, prohibits HHS's offset because it gives force to Colorado insurance law that, the Liquidator asserts, prohibits offset. The Liquidator is wrong on all fronts.

The McCarran-Ferguson Act provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the

[11] In the Liquidator's motion, the heading for Argument § II claims that HHS's offset violated "FEDERAL" law. However, the succeeding argument does not identify any federal law allegedly violated. As we explain, the Liquidator's apparent contention that HHS lacked authority pursuant to federal law to exercise its right of offset/netting is incorrect. *See* MSJ at 23.

business of insurance, . . . unless such Act specifically relates to the business of insurance[.]" 15 U.S.C. § 1012(b). This law has been interpreted to mean that state law "reverse-preempts" federal law if three factors are present: (1) the federal law at issue does not specifically relate to the business of insurance; (2) the state law at issue was enacted for the purpose of regulating the business of insurance; and (3) application of the federal law would "invalidate, impair or supersede" the state law. *United States v. R.I. Insurers' Insolvency Fund*, 80 F.3d 616, 619 (1st Cir. 1996) (citation omitted).

The McCarran-Ferguson Act states that "*silence* on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of [the insurance] business by the several States." 15 U.S.C. § 1101 (emphasis added). The Supreme Court has interpreted this language to mean that, in enacting the McCarran-Ferguson Act, Congress sought merely to avoid the "*unanticipated* interference with state regulation." *Barnett Bank of Marion Cnty. v. Nelson*, 517 U.S. 25, 40-41 (1996) (emphasis added, citations omitted). The Court has made clear that the McCarran-Ferguson Act does "not require avoiding federal pre-emption by future federal statutes that indicate, through their 'specific relation' to insurance, that Congress had focused upon the insurance industry, and therefore, in all likelihood, consciously intended to exert upon the insurance industry whatever pre-emptive force accompanied its law." *Id.* at 40-41 (punctuation omitted). "[W]hen Congress enacts a law specifically relating to the business of insurance, that law controls." *Humana Inc. v. Forsyth*, 525 U.S. 299, 306 (1999).

The ACA not only specifically relates to the business of insurance, it materially altered the legal landscape of the insurance industry nationwide. In enacting the ACA, Congress focused directly and unambiguously on the business of insurance. It established an individual mandate, 26 U.S.C. § 5000A; health insurance exchanges to facilitate the purchase of pre-certified health

insurance policies, 42 U.S.C. § 18031; standards relating to minimum coverage for plans sold on the exchanges, *id.* §§ 18021(a), 18022(b)-(f), 18031(c), (d)(2)(B); insurance subsidies to help qualified individuals afford such plans, *id.* §§ 18071, 18081, 18082; 26 U.S.C. § 36B; premium stabilization programs to mitigate the impact of adverse selection, *id.*, 42 U.S.C. §§ 18061, 18062, 18063; and CO-OP loans to facilitate competition and choice with respect to the sale of health insurance policies. *Id.* § 18042. These interlocking reforms specifically relate to insurance markets and the spreading of risk, and they intended to affect—indeed to fundamentally transform—the relationship between insurers and insureds. *See King*, 135 S. Ct. at 2496 (noting that "Congress passed the Affordable Care Act to improve health insurance markets . . . .").

Moreover, the interlocking ACA reforms are specifically addressed in HHS's Netting Regulation, which unquestionably authorizes HHS's offset here by permitting HHS to "net payments owed" to CHIC for the reinsurance program against "amounts due to" HHS for the risk adjustment program. As such, any Colorado state law prohibiting HHS from netting (which, as described above, no Colorado law actually does so) is preempted by the ACA. *See* 45 C.F.R. § 156.1215.

Therefore, the ACA and the regulations promulgated thereunder "specifically relate to the business of insurance" so as to restore ordinary Supremacy Clause principles and render the McCarran-Ferguson Act's "reverse-preemption" provisions inapplicable. *See R.I. Insurers' Insolvency Fund*, 80 F.3d at 620-22 (holding that Medicare Secondary-Payer Act specifically related to the business of insurance so as to preempt contrary state insolvency law); *see also Geston v. Anderson*, 729 F.3d 1077 (8th Cir. 2013) (federal Medicaid Act preempted state law treatment of annuity payments); *Gunter v. Farmers Ins. Co.*, 736 F.3d 768, 772 (8th Cir. 2013) (National Flood Insurance Act of 1968 preempted state law insurance claims). "Considerations of purpose,

as well as of language, indicate that the [ACA] falls within the scope of the McCarran-Ferguson Act's 'specifically relates' exception to its anti-pre-emption rule." *Barnett Bank*, 517 U.S. at 41 (1996) (citations omitted).

In fact, it is clear that Congress intended the ACA to preempt contrary state law because the Act contains an express preemption provision, providing that "[n]othing 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). Under the ACA state law is preempted to the extent that it "'hinder[s] or impede[s]' the implementation of the ACA[.]" *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015); *see also Coons v. Lew*, 762 F.3d 891, 902 (9th Cir. 2014) (holding that state law is preempted to the extent it "interferes with the methods by which the [ACA] was designed to reach [its] goal") (citation and quotation marks omitted), *cert. denied*, 135 S. Ct. 1699 (2015).

The Liquidator relies upon *United States Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993), but the case is inapposite in light of the ACA. MSJ at 23-25. In *Fabe*, the United States Supreme Court considered the effect of the McCarran-Ferguson Act on the relationship between the Federal Priority Statute, 31 U.S.C. § 3713, and a state law governing the priority of claims in an insurance liquidation proceeding. The Supreme Court held that state liquidation laws do not, in their entirety, "relate to the business of insurance" within the meaning of the McCarran-Ferguson Act, but do "relate to the business of insurance" to the extent they "protect policyholders." *Fabe*, 508 U.S. at 493-94. The Court held that the McCarran-Ferguson Act causes state insolvency laws to reverse-preempt the Federal Priority Statute, a federal statute that does not relate to the business of insurance, to the extent the state laws "afford priority, over claims of the United States, to insurance claims of policyholders and to the costs and expenses of administering the liquidation" but not to the extent they prioritize "other categories of claims" over those of the United States. *Id.* at 493-

94.[12] *Fabe* does not apply to this case because the federal law at issue, the ACA, regulates the business of insurance.

C. Colorado Law Authorizes HHS's Use of Offset

While HHS's right to offset under federal law is independent of any state law, contrary to the Liquidator's arguments, Colorado law also *expressly permits offset* in the context of the liquidation of insolvent insurers. Colo. Rev. Stat. § 10-3-529 states: "Notwithstanding any other provision of this title, 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." Section 529 resolves *any* question of whether the United States' setoff here is permitted by state law.

