No. 2020-1292

IN THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

MICHAEL CONWAY, in his capacity as Liquidator of Colorado Health Insurance Cooperative, Inc.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

On Appeal from the United States Court of Federal Claims,
Case No. 1:18-cv-01623 (Judge Richard A. Hertling)

CORRECTED OPENING BRIEF FOR THE UNITED STATES

JOSEPH H. HUNT
Assistant Attorney General

ALISA B. KLEIN
JEFFREY E. SANDBERG
Attorneys, Appellate Staff
Civil Division, Room 7214
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 532-4453

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases: **Page(s)**

U.S. Constitution:

Statutes:

Regulations:

Rules:

Other Authorities:

STATEMENT OF RELATED CASES

No other appeal from the present civil action has previously been before this or any other appellate court. The government is not aware of any related cases within the meaning of Federal Circuit Rule 47.5(b).

Another appeal, *Farmer v. United States*, No. 20-1359, has been designated as a companion case to be assigned to the same panel. In that case, the Court of Federal Claims dismissed, for lack of Tucker Act jurisdiction, state-law claims asserted by other plaintiffs purporting to challenge a different offset by the U.S. Department of the Health and Human Services.

INTRODUCTION

This case concerns a demand for payment of a debt that the government has already paid through the administrative mechanism of netting (also known as offset). The Patient Protection and Affordable Care Act (ACA) included two premium stabilization programs—"risk adjustment" and "reinsurance"—under which the Department of Health and Human Services (HHS) used amounts collected from certain insurers and other entities to make payments to other eligible insurers. When, as here, a particular insurer owed a debt under one program and was owed a payment under the other, HHS netted those amounts against each other pursuant to a regulation issued in 2014. *See* 45 C.F.R. § 156.1215(b) (the Netting Regulation). Netting enabled HHS to accelerate the distribution of payments to insurers and thus advanced the ACA's purpose of stabilizing the insurance markets.

Plaintiff is the liquidator of Colorado Health Insurance Cooperative (Colorado Health), a now defunct insurer. For benefit year 2015, Colorado Health owed more under the risk adjustment program than it was due to receive under the reinsurance program. Accordingly, HHS netted the amounts against each other, paying Colorado Health by reducing its debt to the government.

Although there is no dispute that Colorado Health owed the government more under the risk adjustment program than it was owed under the reinsurance program, the trial court ruled that plaintiff is entitled to damages equal to the amount that plaintiff claims it is owed under the reinsurance program for benefit year 2015

($24.5 million). The court declared the offsets to be improper because (1) the court believed that the Netting Rule cannot apply when an insolvent insurer is involved, and (2) the court construed Colorado law as forbidding HHS from netting an insolvent insurer's risk adjustment and reinsurance debts.

That ruling rests on multiple, independent legal errors. First, contrary to the trial court's premise, federal law governs the methods and standards for payments under the ACA programs at issue here. The Netting Regulation is a valid rule promulgated pursuant to HHS's express statutory authority to administer the ACA's premium stabilization programs, and HHS's use of netting is critical to administering those programs regardless of whether a particular insurer is defunct or in business. Failing to account for offsets would delay the distribution of payments to other insurers and thus impair the central purpose of the ACA's premium stabilization programs, which is to stabilize insurance markets by transferring costs and risks among insurers. Second, HHS's netting was independently authorized by federal common law. Third, although there is no occasion to apply state law in this case, the trial court also erred in concluding that Colorado law would foreclose HHS from applying its regulations.

In any event, even assuming *arguendo* that HHS's netting of Colorado Health's debts was not authorized, the trial court erred in assuming that the consequence is that the United States now owes plaintiff $24.5 million in damages. Plaintiff does not dispute the validity of the risk adjustment debt that Colorado Health owed the

government. A court's declaration that the netting was unlawful would simply resuscitate the parties' countervailing debts, and the court itself would be obliged by statute and precedent to effectuate an offset and thereby reduce plaintiff's award to zero. Accordingly, the judgment below should be reversed.

STATEMENT OF JURISDICTION

Plaintiff invoked the jurisdiction of the Court of Federal Claims under the Tucker Act, 28 U.S.C. § 1491. Appx29. The court entered final judgment on October 21, 2019. Appx21. The government timely filed a notice of appeal on December 19, 2019. Appx402-403; *see* Fed. R. App. P. 4(a)(1)(B). This Court has appellate jurisdiction under 28 U.S.C. § 1295(a)(3).

STATEMENT OF THE ISSUE

Whether plaintiff's demand for payment under the ACA's reinsurance program fails because HHS already paid the relevant amount by offsetting it against the larger amount that plaintiff owed HHS under the ACA's risk adjustment program.

STATEMENT OF THE CASE

A. Statutory and Regulatory Background

In the Patient Protection and Affordable Care Act, Congress enacted "a series of interlocking reforms designed to expand coverage" in the individual and small-group health insurance markets. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). Among other measures, the ACA provides subsidies to help individuals pay for insurance and prohibits insurers from denying coverage or charging higher premiums based on an

individual's health status. *Id.* at 2486-87. The ACA also established "Health Benefit Exchange[s]" in each State in which health insurance issuers may compete for customers. *Id.* at 2487.

To mitigate pricing risks—and to reduce insurers' incentives to structure their plans to be less attractive to sicker persons—the ACA created three programs to transfer certain financial costs and risks among health insurance issuers. These "premium stabilization" programs, informally known as the "3Rs," are risk adjustment, reinsurance, and risk corridors. *See* 42 U.S.C. § 18063 (risk adjustment); *id.* § 18061 (reinsurance); *id.* § 18062 (risk corridors). Risk adjustment began in 2014 and is a permanent program, while reinsurance and risk corridors were transitional programs for the 2014, 2015, and 2016 benefit years.