The Liquidator, however, misreads and misinterprets section 529 and Colorado law in asserting that the United States' offset is not permitted. MSJ at 26-38.

1. The ACA Debts Owed Between the Parties Are Clearly "Mutual"

The Liquidator asserts that the debts and credits HHS setoff are not "mutual." MSJ at 30-34. The Liquidator first asserts, without citation to any relevant legal authority, that the risk adjustment and reinsurance programs "operate completely independently, with independent resources and pools of money to distribute." MSJ at 30-34; *see id.* at 32 ("the two pools of money are independent and not interchangeable"). The Liquidator's argument misunderstands both offset and the ACA.

The offset mechanism "allows entities that owe each other money to apply their mutual debts against each other, thereby avoiding 'the absurdity of making A pay B when B owes A.'"

[12] Notably, *Fabe* is the *only* case addressing McCarran-Ferguson that the Liquidator cites in its three-page argument on the issue. MSJ at 23-26. The Liquidator also relies upon *Bluewater*, which we address in detail below and does not involve a McCarran-Ferguson claim or issue.

Strumpf, 516 U.S. at 18 (quoting *Studley*, 229 U.S. at 528). In order to possess a common law right of setoff, mutuality must exist between the parties, meaning that the debts are "in the same right and between the same parties standing in the same capacity." *Meyer Med. Physicians Grp., Ltd. v. Health Care Serv. Corp.*, 385 F.3d 1039, 1041 (7th Cir. 2004) (citations omitted). Federal courts have consistently held that the United States acts in a single "unitary creditor" capacity for purposes of setoff. *See, e.g., In re Charter Oak Assocs.*, 361 F.3d 760, 771 (2d Cir. 2004) (citing cases). What matters is not the relationship of the *programs* or the "pools of money" involved in the programs, but the identities of the two parties – and here those identities (HHS and CHIC) are indisputably identical for both the risk adjustment and reinsurance programs.

Moreover, the Liquidator is mistaken that HHS is only a "conduit" for the risk adjustment program rather than a creditor in its own right. MSJ at 30-34. Under the 3Rs programs, issuers do not owe funds to other issuers; rather, they owe money to CMS and CMS owes money to them, establishing a linear debtor/creditor relationship. *See* 42 U.S.C. § 18062(b) ("the Secretary shall pay to the plan [the risk corridors amount]" and "the plan shall pay to the Secretary [the risk corridors amount]"); *id.* § 18063(a) (CMS "shall assess a [risk adjustment] charge" and CMS "shall provide a [risk adjustment] payment"); *id.* § 18061(b) ("health insurance issuers . . . are required to make payments to [CMS]. . . and . . . [CMS] . . . make[s] reinsurance payments to health insurance issuers"). Consistent with this framework, the Congressional Budget Office treats collections and payments under the 3Rs programs as revenues and outlays, reflecting a debtor/creditor relationship. *See* Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, at 9, Congressional Budget Office (April 2014) ("CBO

treats the [3R] payments as outlays and the collections as revenues . . . .").[13]

Fundamentally, "[a]s a sovereign entity, the federal government's fiduciary duties are not defined by . . . common-law conception[s.] . . . Instead, a fiduciary duty only arises if it is plain from the relevant statutes or regulations that the government has accepted such a responsibility." *Grady v. United States*, No. 13-15C, 2013 WL 4957344, at *3 (Fed. Cl. July 31, 2013) (citation omitted), *aff'd*, 565 F. App'x 870 (Fed. Cir.), *cert. denied*, 135 S. Ct. 245 (2014). The ACA neither makes "plain" nor even suggests that the government has accepted such a responsibility with respect to the risk adjustment payments (or any of the other 3R program provisions). The United States acts as an ordinary creditor when it operates the risk adjustment program.

The cases on which the Liquidator relies are easily distinguishable. First, none pertains to the United States' setoff rights and none suggests that an agency of the United States acts as trustee, agent, or fiduciary. In *Fernandes*, a 40-year old bankruptcy case, at issue was a dividend owed by an insurance company (Central) to Fernandes (debtor). The dividend was paid to the insurance agent (Butterfield), who claimed a right to setoff the dividend payment against premiums owed by the debtor. The court rejected offset, because the "dividends, like the actual coverage of the policy itself, are one of the benefits of the policy owed by the insurer to the policyholder." *Fernandes Super Mkt. v. Butterfield Ins. Co., Inc. (In re Fernandes Super Markets, Inc.)*, 1 B.R. 299, 302 (Bankr. D. Mass. 1979). In contrast, the court did permit the insurance agent to setoff a premium refund paid by the insurance company because the agent had paid premiums on behalf of the debtor. *Id.* at 301-02.

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

The Liquidator's reliance on *In re Cullen*, 329 B.R. 52 (Bankr. N.D. Iowa 2005) is puzzling. In *Cullen*, the court rejected a credit union's request to setoff monies in an account in which "none of the funds in the accounts is property of Debtors" against monies owed by the Debtors to the credit union for two vehicle loans and a credit card account. *Id.* at 58. The lack of mutuality in that case was obvious, and of no relevance here. If HHS attempted to setoff monies owed to HHS by a different insurer from monies owed to the Liquidator, then perhaps *Cullen* would apply. But, of course, there is no dispute here that all monies in question have only HHS and the Liquidator as parties.

In the other two cases on which the Liquidator relies, *In re James River Coal Co.* and *In re Winstar Communications*, the courts were careful to emphasize that state law expressly created a fiduciary relationship that destroyed mutuality. *See In re James River Coal Co.*, 534 B.R. 666, 670 (Bankr. E.D. Va. 2015) (noting that statute at issue provided that "[sales] taxes collected [by retailer] under this section *shall be deemed to be held in trust* . . . for and on account of the Commonwealth") (emphasis added); *In re Winstar Commc'ns*, 315 B.R. 660, 663 (D. Del. 2004) (same).

Moreover, simply holding funds in a conduit-like manner is not, as the Liquidator suggests, enough to destroy mutuality. Rather, courts have consistently emphasized that capacity refers to *legal* capacity. *In re Liquidation of Home Ins. Co.*, 953 A.2d 443, 447-48 (2008) ("'Capacity,' for these purposes, 'means legal capacity (*e.g.*, principal, agent, trustee, beneficiary).'") (citation omitted); *Matter of Midland Ins. Co.*, 590 N.E.2d 1186, 1192-93 (1992) ("'Capacity' means legal capacity (*e.g.*, principal, agent, trustee, beneficiary)") (citation omitted). In sum, the debts between HHS and CHIC are mutual debts, subject to setoff.

2. The Federal Circuit Already Rejected Issuers' Risk Corridors Claims—the Government Is Not a "Net Debtor"

The Liquidator also argues that HHS's offsets were "improper" because the United States' liability to CHIC exceeds CHIC's debts. MSJ at 34-35 ("The Government Is a Net Debtor, Not a Net Creditor"). If that were true, any balance would have been paid to CHIC's estate. The only amounts identified by the Liquidator to support his excess liability allegation are risk corridors amounts in excess of CHIC's pro rata share, Compl. ¶ 39, and the Federal Circuit has already determined that issuers, including CHIC, are not entitled to additional risk corridors payments beyond their pro rata shares. *See Moda*, 892 F.3d at 1331; *Land of Lincoln*, 892 F.3d at 1185. This Court should reject the Liquidator's apparent demand that it defy binding precedential Federal Circuit authority.

The Liquidator's argument is based upon a contention that the Federal Circuit found a risk corridors "payment obligation" that was merely "suspended" by Congress, such that "the Government continues to owe [CHIC] $111,420,992 in Risk Corridors debt." MSJ at 34-35. But the Federal Circuit in *Moda* was unequivocal in rejecting the insurer's statutory claim for risk corridors payments, concluding that "Congress made the policy choice to cap payments out, and it remade that decision for each year of the program." 829 F.3d at 1329. The Court held "that the appropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program." *Id.* The Court found the insurer's claim ripe and entered judgment in favor of the United States on the merits, rejecting the insurer's claim for risk corridors payments.

3. Colorado Law Does Not Limit Offset to Contractual Debts

The Liquidator misreads Colorado law, Colo. Rev. Stat. § 10-3-529, in arguing that it allows setoff *only* for contract debts and credits. MSJ at 28. The relevant portion of the statute

reads: "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 . . ." § 529(a). The Liquidator apparently reads the "whether . . ." clause as restrictive, arguing that debts and credits can *only* be set off if arising out of contract. But, the fact that the clause is set off by commas indicates it is *non*-restrictive, meaning the clause tells the reader something about debts and credits, but does not limit or restrict the meaning of those terms.

The use of the conjunction "whether" supports that conclusion. "Whether" generally suggests a choice between stated or implied alternatives, such as "she decided whether to eat apples or pears" or "he wondered whether to stay." The second example involves an implied alternative – "he wondered whether to stay [or go]." Based on the Colorado legislature's use of commas to set off the phrase, and its use of "whether" – as opposed to "when" or "only when" or "if they" – the clear intent is that mutual debts and credits may be set off even if not arising out of contract. The Liquidator offers no explanation, much less any supporting legal authority, to the contrary.

In any event, even if this Court agrees with the Liquidator that section 529 itself limits offsets only to debts and credits arising out of contracts, HHS's offsets are consistent with Colorado law, which appears to recognize the common law right of offset. In *Bluewater Ins. Ltd. v. Balzano*, 823 P.2d 1365 (Colo. 1992), discussed in more detail below, the Colorado Supreme Court addressed whether a reinsurer may offset against an insurer in liquidation. In denying offset for reinsurers, the court recognized a distinction between "a unique class of fiduciary obligations" and "the common class of obligations arising out of mutual debts and credits where the right to offset is normally allowed." *Id.* at 1374. By concluding that "equity requires that in cases of fiduciary or quasi-fiduciary obligation the right to offset does not apply," the Colorado Supreme

Court appeared to acknowledge that Colorado law permits an equitable right to offset in situations, such as here, not involving a "fiduciary or quasi-fiduciary obligation."

4. Colorado Law Concerning Distribution Priority Does Not Hinder HHS's Right of Offset

Notwithstanding that section 529 of Colorado's statutory scheme governing the liquidation of insurers explicitly permits mutual debts and credits to be offset, and does so "[n]otwithstanding any other provision of" Colorado Statutes Title 10, which governs "Insurance," the Liquidator nonetheless contends that HHS's use of offset violated another provision of Title 10, Colo. Rev. Stat. § 10-3-541, which governs the order in which an insolvent insurer's claims are paid. Compl. ¶ 80; MSJ at 26-28. But courts have repeatedly rejected the assertion that the right of setoff is limited by a state priority scheme. *See, e.g., Chesapeake Ins. Co. Ltd v. Curiale (In re Liquidation of Realex Grp. N.V.),* 210 A.D.2d 91, 94 (N.Y. App. Div. 1994) ("Although permitting offsets may conflict with the statutory purpose of providing for the pro rata distribution of the insolvent's estate to creditors, the Legislature has resolved the competing concerns and recognized offsets as a species of *lawful* preference. Indeed, . . . it is '*only the balance, if any, after the set-off is deducted which can justly be held to form part of the assets of the insolvent*'" (emphasis added; quoting *Scott v. Armstrong,* 146 U.S. 499, 510 (1892)); *Prudential Reinsurance Co. v. Superior Court,* 3 Cal. 4th 1118, 1124-25 (Cal. 1992) (adopting position of "the majority of state and federal courts addressing the statutory right of setoff" and holding that the setoff provision "may not reasonably be construed as conditioning [a creditor's] right to set off on the insolvent insurer's ability to pay in full the claims of those in higher priority classes"); *see also In re Liquidation of Home Ins. Co.*, 972 A.2d 1019, 1022-23 (N.H. 2009) (noting that "setoff is an exception to the [priority framework] for discharging claims against an insolvent debtor"); *In re Agriprocessors, Inc.*, 547

B.R. 292, 325 (N.D. Iowa 2016) ("Setoffs are not 'transfers' . . . and, therefore, are not avoidable as preferences.").

Nonetheless, the Liquidator misrepresents a superseded-by-law Colorado Supreme Court case to argue that "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." MSJ at 24. *Bluewater Ins. Ltd. v. Balzano*, 823 P.2d 1365 (Colo. 1992), is not relevant here for at least three reasons.