Although broadly similar in nature and purpose, the three premium stabilization programs varied in the classes of insurers covered and the criteria for determining which insurers would make or receive payments. Under the risk adjustment program, funds are collected from health insurance issuers whose plans have lower "actuarial risk" (*i.e.*, statistically healthier enrollees), and transferred to issuers whose plans have higher "actuarial risk." 42 U.S.C. § 18063(a)(1)-(2). Under the reinsurance program, funds are collected from all issuers and certain self-insured group health plans, then transferred to those issuers in the individual market that insured particularly costly individual enrollees in a given year. *Id.* § 18061(b).

Under the risk corridors program, funds were collected from plans that were relatively profitable and transferred to those that were relatively unprofitable. *Id.* § 18062.

Congress provided that each State would administer its own risk adjustment and reinsurance programs, subject to federal standards. 42 U.S.C. §§ 18061(a), 18063(a). But Congress also provided that a State could choose not to assume those responsibilities, in which case the federal government instead would operate the programs for that State. *Id.* § 18041(c)(1)(B)(ii). In practice, HHS has run the risk adjustment and reinsurance programs for almost every State, including Colorado.

From the outset, HHS has implemented the three premium stabilization programs in a budget-neutral manner, meaning that money collected from insurers is the only source of funds used to make payments. *See, e.g.*, 45 C.F.R. § 153.230(d) (reinsurance payments to issuers are contingent on "reinsurance contributions collected"); 78 Fed. Reg. 15,410, 15,441 (Mar. 11, 2013) ("The [ACA] risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers."); 79 Fed. Reg. 13,744, 13,829 (Mar. 11, 2014) ("HHS intends to implement this [risk corridors] program in a budget neutral manner."); *New Mexico Health Connections v. U.S. Dep't of HHS*, 946 F.3d 1138, 1167 (10th Cir. 2019) (holding that "HHS did not violate the APA when it designed the risk adjustment program as budget neutral").[1]

[1] The government's administration of the risk corridors program in a budget-neutral matter is the subject of *Maine Community Health Options et al. v. United States*, No. 18-1023 (S. Ct.), in which a decision was issued today (April 27, 2020). This appeal

The ACA directed HHS to "issue regulations setting standards for meeting the requirements of" various ACA programs, including the risk adjustment and reinsurance programs, and "such other requirements as the Secretary determines appropriate." 42 U.S.C. § 18041(a)(1)(C)-(D). It further instructed HHS to "take such actions as are necessary to implement" the risk adjustment and reinsurance programs in each State that does not operate its own programs. *Id.* § 18041(c)(1).

Pursuant to that statutory authorization, HHS promulgated the Netting Regulation in 2014, providing for HHS to offset amounts owed by an insurer under one ACA program against amounts owed to the same insurer under another ACA program. 45 C.F.R. § 156.1215(b); *see* 79 Fed. Reg. at 13,817 (final rule). The regulation states that, for the 2015 benefit year and beyond, "[a]s part of its payment and collections process, HHS may net payments owed to issuers and their affiliates … against amounts due to the Federal or State governments from the issuers and their affiliates … for" payments under various ACA programs, including "risk adjustment, reinsurance, and risk corridors payments and charges." 45 C.F.R. § 156.1215(b).[2]

---

does not involve the risk corridors program. Plaintiff joined a separate class action seeking risk corridors payments. *See* Notice of Lodging of Certification of Class Membership, *Health Republic Ins. Co. v. United States*, No. 16-cv-259 (Fed. Cl. June 12, 2017) (ECF No. 57).

[2] As amended, the regulation also permits netting of "advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, [and] payment of any fees for State-based Exchanges utilizing the Federal platform." 45 C.F.R.

HHS explained that by streamlining payment flows, HHS could operate a monthly accounting cycle and thereby expedite the provision of funds to insurers. *See* 79 Fed. Reg. at 13,817; 78 Fed. Reg. 72,322, 72,370-71 (Dec. 2, 2013) (proposed rule) (same).

B. Factual Background

Plaintiff is the liquidator of Colorado Health Insurance Cooperative, Inc., a nonprofit insurer that sold health insurance on Colorado's exchanges in 2014 and 2015. Colorado Health participated in the ACA's CO-OP program, which provided loans for start-up costs ("start-up loans") and loans to enable insurers to meet the solvency and capital reserve requirements of the States in which they are licensed to operate ("solvency loans"). 42 U.S.C. § 18042(b)(1). Colorado Health received some $72 million in taxpayer-funded start-up and solvency loans, which it has not repaid.[3]

This case concerns risk adjustment and reinsurance payments for benefit year 2015. For that year, there is no dispute that Colorado Health was a net debtor under the risk adjustment program and a net creditor under the reinsurance program. Specifically, Colorado Health ultimately owed $42.0 million under the risk adjustment program, and was itself owed $38.7 million under the reinsurance program. *See* Ctrs.

§ 156.1215(b); *see* 81 Fed. Reg. 12,204, 12,317-18, 12,351-52 (Mar. 8, 2016) (amending regulation to add "fees for State-based Exchanges utilizing the Federal platform").

[3] HHS agreed with Colorado Health to treat the start-up and solvency loans as "surplus notes," meaning that Colorado Health's obligation to repay the loans was conditioned on it generating sufficient revenues in excess of liabilities. Because the insurer is now in liquidation, those loans will likely never be repaid.

for Medicare & Medicaid Servs., HHS, *Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year*, at 7 (Dec. 6, 2016), https://go.usa.gov/xvNQ3. Accordingly, if HHS had awaited a final annual accounting before making any payments, offsetting the debts would have meant that Colorado Health owed HHS a net balance of $3.3 million across those two programs.