First, *Bluewater* is not relevant because the court never addressed whether offset is contrary to distribution priority. There, the Colorado Supreme Court granted certiorari on two questions: "whether the reinsurers have an equitable right . . . to offset unpaid insurance premiums against reinsurance proceeds due under contracts with the primary insurer, and whether that equitable right to offset, if not abrogated, would create a preference contrary to the order of distribution provided in the liquidation act." 823 P.2d at 1365, 1369. The Liquidator apparently relies upon *Bluewater* believing the court answered the second question "yes," but the court never reached the question at all: "Since we hold in this opinion that the right to offset is and has been permissibly excluded by the commissioner, the issue as to whether the right creates an impermissible preference is mooted." *Id.* at 1374. As such, *Bluewater* is not relevant here.

Second, even if *Bluewater* had concluded that common law offset was contrary to Colorado's insurance liquidation-distribution-priority scheme, that holding would have been rendered meaningless when, only *four months* after *Bluewater* was issued, the Colorado legislature passed section 529 explicitly permitting setoff "notwithstanding" any other insurance liquidation provision, *including* section 541, which describes the distribution scheme.

Third, the Liquidator misreads *Bluewater*, a case that involves "reinsurance" and "offset," but has nothing to do with the United States' federal right to offset ACA reinsurance payments owed to the Liquidator against ACA risk adjustment payments owed by the Liquidator. As the Colorado Supreme Court explained, Colorado law requires "a reinsurer to pay in full the policy liabilities of an insolvent ceding insurer without diminution." *Bluewater*, 823 P.2d at 1366. Thus, the reinsurer could not "offset unpaid premiums from the reinsurance proceeds due." *Id.* As the court explained, Colorado has a "fairly comprehensive insurance code[]" with a "specific statute regulating the reinsurance business." *Id.* at 1367. That statute, of course, does not apply to the United States, which is not a reinsurer.

Moreover, the court did not address the question of whether the reinsurers "enjoyed an equitable right to offset," because they "freely enter[ed] into enforceable contracts from which an offset clause was deliberately excluded." *Id.* at 1369. The Court concluded "as a matter of contract law" that "the reinsurers here do not have the right to offset" because "the expectations of the parties here were that the right to offset was *not* a term of the contracts." *Id.* at 1373 *Bluewater* did not specifically decide the common law of offset in Colorado, much less the federal law of offset, which we detail above. The court did recognize a distinction between, as the insurers asserted in that case, "a unique class of fiduciary obligations" from "the common class of obligations arising out of mutual debts and credits where the right to offset is normally allowed." *Id.* at 1374.

The court concluded by holding that "equity requires that in cases of fiduciary or quasi-fiduciary obligation the right to offset does not apply," *id.* at 1376, suggesting that in situations not involving a "fiduciary or quasi-fiduciary obligation," Colorado *did* recognize an equitable right to offset (again, four months after *Bluewater*, Colorado recognized setoff by statute). For purposes

of this case, whether or not Colorado recognizes a common law or equitable right of offset is not relevant, because (a) Colorado now recognizes setoff expressly by statute, and (b) federal offset law determines whether HHS may offset risk adjustment collections against reinsurance payments.

Here, the United States is not a reinsurer and the Liquidator does not, and cannot, assert any fiduciary obligation flowing from the United States to the Liquidator. Rather, the ACA payments and collections owed between CHIC and the United States are nothing more than "common . . . obligations arising out of mutual debts and credits." As the Colorado Supreme Court recognized pre-section 529, offset was "normally" allowed for such mutual debts and credits. Now, of course, offset is explicitly permitted by statute.

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

In the absence of any specific legal authority foreclosing setoff, the Liquidator claims the state court stripped HHS of its offset rights when it affirmed the Liquidator's denial of HHS's proof of claim. MSJ 37-38. This argument is a red herring. A liquidator's denial of a proof of claim has no bearing on HHS's administration of the 3Rs programs via offset under the HHS Netting Regulation. Nor does it implicate HHS's right of offset to collect a risk adjustment debt that the Liquidator does not (and cannot) contest is undisputedly owed.

In any event, Congress has not waived sovereign immunity such that a state court could enjoin HHS's operation of the 3Rs programs via offset under the HHS Netting Regulation. *See Cal. Ins. Guarantee Ass'n v. Burwell*, 170 F. Supp. 3d 1270, 1274 (C.D. Cal. 2016) (holding that the United States has not waived sovereign immunity so as to be subject to the bar date of the state insurance insolvency statute); *see also TransAmerica Assurance Corp. v. Settlement Capital Corp.*, 489 F.3d 256, 260-63 (6th Cir. 2007) (state court order purporting to affect the rights of the United States was void as to the United States, having been entered without a waiver of sovereign

immunity); *Twin City Fire Ins. Co. v. Adkins*, 400 F.3d 293, 299 (6th Cir. 2005) ("Where a federal court finds that a state-court decision was rendered in the absence of subject matter jurisdiction . . . it may declare the state court's judgment void *ab initio* and refuse to give the decision effect in the federal proceeding.") (citations omitted); *Settlement Funding, LLC v. Garcia*, 533 F. Supp. 2d 685, 690 (W.D. Tex. 2006) (holding state court order "not binding or enforceable against the United States").[14]

Thus, although the state court has *in rem* jurisdiction over CHIC's assets, which allows it to administer claims and determine distributions, that jurisdiction does not empower the State Court to enjoin or compel any action by the United States in the absence of a specific statutory waiver of sovereign immunity.[15] *United States v. Nordic Vill. Inc.*, 503 U.S. 30, 38 (1992). The state court's affirmance of the Liquidator's decision cannot and does not hinder the United States' lawful exercise of setoff.

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

[15] The Liquidator argues that the United States "subjected itself to the [state court's] jurisdiction with respect to [CHIC's] liquidation when it submitted its [proof of claim]." MSJ at 36 (quoting Colo. Rev. Stat. § 10-3-504(2)). But section 504(2) is not applicable here. The United States did not submit a "complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of [CHIC], or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings." In any event, even if the United States had submitted such a complaint, sovereign immunity would still prevent any injunction by the state court purporting to bar HHS from netting.

III. The State Law Claim (Count II) Should Be Dismissed for Lack of Jurisdiction

We have demonstrated above that HHS's offset was consistent with federal and Colorado law, the offset did not violate Colorado's distribution priority scheme, and Colorado's liquidation proceedings cannot enjoin HHS from netting. As such, the United States has demonstrated that the Liquidator cannot state a claim for relief under Count II, in which the Liquidator argues that HHS's "setoff violated applicable Colorado laws." In any event, the Tucker Act does not provide jurisdiction in this Court for state law claims.

The Tucker Act, under which the Liquidator asserts jurisdiction, Compl. ¶ 13, waives sovereign immunity for certain non-tort claims against the United States founded upon the Constitution, a federal statute or regulation, or a contract. 28 U.S.C. § 1491(a)(1). The Tucker Act "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). "Thus, jurisdiction under the Tucker Act requires the litigant to identify a substantive right for money damages against the United States separate from the Tucker Act itself." *Todd v. United States*, 386 F.3d 1091, 1094 (Fed. Cir. 2004) (citing *Testan*, 424 U.S. at 398). In meeting this burden, it is not enough for a Liquidator to point to a law requiring the payment of money in the abstract. Instead, the law must "fairly be interpreted as mandating compensation for damages sustained as a result of a breach of . . . duties [it] impose[s]." *United States v. Mitchell*, 463 U.S. 206, 219 (1983).

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

Nor can the Court hear state law claims based on supplemental jurisdiction. Under 28

U.S.C. § 1367, only district courts are authorized to exercise supplemental jurisdiction. *See Hall v. United States*, 69 Fed. Cl. 51, 57 (2005); *Waltner v. United States*, 98 Fed. Cl. 737, 765 (2011), aff'd, 679 F.3d 1329 (Fed. Cir. 2012); *Trek Leasing, Inc. v. United States*, 62 Fed. Cl. 673, 678 (2004).

Here, Count II asserts only state law claims. Because the Court lacks jurisdiction over those claims, they should be dismissed under Rule 12(b)(1).

CONCLUSION

For the foregoing reasons, the Complaint should be dismissed. Alternatively, the Court should deny the Liquidator's motion for summary judgment and grant summary judgment to the United States.

Dated: March 15, 2019

Respectfully submitted,

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APPENDIX

Sort Sequence
Invoice Date/Invoice Number

Centers for Medicare and Medicaid Services
Healthcare Integrated General Ledger Accounting System
Payee Statement Report

Run Date: 08-MAR-2019 10:13:28
Request ID: 62660162

Parameters
Payee ID : **A104001**
Payee Name **IN**
Payee Status as of 08-MAR-2019 : **HOLD**
Date From : **01-JAN-2014**
Date To : **08-MAR-2019**

Payables

Program	Invoice Number	Invoice Date	Payment Date	Invoice Amount	Amount Netted	Amount Paid
APTC	A1403A104001001	7-Mar-14	11-Mar-14	1,801,449.76	0	1,801,449.76
CSR	C1403A104001001	7-Mar-14	11-Mar-14	187,934.94	0	187,934.94
APTC	A1404A104001001	7-Apr-14	9-Apr-14	1,163,338.40	0	1,163,338.40
CSR	C1404A104001001	7-Apr-14	9-Apr-14	130,604.48	0	130,604.48
APTC	A1405A104001001	7-May-14	8-May-14	1,047,464.52	0	1,047,464.52
CSR	C1405A104001001	7-May-14	8-May-14	110,195.15	0	110,195.15
APTC	A1406A104001001	6-Jun-14	10-Jun-14	1,063,376.38	0	1,063,376.38
CSR	C1406A104001001	6-Jun-14	10-Jun-14	108,860.43	0	108,860.43
APTC	A1407A104001001	7-Jul-14	9-Jul-14	1,043,341.15	0	1,043,341.15
CSR	C1407A104001001	7-Jul-14	9-Jul-14	108,701.53	0	108,701.53
APTC	A1408A104001001	5-Aug-14	7-Aug-14	1,576,408.98	0	1,576,408.98
CSR	C1408A104001001	5-Aug-14	7-Aug-14	153,097.36	0	153,097.36
APTC	A1409A104001001	5-Sep-14	9-Sep-14	1,432,593.88	0	1,432,593.88
CSR	C1409A104001001	5-Sep-14	9-Sep-14	158,858.33	0	158,858.33
APTC	A1410A104001001	6-Oct-14	8-Oct-14	1,120,572.54	0	1,120,572.54
CSR	C1410A104001001	6-Oct-14	8-Oct-14	118,415.74	0	118,415.74
APTC	A1411A104001001	5-Nov-14	7-Nov-14	3,577,732.57	0	3,577,732.57
CSR	C1411A104001001	5-Nov-14	7-Nov-14	381,587.94	0	381,587.94
APTC	A1412A104001001	5-Dec-14	9-Dec-14	1,391,118.36	0	1,391,118.36
CSR	C1412A104001001	5-Dec-14	9-Dec-14	136,758.61	0	136,758.61
APTC	A1501A104001001	8-Jan-15	9-Jan-15	961,136.50	0	961,136.50
APTC	A1501A104001002	8-Jan-15	9-Jan-15	9,921.89	0	9,921.89
CSR	C1501A104001001	8-Jan-15	9-Jan-15	164,787.16	0	164,787.16
CSR	C1501A104001002	8-Jan-15	9-Jan-15	926.09	0	926.09
APTC	A1502A104001001	9-Feb-15	10-Feb-15	749,930.32	0	749,930.32
APTC	A1502A104001002	9-Feb-15	10-Feb-15	4,751,531.45	0	4,751,531.45
CSR	C1502A104001001	9-Feb-15	10-Feb-15	70,956.71	0	70,956.71
CSR	C1502A104001002	9-Feb-15	10-Feb-15	695,188.37	0	695,188.37
APTC	A1503A104001002	9-Mar-15	11-Mar-15	7,666,690.51	1,124,287.32	6,542,403.19
CSR	C1503A104001002	9-Mar-15	11-Mar-15	1,142,307.96	0	1,142,307.96
	NET121207064	11-Mar-15	11-Mar-15	-1,040,844.26	0	-1,040,844.26
	NET121207065	11-Mar-15	11-Mar-15	-83,443.06	0	-83,443.06
APTC	A1504A104001002	3-Apr-15	7-Apr-15	6,557,416.27	9,488.27	6,547,928.00
CSR	C1504A104001002	3-Apr-15	7-Apr-15	969,955.30	0	969,955.30
	NET122521259	7-Apr-15	7-Apr-15	-7,828.57	0	-7,828.57
	NET122521260	7-Apr-15	7-Apr-15	-1,659.70	0	-1,659.70
APTC	A1505A104001001	7-May-15	8-May-15	53,086.37	0	53,086.37
APTC	A1505A104001002	7-May-15	8-May-15	7,294,120.47	0	7,294,120.47
CSR	C1505A104001001	7-May-15	8-May-15	1,097.48	0	1,097.48
CSR	C1505A104001002	7-May-15	8-May-15	1,098,944.38	0	1,098,944.38
APTC	A1506A104001001	15-Jun-15	16-Jun-15	6,253,190.49	0	6,253,190.49
CSR	C1506A104001001	15-Jun-15	16-Jun-15	1,026,100.97	0	1,026,100.97
APTC	A1507A104001001	7-Jul-15	9-Jul-15	7,093,903.60	0	7,093,903.60