As noted, however, HHS administers a monthly payment cycle, through which it collects and makes payments on a rolling basis (subject to later reconciliation). In the March 2016 payment cycle, HHS determined that Colorado Health was due an initial balance of reinsurance funds for 2015, which HHS immediately paid. Appx4. In subsequent payment cycles, however, HHS determined that Colorado Health owed more in risk adjustment than it was due in reinsurance. Thus, for the remaining reinsurance funds due to Colorado Health for 2015 ($24.5 million), HHS did not make direct payments, but instead credited that amount through a series of offsets against the balance owed by Colorado Health under the risk adjustment program. *See* Appx337-344. HHS then distributed the funds made available by these offsets to other Colorado insurers that were due funds under the risk adjustment program.

C. Prior Proceedings

By 2015, Colorado Health began to experience serious financial difficulties. Following almost a year of state supervision, in January 2016, a Colorado state court

ordered Colorado Health into liquidation and appointed the State's commissioner of insurance as liquidator. Appx37-38.

In 2018, plaintiff brought this suit in the Court of Federal Claims contesting HHS's offsets and demanding direct payment of $24.5 million in reinsurance funds. *See* Appx44-46. Plaintiff argued that under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), state law rather than federal law should control HHS's use of offsets in administering payments to Colorado Health, and further asserted that Colorado law forbade such offsets. That is, plaintiff maintained that HHS was required to disregard its Netting Regulation so as to dramatically enhance the flow of program funds—all collected from other insurers—into Colorado Health's liquidation estate.

The government opposed plaintiff's motion for summary judgment and moved to dismiss. The government explained that HHS's administration of payments under ACA programs is governed by federal law, and that the Netting Regulation expressly authorized HHS's use of offsets to pay Colorado Health the $24.5 million it claimed. The government further argued that plaintiff's state-law claims were not cognizable in this Tucker Act suit; that even if Colorado law conflicted with federal law, it would be preempted by the ACA, which preserves state authority only to the extent that it "does not prevent the application of the provisions of this title [Title I of the ACA]," 42 U.S.C. § 18041(d); and that Colorado law would not forbid the use of offsets under these circumstances in any event.

The trial court granted summary judgment in plaintiff's favor. Appx1-17. The court agreed with the government that "federal law governs HHS's rights as a creditor in implementing the nationwide reinsurance and risk-adjustment programs." Appx7; *see* Appx13 ("Federal law governs HHS's rights here."). The court rejected plaintiff's reliance on the McCarran-Ferguson Act, reasoning that "McCarran-Ferguson does not affect whether the Netting Rule preempts Colorado law." Appx9. The court further acknowledged that federal common law generally permits the government to pay its debtors either directly or via offset of other debts. Appx9-10.

The court nonetheless declared that "HHS's offset was invalid under Colorado's insurance liquidation priority scheme." Appx7. Although the Netting Regulation has no exemption for insolvent insurers, the court stated that HHS could not apply that regulation to an insolvent insurer unless the ACA or another statute specifically "authorize[d] the Netting Rule's application in the insurance liquidation context." *Id.* Having posited such a requirement, the court then concluded that HHS's offsets were invalid "because neither the ACA nor another statute require or authorize HHS to issue a rule offsetting among different ACA programs payments HHS owes to an insurer in liquidation proceedings and contributions HHS is owed." *Id.*

After declining to apply the Netting Regulation, the court turned to a federal common law analysis. The court acknowledged that "federal courts have repeatedly recognized a general right of offset when determining the rights of agency creditors

and government contractor debtors," Appx9, and it found that "all three requirements for a procedurally valid offset under the federal common law" were satisfied here, Appx10. The court nonetheless concluded that existing law was insufficient to "answer the question of whether an agency-creditor has a right to use offset" in the specific context of debtors in "state-law insurance liquidation proceedings." *Id.* Having posited such a gap, the court decided that federal law ought to borrow "Colorado insurance liquidation law" as the federal rule of decision because the court believed that "federal interests do not require a uniform, federal rule." Appx12. The court opined that the "financial viability" of the ACA's "reinsurance and risk-adjustment programs" was "too general of an interest to support" adherence to the federal government's long-recognized right of offset. Appx16.

Applying Colorado law, the court declared HHS's offsets to be unlawful. The court acknowledged that Colorado law generally provides for offsets in insurance liquidations, *see* Colo. Rev. Stat. § 10-3-529(1), but concluded that that statute was not applicable here, *see* Appx10-12. The court further concluded that HHS's offsets of ACA debts had the impermissible effect of "leap-frogging claimants with higher priority" under state law. Appx10. Having declared the offsets to be invalid, the court bypassed further consideration of the proper remedy and entered a money judgment in plaintiff's favor in the amount of $24,489,799.00. Appx20, Appx21.

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act enacted a series of reforms to expand health coverage and improve insurance markets. As relevant here, the ACA established two premium stabilization programs—risk adjustment and reinsurance—designed to transfer financial costs and risks among health insurance issuers. The two programs are budget-neutral, *i.e.*, involve no taxpayer funds. Congress directed the Department of Health and Human Services to administer those programs in any State that elected not to do so itself and empowered HHS to promulgate implementing regulations. Under those regulations, HHS makes or demands payment to or from insurers only after "netting" any offsetting debts. In this way, HHS is able to operate a monthly payment cycle that expedites the transfer of funds to those insurers ultimately entitled to them.

I. The trial court erred in concluding that plaintiff is entitled to a $24.5 million judgment. HHS has already paid that amount to Colorado Health by discharging offsetting debts under the parallel risk adjustment program. That netting action was expressly authorized by a federal regulation, *see* 45 C.F.R. § 156.1215(b), which in turn was validly issued pursuant to HHS's statutory powers to administer and operate the risk adjustment and reinsurance programs, *see* 42 U.S.C. § 18041(a)(1)(C)-(D), (c)(1). The Netting Regulation alone is sufficient to sustain the lawfulness of HHS's method of payment here and reject plaintiff's claim.

II. The netting at issue here was also independently authorized by federal common law. The trial court acknowledged that "[f]ederal law governs HHS's rights here." Appx13. Federal common law has long recognized the government's right to make payments either directly or through offset, Appx9-10, and HHS's offsets here met "all three requirements for a procedurally valid offset under the federal common law," Appx10. There was no sound basis for the court to treat this case as involving a question of first impression, much less for the court to further conclude that HHS lacks a sufficient interest in adhering to the nationwide payment regulations that it designed to achieve the ACA's objectives. The court thus erred in concluding that state law rather than federal law is applicable, and then compounded that error by mistakenly declaring that Colorado law would forbid offset in these circumstances. Colorado law imposes no such prohibition.

III. Even assuming *arguendo* that HHS's offsets were not authorized when taken, the trial court nonetheless erred in entering its money judgment. Statutes governing the Court of Federal Claims' jurisdiction independently require the court to give effect to the federal government's rights of offset, as does the statute governing payments from the Judgment Fund. 28 U.S.C. §§ 1503, 2508; 31 U.S.C. § 3728(a). Plaintiff has no legal basis for demanding $24.5 million in taxpayer funds free from any offset of its countervailing debt, and that offset reduces plaintiff's (putative) right to payment to zero dollars.

STANDARD OF REVIEW

The decision below rests on conclusions of law that are subject to de novo review. *See, e.g.*, *Starr Int'l Co. v. United States*, 856 F.3d 953, 963 (Fed. Cir. 2017).

ARGUMENT

I. HHS LAWFULLY APPLIED ITS NETTING REGULATION IN DETERMINING AMOUNTS DUE UNDER THE ACA'S PREMIUM STABILIZATION PROGRAMS

A. HHS's Offsets Were Authorized By Validly Issued Federal Regulations.

1. The Affordable Care Act included two premium stabilization programs—risk adjustment and reinsurance—to help stabilize the expanded insurance markets by redistributing certain risks and costs among insurers. From the outset, Congress directed HHS to establish nationwide standards for these two programs and further instructed HHS to operate the programs in each State that opted not to do so itself.

Congress vested HHS with broad authority to promulgate regulations governing risk adjustment and reinsurance, as well as related programs. The ACA directed HHS to "issue regulations setting standards for meeting the requirements under this title … with respect to … the establishment of the reinsurance and risk adjustment programs" and with respect to "such other requirements as the Secretary determines appropriate." 42 U.S.C. § 18041(a)(1)(C)-(D). And for each State that did not timely establish risk adjustment and reinsurance programs that conform to federal standards, the ACA further instructed HHS to "take such actions as are necessary to

implement" those programs for such States. *Id.* § 18041(c)(1). Pursuant to these broad grants of authority, HHS promulgated numerous rules governing the process for collecting funds from, and making payments to, insurers under the various ACA programs. *See, e.g.*, 77 Fed. Reg. 17,220 (Mar. 23, 2012); 78 Fed. Reg. 15,410 (Mar. 11, 2013); 79 Fed. Reg. 13,744 (Mar. 11, 2014); 80 Fed. Reg. 10,750 (Feb. 27, 2015).

As directly relevant here, in 2014, HHS promulgated a regulation specifically addressing the matter of "[n]etting" (*i.e.*, offsets) for benefit year 2015 and successive years. *See* 79 Fed. Reg. at 13,841 (codified at 45 C.F.R. § 156.1215(b)). In the regulatory preamble, HHS noted that for benefit year 2014, it had "established a monthly payment and collections cycle" for certain ACA programs but an "annual payment and collections cycle for the premium stabilization programs," including risk adjustment and reinsurance. *Id.* at 13,817.[4] HHS explained, however, that it intended for future benefit years to operate a single "integrated monthly payment and collection cycle," which would be more "efficient for both issuers and HHS." *Id.*

To facilitate that integrated monthly cycle, HHS adopted a new rule—the Netting Regulation—providing that for 2015 and successive years, "HHS may net payments owed to issuers and their affiliates … against amounts due … from th[ose] issuers and their affiliates" for various ACA programs, including "advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing

[4] The monthly cycle then applied only to "advance payments of the premium tax credit, cost-sharing reductions, and FFE user fees." 79 Fed. Reg. at 13,817.

reductions, payment of Federally-facilitated Exchange user fees, and *risk adjustment*, *reinsurance*, and risk corridors *payments and charges*." 79 Fed. Reg. at 13,841 (codified at 45 C.F.R. § 156.1215(b)) (emphasis added). HHS explained that by "streamlin[ing] payment and charge flows from all of these programs," the Netting Regulation would "permit HHS to calculate amounts owed each month" and "pay or collect those amounts from issuers more efficiently." *Id.* at 13,817. HHS indicated that it would send money to insurers only in months when the insurer enjoyed a net balance, and conversely, would demand money from insurers "only when there is a net balance due to the Federal government." *Id.*[5]

2. HHS's payments to Colorado Health were made in conformity with that regulation. As discussed (*see supra* p. 8), in the March 2016 monthly cycle, HHS determined that Colorado Health was due a balance in reinsurance funds, and so HHS remitted payment to the insurer. In subsequent monthly cycles, however, HHS determined that the remaining funds due to Colorado Health under the reinsurance program were more than offset by funds that the insurer owed under the risk adjustment program. HHS accordingly paid Colorado Health its remaining share of

[5] The payment rules codified in the Netting Regulation are consistent with longstanding practice. Since 1983, HHS has sought to "recover[] amounts of claims due from debtors" through "[o]ffsets against monies owed to the debtor by the Federal government where possible." 42 C.F.R. § 401.607(a)(2). To that end, HHS's regulations provide that the agency "may offset, where possible, the amount of a claim [to be collected] against the amount of pay, compensation, benefits or other monies that a debtor is receiving or is due from the Federal government." *Id.* § 401.607(d)(1); *see* 48 Fed. Reg. 39,060, 39,062 (Aug. 29, 1983) (promulgating rule).

reinsurance funds—some $24.5 million—through the mechanism of offset, as the Netting Regulation expressly permits. *See* 45 C.F.R. § 156.1215(b).