Payables						
Program	**Invoice Number**	**Invoice Date**	**Payment Date**	**Invoice Amount**	**Amount Netted**	**Amount Paid**
CSR	C1507A104001001	7-Jul-15	9-Jul-15	997,785.91	0	997,785.91
APTC	A1508A104001001	5-Aug-15	7-Aug-15	6,330,407.85	0	6,330,407.85
CSR	C1508A104001001	5-Aug-15	7-Aug-15	1,033,561.80	0	1,033,561.80
RIP	P1507A104001002	5-Aug-15	7-Aug-15	18,143,082.24	4,502,990.45	13,640,091.79
APTC	A1509A104001001	4-Sep-15	9-Sep-15	6,071,368.39	0	6,071,368.39
CSR	C1509A104001001	4-Sep-15	9-Sep-15	961,032.11	0	961,032.11
APTC	A1510A104001001	6-Oct-15	8-Oct-15	5,328,796.30	0	5,328,796.30
CSR	C1510A104001001	6-Oct-15	8-Oct-15	919,304.57	0	919,304.57
APTC	A1511A104001001	5-Nov-15	9-Nov-15	5,247,912.70	0	5,247,912.70
CSR	C1511A104001001	5-Nov-15	9-Nov-15	842,140.40	0	842,140.40
RIP	P1510A104001001	5-Nov-15	9-Nov-15	1,428,743.26	0	1,428,743.26
APTC	A1512A104001001	7-Dec-15	9-Dec-15	6,447,860.43	0	6,447,860.43
CSR	C1512A104001001	7-Dec-15	9-Dec-15	1,080,498.09	0	1,080,498.09
RC	K1511A104001001	7-Dec-15	9-Dec-15	1,548,902.29	0	1,548,902.29
APTC	A1601A104001001	7-Jan-16	12-Jan-16	614,835.97	92,796.42	522,039.55
RC	K1601A104001001	7-Jan-16	12-Jan-16	6,562.36	0	6,562.36
RC	K1603A104001001	5-Feb-16	10-Feb-16	181,108.02	181,108.02	0
APTC	A1603A104001002	7-Mar-16	11-Mar-16	507,681.86	0	507,681.86
CSR	C1603A104001002	7-Mar-16	11-Mar-16	402,308.48	0	402,308.48
RC	K1603A104001002	7-Mar-16	11-Mar-16	16,761.56	0	16,761.56
RIP	P1603A104001001	11-Mar-16	11-Mar-16	14,196,334.12	4,520,834.05	9,675,500.07
APTC	A1604A104001002	7-Apr-16	11-Apr-16	2,010,409.68	0	2,010,409.68
CSR	C1604A104001002	7-Apr-16	11-Apr-16	623,214.28	0	623,214.28
APTC	A1605A104001001	6-May-16	10-May-16	606,631.64	0	606,631.64
APTC	A1606A104001001	6-Jun-16	9-Jun-16	275,587.18	0	275,587.18
APTC	A1607A104001001	7-Jul-16	12-Jul-16	83,715.72	0	83,715.72
RIP	P1608A104001003	8-Aug-16	9-Aug-16	20,225,084.41	20,225,084.41	0
RC	K1610A104001001	5-Oct-16	11-Oct-16	30,214.66	30,214.66	0
APTC	A1611A104001002	4-Nov-16	9-Nov-16	466,035.22	466,035.22	0
RC	K1612A104001001	7-Dec-16	8-Feb-17	344,041.22	344,041.22	0
RC	K1701A104001001	5-Jan-17	8-Feb-17	25,571.07	25,571.07	0
RIP	P1701A104001001	5-Jan-17	8-Feb-17	1,934,757.37	1,934,757.37	0
RC	K1702A104001001	6-Feb-17	8-Feb-17	13,197.44	13,197.44	0
RIP	P1703A104001001	7-Mar-17	9-Mar-17	2,473,683.38	2,473,683.38	0
RC	K1704A104001001	6-Apr-17	10-Apr-17	40,736.10	40,736.10	0
CSR	R1704A104001001	6-Apr-17	10-Apr-17	133,897.53	133,897.53	0
RC	K1708A104001002	8-Aug-17	9-Aug-17	62,557.53	62,557.53	0
RIP	P1712A104001001	6-Dec-17	8-Dec-17	34,488.52	34,488.52	0
RC	K1801A104001001	5-Jan-18	9-Jan-18	105,679.25	105,679.25	0
RC	K1802A104001001	5-Feb-18	7-Feb-18	57.5	57.5	0
RC	K1805A104001002	8-May-18	10-May-18	19,278.62	19,278.62	0
				164,055,654.78	**36,340,784.35**	**127,714,870.43**