Plaintiff has not disputed that HHS correctly calculated the reinsurance funds due to Colorado Health for 2015. Similarly, plaintiff has not disputed that Colorado Health owed more in risk adjustment for that year than it was due to receive in reinsurance. *See* Ctrs. for Medicare & Medicaid Servs., HHS, *Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year*, at 7 (Dec. 6, 2016), https://go.usa.gov/xvNQ3 (reflecting that Colorado Health owed $42.0 million in risk adjustment and was due $38.7 million in reinsurance). Nor has plaintiff disputed that HHS applied the Netting Regulation to effectuate offsets of those amounts.

Application of the Netting Regulation is dispositive and forecloses plaintiff's demand for additional money. Plaintiff's claim is for "immediate full payment of the Reinsurance payment to which [Colorado Health] is entitled from the Government under the ACA for benefit year 2015." Appx29. But HHS already made full payment of that sum through offset of debts that Colorado Health owed in the risk adjustment program. This Court has long recognized that "[c]ancellation of debt owed to the federal government" is a form of payment. *Brazos Elec. Power Co-Op., Inc. v. United States*, 144 F.3d 784, 787 (Fed. Cir. 1998); *see also Gonzales & Gonzales Bonds & Ins. Agency v. DHS*, 490 F.3d 940, 945 (Fed. Cir. 2007) ("An award in the form of an offset of other debt is a form of monetary relief"). Plaintiff accordingly has failed to state

any claim for "actual, presently due money damages from the United States." *United States v. Testan*, 424 U.S. 392, 398 (1976).

B. The Trial Court Erred In Concluding That Federal Law Does Not Authorize HHS To Apply Its Netting Regulation To An Insolvent Insurer.

The trial court acknowledged that federal law controls this case, and it did not question the validity of the Netting Regulation in general. The court nonetheless declared that the Netting Regulation could not be applied to Colorado Health because it was insolvent. The court interpreted Congress's grant of authority to HHS to "take such actions as are necessary to implement" the risk adjustment and reinsurance programs, 42 U.S.C. § 18041(c)(1), to require a showing that a particular application of the Netting Regulation is indispensable to the ACA programs that HHS administers.

That ruling rests on a basic misunderstanding of federal administrative law. The Supreme Court has long made clear that a statutory grant of authority to issue regulations necessary to administer a federal program represents a broad delegation to the agency to "work out" the program's "details" in the manner the agency sees as most appropriate. *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 165 (2007). When Congress empowers an agency to take "necessary" actions or prescribe "necessary" regulations, it does not authorize only those measures that are indispensable to every conceivable means of implementing the statute. On the contrary, when Congress directs or authorizes agencies to proceed by regulation rather than delineating a particular approach in the statute, it often does so precisely

because it believes that the agency is "in a better position" to identify the most efficacious among various possible alternatives. *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843-44 (1984).

The Supreme Court, this Court, and other courts of appeals have long applied this principle in construing statutory language similar to the provisions involved here. For example, the Supreme Court held that a statute authorizing an agency to "prescribe necessary rules, regulations, and orders" vested the agency with the power to "'fill any gap left, implicitly or explicitly, by Congress.'" *Long Island Care at Home*, 551 U.S. at 165 (quoting *Chevron*, 467 U.S. at 843); *see also Home Care Ass'n of Am. v. Weil*, 799 F.3d 1084, 1087, 1092 (D.C. Cir. 2015) (characterizing same language as a "general grant" to "work out' the statutory 'gaps' through rules and regulations," and upholding challenged regulation because it was "grounded in a reasonable interpretation of the statute"); *PhRMA v. FTC*, 790 F.3d 198, 207 (D.C. Cir. 2015) (statute authorizing FTC to "prescribe such other rules as may be necessary and appropriate to carry out the purposes of this section" provides broad authority to fill "gaps" in statutory scheme).

This Court has repeatedly recognized the same principle. In *Contreras v. United States*, 215 F.3d 1267 (Fed. Cir. 2000), the Court considered a federal statute authorizing the Office of Personnel Management (OPM) to "issue regulations 'necessary for the administration' of the Annual and Sick Leave Act." *Id.* at 1274. In upholding the validity of a challenged OPM regulation, the Court explained that "[a]n

agency that has been granted authority to promulgate regulations necessary to the administration of a program it oversees may fill gaps in the statutory scheme left by Congress if it does so in a manner that is consistent with the policies reflected in the statutory program." *Id.* (citing *NationsBank, N.A. v. Variable Annuity Life Ins.*, 513 U.S. 251, 257 (1995), among other authorities). Similarly, in considering a statute empowering OPM to "prescribe regulations … necessary for the administration of th[e] [Federal Employees Pay Act]," this Court explained that the provision authorized the agency to "'fill gaps in the statutory scheme left by Congress,'" without requiring it to prove its chosen regulations were the only possible means of implementing the statute. *Doe v. United States*, 372 F.3d 1347, 1357 (Fed. Cir. 2004) (emphasis omitted) (quoting *Contreras*, 215 F.3d at 1274).[6]

In any event, the trial court was mistaken in discounting the Netting Regulation's importance in HHS's administration of the ACA, including the risk adjustment and reinsurance programs in particular. Both programs are budget-neutral vis-à-vis federal taxpayers; Congress made no independent appropriations for either program. As a result, HHS's ability to make payments to insurers under those

[6] The Supreme Court also has long held that Congress's authority to "make all Laws which shall be necessary and proper" for carrying out other enumerated powers, U.S. Const. art. I, § 8, cl. 18, gives Congress "broad power to enact laws that are 'convenient, or useful' or 'conducive' to the … 'beneficial exercise'" of Congress's other authorities, and does not "demand[] that an Act of Congress be '*absolutely* necessary' to the exercise of an enumerated power," *United States v. Comstock*, 560 U.S. 126, 133-34 (2010); *see M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 413-21 (1819).

programs is entirely dependent on receiving collections under those programs in the first place. As HHS explained in promulgating the Netting Regulation, offsetting countervailing program debts allows HHS to simplify payment flows and thereby operate a monthly payment cycle that expedites the provision of funds to insurers. *See, e.g.*, 79 Fed. Reg. at 13,817 ("[T]his [netting] process will enable HHS to operate a monthly payment cycle that will be efficient for both issuers and HHS."). That, in turn, advances the ACA's core goal of stabilizing health insurance markets by providing immediate funds to those insurers that are determined to have assumed the greatest costs and risks. *See, e.g.*, 81 Fed. Reg. 29,146, 29,152 (May 11, 2016) (stating that "a robust risk adjustment program" is "critical to the proper functioning of the[] new [insurance] markets" in each State).

The trial court did not dispute that the Netting Regulation is essential to the administration of the ACA's risk adjustment and reinsurance programs. Instead, the court concluded only that "its application of offset *in an insolvency proceeding* is not vital to the application of the ACA's provisions." Appx7 (emphasis added); *see also* Appx8 ("[T]he Court will not infer from the ACA's requirements … that applying the Netting Rule's combined accounting regime in state insurance liquidation proceedings is necessary[.]"). But nothing in the Netting Regulation or the ACA contemplates that a different, more generous payment regime should apply to failed insurers in liquidation proceedings. On the contrary, it is especially important to offset debts owed by a defunct insurer, so that program funds can be used to support the

operations of other insurers that are still doing business and providing essential health coverage in the State.

The importance of the Netting Regulation to the functioning of the ACA's premium stabilization programs is highlighted by the implications of the trial court's ruling. That ruling would mean that once Colorado Health entered insolvency, it would be exempted from immediate responsibility under ACA programs, yet would continue to receive immediate payments—enabling it not only to keep receiving funds from other insurers, but to do so in amounts far in excess of those to which it would normally be entitled. Because the risk adjustment and reinsurance programs are budget-neutral, any increase in funds directed to Colorado Health (or other insolvent insurers) would mean that there are fewer funds immediately available to those insurers that, under federal law, are otherwise entitled to them. The trial court's interpretation of the statute thus would require HHS to siphon funds from insurers that are still providing health coverage and instead direct them to insurers that have failed—unsettling markets and compounding losses across the insurance industry.

Nothing in the ACA contemplates that counterproductive result. On the contrary, the very point of the risk adjustment and reinsurance programs is to stabilize the health insurance markets in each State, thereby making health coverage more

widely available.[7] *See, e.g.*, 83 Fed. Reg. 36,456, 36,458 (July 30, 2018) (explaining that a "central objective[] of the risk adjustment program" is "to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a high risk population compared to other issuers"). Congress expressly delegated to HHS the power to work out the details of how to allocate and distribute funds under those programs, and applying HHS's payment regime consistently to all insurers within each State is demonstrably in keeping "with the policies reflected in the statutory program." *Contreras*, 215 F.3d at 1274.

The trial court correctly rejected plaintiff's contention that the McCarran-Ferguson Act preserves state laws that conflict with the Netting Regulation. The McCarran-Ferguson Act provides that "[n]o Act of Congress shall be construed to … supersede any law enacted by any State for the purpose of regulating the business of insurance … *unless such Act specifically relates to the business of insurance*." 15 U.S.C. § 1012(b) (emphasis added). Because the ACA specifically relates to the business of insurance, section 1012(b) would not save conflicting state laws from preemption.

[7] In its filings below, plaintiff suggested that HHS's offsets would harm Colorado Health's policyholders by resulting in fewer funds available to pay outstanding claims. But Colorado, like most States, has a guaranty association that generally ensures that policyholder claims are paid even if an insurer has failed and has insufficient funds to cover its claims. *See* Colorado Dep't of Regulatory Agencies, *Information for Colorado HealthOP Members*, *Fact Sheet: Will My Colorado HealthOP Claims Be Paid?* (Dec. 2015), https://www.colorado.gov/pacific/dora/information-colorado-healthop-members (informing policyholders that "if for some reason, [Colorado Health] is unable to pay claims, the Colorado Life & Health Insurance Protection Association … would step in and pay claims"). Plaintiff has not shown that individual policyholders would bear any appreciable losses from reversal of the judgment below.

Instead, conflicting state laws are preempted because they would "prevent the application" of Title I of the ACA, which includes the delegations of authority to HHS discussed above. 42 U.S.C. § 18041(d); *see Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 153 (1982) ("Federal regulations have no less pre-emptive effect than federal statutes").

II. HHS'S OFFSETS WERE INDEPENDENTLY AUTHORIZED BY FEDERAL COMMON LAW AND ALSO CONSISTENT WITH COLORADO LAW

To reverse the trial court's judgment, it is sufficient to conclude that HHS lawfully applied its Netting Regulation. But even if that regulation were not controlling, the trial court erred in declaring HHS's offsets unlawful.