Account Receivables										
Program	Receivable Number	Invoice Date	Receivable Amount	Demand Letter Date	Amount Due on Demand Letter	Amount Netted/Collected	Payable Invoice Number	Source Collections	Date of Collections	Receivable Outstanding Balance as of 08-MAR-2019
APTC	A1503A104001001	9-Mar-15	1,040,844.26			1,040,844.26	A1503A104001002	APTC	11-Mar-15	0
CSR	C1503A104001001	9-Mar-15	83,443.06			83,443.06	A1503A104001002	APTC	11-Mar-15	0
APTC	A1504A104001001	3-Apr-15	7,828.57			7,828.57	A1504A104001002	APTC	7-Apr-15	0
CSR	C1504A104001001	3-Apr-15	1,659.70			1,659.70	A1504A104001002	APTC	7-Apr-15	0
RAUF	D1507A104001001	5-Aug-15	11,611.53			11,611.53	P1507A104001002	RIP	7-Aug-15	0
RA	I14CO150720472001	5-Aug-15	4,074,755.81			4,074,755.81	P1507A104001002	RIP	7-Aug-15	0
RA	L14CO150720472003	5-Aug-15	97,502.97			97,502.97	P1507A104001002	RIP	7-Aug-15	0
RA	T14CO150720472002	5-Aug-15	319,120.14			319,120.14	P1507A104001002	RIP	7-Aug-15	0
CSR	C1601A104001001	7-Jan-16	92,796.42			92,796.42	A1601A104001001	APTC	12-Jan-16	0
APTC	A1603A104001001	5-Feb-16	3,472,103.09	15-Feb-16	3,290,995.07	181,108.02	K1603A104001001	RC	10-Feb-16	0
APTC	A1603A104001001	5-Feb-16				3,290,995.07	P1603A104001001	RIP	11-Mar-16	
CSR	C1603A104001001	5-Feb-16	1,229,838.98	15-Feb-16	1,229,838.98	1,229,838.98	P1603A104001001	RIP	11-Mar-16	0
RAUF	D1608A104001003	8-Aug-16	74,917.92	12-Aug-16	74,917.92					74,917.92
RAUF	D1608A104001003ADM	8-Aug-16	15							15
RAUF	D1608A104001003INT	8-Aug-16	1,802.70							1,802.70
RA	I15CO160820472003	8-Aug-16	39,840,127.92	12-Aug-16	19,615,043.51	20,225,084.41	P1608A104001003	RIP	9-Aug-16	14,401,393.68
RA	I15CO160820472003	8-Aug-16				181,576.90	A1611A104001002	APTC	9-Nov-16	
RA	I15CO160820472003	8-Aug-16				25,571.07	K1701A104001001	RC	8-Feb-17	
RA	I15CO160820472003	8-Aug-16				344,041.22	K1612A104001001	RC	8-Feb-17	
RA	I15CO160820472003	8-Aug-16				1,778,884.77	P1701A104001001	RIP	8-Feb-17	
RA	I15CO160820472003	8-Aug-16				13,197.44	K1702A104001001	RC	8-Feb-17	
RA	I15CO160820472003	8-Aug-16				2,473,683.38	P1703A104001001	RIP	9-Mar-17	
RA	I15CO160820472003	8-Aug-16				133,897.53	R1704A104001001	CSR	10-Apr-17	
RA	I15CO160820472003	8-Aug-16				40,736.10	K1704A104001001	RC	10-Apr-17	
RA	I15CO160820472003	8-Aug-16				62,557.53	K1708A104001002	RC	9-Aug-17	
RA	I15CO160820472003	8-Aug-16				34,488.52	P1712A104001001	RIP	8-Dec-17	
RA	I15CO160820472003	8-Aug-16				105,679.25	K1801A104001001	RC	9-Jan-18	
RA	I15CO160820472003	8-Aug-16				57.5	K1802A104001001	RC	7-Feb-18	
RA	I15CO160820472003	8-Aug-16				19,278.62	K1805A104001002	RC	10-May-18	
RA	I15CO160820472003ADM	8-Aug-16	15			15	K1610A104001001	RC	11-Oct-16	0
RA	I15CO160820472003INT	8-Aug-16	470,530.58			30,199.66	K1610A104001001	RC	11-Oct-16	0
RA	I15CO160820472003INT	8-Aug-16				284,458.32	A1611A104001002	APTC	9-Nov-16	
RA	I15CO160820472003INT	8-Aug-16				155,872.60	P1701A104001001	RIP	8-Feb-17	
RA	L15CO160820472003	8-Aug-16	819,602.44	12-Aug-16	819,602.44					819,602.44
RA	L15CO160820472003ADM	8-Aug-16	15							15
RA	L15CO160820472003INT	8-Aug-16	19,721.67							19,721.67
CSR	R1608A104001003	8-Aug-16	2,180,837.60	12-Aug-16	2,180,837.60					2,180,837.60
CSR	R1608A104001003ADM	8-Aug-16	15							15
CSR	R1608A104001003INT	8-Aug-16	52,476.39							52,476.39
RA	T15CO160820472003	8-Aug-16	1,340,786.05	12-Aug-16	1,340,786.05					1,340,786.05
RA	T15CO160820472003ADM	8-Aug-16	15							15
RA	T15CO160820472003INT	8-Aug-16	32,262.66							32,262.66
RIC	E1701A104001001	5-Jan-17	771,298.00	12-Jan-17	771,298.00					771,298.00
RIC	E1701A104001001ADM	5-Jan-17	15			15		Adjustment	3-Mar-17	0
RIC	E1701A104001001INT	5-Jan-17	12,372.90			12,372.90		Adjustment	17-Apr-17	0
			56,048,331.36		**29,323,319.57**	**36,353,172.25**				**19,695,159.11**

Note: If the invoice date and the payment date are in different months, the Payee was on hold during that period.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

February 28, 2017

VIA ELECTRONIC MAIL: Kyle.Turnwall@COHealthOP.org
Mr. Kyle Turnwall
Controller
Colorado Health Insurance Cooperative Inc.
HIOS ID 20472, Payee ID A104001
8000 E. Maplewood Avenue, Bldg. 5
Suite 200
Greenwood Village CO 80111

Dear Mr. Turnwall:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s wind-down. Because Colorado Health Insurance Cooperative Inc. has entered liquidation, CMS has implemented an administrative hold on payables to Colorado Health Insurance Cooperative Inc.

This letter is to inform you that after the February 2017 payment cycle, CMS has offset $2,317,567.10 from your 2015 benefit year risk adjustment charges using the Account Payable(s)(AP)[1] set forth in the February 2017 Preliminary Payment Report (PPR). For more detail, see the HIX820 and/or PPR for the February 2017 payment cycle.

Colorado Health Insurance Cooperative Inc. also owes CMS additional amounts, as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS.

CMS remains committed to protecting consumers and taxpayer dollars and appreciates the hard work being done during Colorado Health Insurance Cooperative Inc.'s wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Jeffrey Grant
Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

[1] APs are payments owed to the issuer.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

March 31, 2017

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: ray.seggelke@cohealthop.org
Mr. Joe Holloway
Receiver
Colorado Health Insurance Cooperative Inc.
HIOS ID 20472, Payee ID A104001
8000 E. Maplewood Avenue, Bldg. 5
Suite 200
Greenwood Village CO 80111

Dear Mr. Holloway:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s (HealthOP) wind-down. As CMS advised you in a letter dated May 23, 2016, because of the wind-down of HealthOP, CMS has implemented an administrative hold on payables to HealthOP.

This letter is to inform you that after the March 2017 payment cycle, CMS has offset $2,473,683.38 against your 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[1] set forth in the March 2017 Preliminary Payment Report (PPR). For more detail, see the HIX820 and/or PPR for the March 2017 payment cycle.

HealthOP also owes CMS additional amounts; as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS.