A. HHS's Offsets Were Authorized By Federal Common Law.

1. HHS's offsets were independently justified under federal common law. It has long been recognized that "[t]he government has the same right which belongs to every creditor, to apply the unappropriated moneys of his debtor, in his hands, in extinguishment of the debts due to him." *United States v. Munsey Tr. Co. of Washington, DC*, 332 U.S. 234, 239 (1947) (quotation marks omitted). This right of "setoff (also called 'offset') allows entities that owe each other money to apply their mutual debts against each other, thereby avoiding the 'absurdity of making A pay B when B owes A.'" *Citizens Bank of Md. v. Strumpf*, 516 U.S. 16, 18 (1995) (quoting *Studley v. Boylston Nat'l Bank*, 229 U.S. 523, 528 (1913)).

This Court, and its predecessor Court of Claims (whose decisions remain precedential), "have repeatedly recognized the government's right of set-off" as a "common law right." *Johnson v. All-State Constr., Inc.*, 329 F.3d 848, 852 (Fed. Cir. 2003); *see id.* (collecting cases); *cf. McCall Stock Farms, Inc. v. United States*, 14 F.3d 1562, 1566 (Fed. Cir. 1993) (noting that federal statutes governing debt collection were "intended to supplement, and not displace, the government's pre-existing offset rights under the common law"). Though that right of offset can be waived, the government's mere "agreement to 'pay' a certain amount does not bar the government from exercising its common law right of setoff against the agreed-to obligation." *Applied Cos. v. United States*, 144 F.3d 1470, 1475 (Fed. Cir. 1998). Rather, "the government retains its setoff right unless there is some explicit statutory or contractual provision that bars its exercise." *Johnson*, 329 F.3d at 853 (quoting *Applied Cos.*, 144 F.3d at 1476) (emphasis omitted).

Other courts of appeals have long recognized the same principle. *See, e.g.*, *In re Myers*, 362 F.3d 667, 674 (10th Cir. 2004) (noting, in bankruptcy context, that "[t]he existence of the federal government's general common law setoff right has been well established for over a century") (quoting 5 *Collier on Bankruptcy* ¶ 553.04[3] (15th ed. 2003)); *Marré v. United States*, 117 F.3d 297, 302 (5th Cir. 1997) ("The government's common law right of setoff—which is inherent in the federal government—is broad and 'exists independent of any statutory grant of authority to the executive branch.'") (quoting *United States v. Tafoya*, 803 F.2d 140, 141 (5th Cir. 1986)); *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" and stating that "the availability of a setoff by the United States need not depend upon specific statutory authorization").

2. The trial court erred in failing to give effect to that established common-law right. The court recognized that federal law controls, Appx7, Appx13, and it correctly acknowledged that the ACA does not abrogate the government's common-law rights, Appx6. But the court departed from the proper analysis when it assumed that, as to this case, the content of federal law was an open question. As just described, the government's common-law right of offset is well established. *See, e.g.*, *Johnson*, 329 F.3d at 852 (collecting cases); *Marré*, 117 F.3d at 302; *DeQueen*, 271 F.2d at 599.

Even assuming that the government's right of offset were not yet clear, the trial court erred in its further analysis. As the court acknowledged, in the absence of existing federal law, a "court must determine whether to create federal common law or to incorporate state law as the rule of decision." Appx13 (quoting *Montana v. United States*, 124 F.3d 1269, 1274 (Fed Cir. 1997)). In so doing, the court must consider whether "application of state law would frustrate specific objectives of the federal programs" at issue. *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 728 (1979).

For the reasons discussed (*see supra* pp. 20-23), HHS has a substantial interest in applying its payment rules in administering the ACA premium stabilization programs. As it explained in promulgating the Netting Regulation, offsets are necessary to operate the agency's "integrated monthly payment and collection cycle" and ensure

"efficien[cy] for both issuers and HHS." 79 Fed. Reg. at 13,817. Indeed, because the risk adjustment and reinsurance programs are budget-neutral, applying offsets is critical for enabling HHS to direct funds on a monthly basis to those insurers who are entitled to them. Moreover, the consistent application of federal payment rules, regardless of each particular insurer's current condition, is essential to maintaining predictability and instilling confidence in insurance markets. The trial court improperly failed to give effect to those important federal interests. *Cf. Hammer v. U.S. Dep't of HHS*, 905 F.3d 517, 533 (7th Cir. 2018) (reversing district court that had erroneously remanded to state court a case challenging a similar ACA offset, concluding that the district court had "g[iven] too much weight to the [State's] interests in a uniform liquidation proceeding" and "diminish[ed] the complex federal policies and interests at play").

B. Colorado Law, Even Were It Relevant, Would Not Forbid HHS's Offsets.

As discussed, HHS's offsets were authorized by federal law, including both the Netting Regulation and federal common law. Analysis of state law is therefore unnecessary. Even assuming it had any relevance here, however, the trial court erred in concluding that HHS's offsets violated Colorado law.

First, creditors in Colorado, as in other States, generally enjoy an equitable right of offset. *See Bluewater Ins. Ltd. v. Tennessee Ins. Co. v. Balzano*, 823 P.2d 1365, 1369 (Colo. 1992) (assuming right's existence). That right applies even when the creditor

taking the offset ranks lower in priority than other creditors under a State's insurance liquidation scheme.[8] That is because 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" and thus available for distribution in accordance with relevant priority rules. *Scott v. Armstrong*, 146 U.S. 499, 510 (1892); *see also Transit Cas. Co.*, 137 F.3d at 543 (crediting argument that "set-offs merely establish the bounds of the pre-receivership assets and that the Insurance Code governs only the distribution of those assets, rather than their definition"); *FDIC v. Liberty Nat'l Bank & Tr. Co.*, 806 F.2d 961, 967 (10th Cir. 1986) ("Only the balance, if any, after the setoff is deducted is considered an asset of the receivership."); *In re Liquidation of Realex Grp.*, 620 N.Y.S.2d 37, 39 (N.Y. App. Div. 1994) (applying *Scott* principle in state insurance liquidation).