CMS remains committed to protecting consumers and taxpayer dollars and appreciates the hard work being done during the HealthOP wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Jeffrey Grant
Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

April 28, 2017

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: helen.hadji@cohealthop.org
Mr. Joe Holloway, Receiver
Colorado Health Insurance Cooperative, Inc.
8000 E. Maplewood Avenue, Bldg. 5
Suite 200
Greenwood Village CO 80111

Dear Mr. Holloway:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative, Inc., (HealthOP) wind-down. As CMS advised you in a letter dated May 23, 2016, because of the wind-down of HealthOP, CMS has implemented an administrative hold on payables to HealthOP.

This letter is to inform you that after the April 2017 payment cycle, CMS has offset $174,633.63 against your 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[1] set forth in the April 2017 Preliminary Payment Report (PPR). For more detail, see the HIX820 and/or PPR for the April 2017 payment cycle.

HealthOP also owes CMS additional amounts; as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS.

CMS remains committed to protecting consumers and taxpayer dollars and appreciates the hard work being done during the HealthOP wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Jeffrey Grant
Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

August 31, 2017

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: helen.hadji@cohealthop.org
Mr. Joe Holloway
Receiver
Colorado Health Insurance Cooperative Inc. (HealthOp)
8000 E. Maplewood Avenue, Bldg. 5
Suite 200
Greenwood Village CO 80111

Dear Mr. Holloway:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s (HealthOp) wind-down. As CMS advised you in a letter dated February 28, 2017, because of the wind-down of HealthOp, CMS has implemented an administrative hold on payables to HealthOp.

This letter is to inform you that after the August 2017 payment cycle, CMS has offset $62,557.53 against HealthOp's 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[1] set forth in the August 2017 Preliminary Payment Report (PPR). For more detail, see the HIX820, Payee Information Report and/or PPR for the August 2017 payment cycle.

HealthOp also owes CMS additional amounts, as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS.

CMS remains committed to protecting consumers and taxpayer dollars. We appreciate the hard work being done during the HealthOp wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Jeffrey Grant
Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

[1] APs are payments owed to the issuer.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

December 29, 2017

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: helen.hadji@cohealthop.org
Mr. Joe Holloway
Receiver
Colorado Health Insurance Cooperative Inc. (HealthOp)
8000 E. Maplewood Avenue, Bldg. 5
Suite 200
Greenwood Village CO 80111

Dear Mr. Holloway:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s (HealthOp) wind-down. As CMS advised you in a letter dated February 28, 2017, because of the wind-down of HealthOp, CMS has implemented an administrative hold on payables to HealthOp.

This letter is to inform you that after the December 2017 payment cycle, CMS has offset $34,488.52 against HealthOp's 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[1] set forth in the December 2017 Preliminary Payment Report (PPR). For more detail, see the HIX820, Payee Information Report and/or PPR for the December 2017 payment cycle.

HealthOp also owes CMS additional amounts; as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS. CMS remains committed to protecting consumers and taxpayer dollars. We appreciate the hard work being done during the HealthOp wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Elizabeth Parish
Acting Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

[1] APs are payments owed to the issuer.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

January 31, 2018

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: helen.hadji@cohealthop.org
Mr. Joe Holloway
Receiver
Colorado Health Insurance Cooperative Inc. (HealthOp)
8000 E. Maplewood Avenue, Bldg. 5
Suite 200
Greenwood Village CO 80111

Dear Mr. Holloway:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s (HealthOp) wind-down. As CMS advised you in a letter dated February 28, 2017, because of the wind-down of HealthOp, CMS has implemented an administrative hold on payables to HealthOp.

This letter is to inform you that after the January 2018 payment cycle, CMS has offset $105,679.25 against HealthOp's 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[1] set forth in the January 2018 Preliminary Payment Report (PPR). For more detail, see the HIX820, Payee Information Report and/or PPR for the January 2018 payment cycle.

HealthOp also owes CMS additional amounts; as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS. CMS remains committed to protecting consumers and taxpayer dollars. We appreciate the hard work being done during the HealthOp wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Elizabeth Parish
Acting Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

[1] APs are payments owed to the issuer.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

February 28, 2018

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: helen.hadji@cohealthop.org
Mr. Joe Holloway
HealthOp
8000 E. Maplewood Avenue, Bldg. 5 STE 200
Greenwood Village CO 80111

Dear Mr. Joe Holloway

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s (HealthOp) wind-down. As CMS advised you in a letter dated February 28, 2017, because of the wind-down, CMS has implemented an administrative hold on payables.

This letter is to inform you that after the February 2018 payment cycle, CMS has offset $57.50 against HealthOp's 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[3] set forth in the February 2018 Preliminary Payment Report (PPR). For more detail, see the HIX820, Payee Information Report and/or PPR for the February 2018 payment cycle.

HealthOp also owes CMS additional amounts; as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS. CMS remains committed to protecting consumers and taxpayer dollars. We appreciate the hard work being done during the wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Elizabeth Parish
Acting Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

[3] APs are payments owed to the issuer.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

May 31, 2018

VIA ELECTRONIC MAIL: HollowayJ@caclo.org
Cc: helen.hadji@cohealthop.org
Colorado Health Insurance Cooperative Inc.
Mr. Joe Holloway
8000 E. Maplewood Avenue, Bldg. 5 STE 200
Greenwood Village CO 80111

Dear Mr. Joe Holloway:

We appreciate your continued collaboration with the Centers for Medicare & Medicaid Services (CMS) during the process of Colorado Health Insurance Cooperative Inc.'s (HealthOp) wind-down. As CMS advised you in a letter dated February 28, 2017, because of the wind-down, CMS has implemented an administrative hold on payables.

This letter is to inform you that after the May 2018 payment cycle, CMS has offset $19,278.62 against HealthOp's 2015 benefit year risk adjustment charge using the Account Payable(s)(AP)[3] set forth in the May 2018 Preliminary Payment Report (PPR). For more detail, see the HIX820, Payee Information Report and/or PPR for the May 2018 payment cycle.

HealthOp also owes CMS additional amounts; as such, CMS will continue to exercise its right of offset to recover the remaining amounts owed to CMS. CMS remains committed to protecting consumers and taxpayer dollars. We appreciate the hard work being done during the wind-down. If you have any questions please feel free to contact CMS at CCIIOInvoices@cms.hhs.gov.

Sincerely,

Elizabeth Parish
Acting Director, Payment Policy & Financial Management Group
Centers for Consumer Information and Insurance Oversight

[3] APs are payments owed to the issuer.