That the Colorado Supreme Court in *Bluewater* ultimately disapproved the offset at issue casts no doubt on these principles. In *Bluewater*, the reinsurers had effectively

[8] *See Transit Cas. Co. v. Selective Ins. Co. of Se.*, 137 F.3d 540, 543 (8th Cir. 1998) (Missouri law) (acknowledging that "the application of set-off principles works to the advantage of one particular creditor, or class of creditors, and to the disadvantage of others," but stating that "courts and legislatures have resolved the tension between these competing public policies in favor of set-offs"); *Prudential Reinsurance Co. v. Superior Court*, 842 P.2d 48, 51 (Cal. 1992) (adopting position of "the majority of state and federal courts addressing the statutory right of setoff" and holding that a 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"); *In re Liquidation of Home Ins. Co.*, 972 A.2d 1019, 1022-23 (N.H. 2009) (recognizing that "setoff is an exception to the [priority framework] for discharging claims against an insolvent debtor").

waived their rights of offset during contract negotiations and in consultation with Colorado's commissioner of insurance. *See* 823 P.2d at 1369 (concluding that "[e]ven if the reinsurers otherwise enjoyed an equitable right to offset, nothing prevented the reinsurers from freely entering into enforceable contracts from which an offset clause was deliberately excluded," and "[h]aving entered into such contracts, the reinsurers are bound"). The Court thus concluded that the broader question "whether the right [of offset] creates an impermissible preference" under the State's priority rules was "mooted." *Id.* at 1374.[9]

Second, in any event, a Colorado statute enacted shortly after *Bluewater* expressly authorizes offsets in the insurance liquidation context. That statute provides that "[n]otwithstanding 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, and the balance only shall be allowed or paid, except as provided in [subsections not relevant here]." Colo. Rev. Stat. § 10-3-529(1). That provision authorized the "mutual debts" of HHS and Colorado Health to be "set off," so that "the [resulting]

[9] As part of its equitable analysis, the *Bluewater* Court also placed weight on the fact that the reinsurers had failed to invoke other express contractual remedies that, if pursued, would have prevented the indebtedness that the reinsurers later attempted to set off. *See* 823 P.2d at 1371 (explaining that reinsurers could have "obviate[d] the need to net or offset any balances on account of premiums"); *id.* at 1374 (emphasizing that this equitable consideration "bears repeating").

balance only" became a debt subject to the State's rules governing the distribution of an insurer's liquidation estate.

The trial court mistakenly concluded that this Colorado statute permits only "offset[s] involving a contract," Appx11, and not the offset of debts arising by operation of federal or state law. On the contrary, the statute expressly authorizes offset "*whether*" the debts arise under contract. Colo. Rev. Stat. § 10-3-529(1) (emphasis added). As even the trial court recognized, it is "grammatically preferable" to read the "whether" clause, which is set off by commas, as non-restrictive in nature. Appx12.

The trial court departed from the most straightforward reading of the Colorado statute only because it observed that its effective-date provision contains several explanatory clauses relating to contracts, which led the court to assume that contractual offsets must have been all that the legislature intended to authorize. Appx11. Those clauses clarify that, in addition to applying to "contracts entered into … on or after [January 1, 1993]," the statute also applies to "transactions occurring after January 1, 1993" but undertaken pursuant to contracts "in existence prior to January 1, 1993." Colo. Rev. Stat. § 10-3-529(6). But those clauses simply elucidate how the statute's general effective-date provision—"[t]his section shall be effective January 1, 1993," *id.*—would apply to fact patterns involving contracts. Nothing in that language suggests that the legislature, in broadly authorizing offset of "mutual debts or mutual credits," *id.* § 10-3-529(1), implicitly intended to withhold that right

from federal and state governments in the course of administering essential government programs.

III. A MONEY JUDGMENT IS INAPPROPRIATE IN ALL EVENTS, BECAUSE THE TRIAL COURT ITSELF IS REQUIRED TO ACCOUNT FOR THE INSURER'S DEBT TO THE GOVERNMENT

Finally, even if HHS's offsets were not authorized when taken, the trial court erred in entering a money judgment in plaintiff's favor.

1. The Tucker Act permits the Court of Federal Claims to enter relief only to the extent that a plaintiff proves "actual, presently due money damages." *Lummi Tribe of the Lummi Reservation v. United States*, 870 F.3d 1313, 1318-19 (Fed. Cir. 2017). As part of its remedial analysis, the trial court is obliged to account for any outstanding debts shown to be owed by the plaintiff to the federal government. Congress mandated that "[u]pon the trial of any suit in the United States Court of Federal Claims in which any setoff, counterclaim, claim for damages, or other demand is set up on the part of the United States against any plaintiff making claim against the United States in said court, the court shall hear and determine such claim or demand both for or against the United States and plaintiff." 28 U.S.C. § 2508; *see also id.* § 1503 ("The United States Court of Federal Claims shall have jurisdiction to render judgment upon any set-off or demand by the United States against any plaintiff in such court.").

The Supreme Court and this Court's predecessor have recognized that these statutes impose a mandatory duty to give effect to the government's offsets. *See*

Munsey Tr. Co., 332 U.S. at 239-40 (concluding that the Court of Claims was "under statutory duty to recognize the undisputed claim for damages of the United States" when adjudicating a claim against the government); *Blake Constr. Co. v. United States*, 585 F.2d 998, 1005 (Ct. Cl. 1978) ("By special statute, set-off is allowed in this court where the Government is always the defendant."); *Atlantic Contracting Co. v. United States*, 35 Ct. Cl. 30, 33-34 (1899) (recognizing that when a claimant "seeks the jurisdiction" of the Claims Court, "he is subjected to … determination of whatever claims the United States may have against him which can be properly pleaded by way of set-off"). That duty follows from the fundamental principle of sovereign immunity that a court may award monetary relief against the government only on the terms and conditions allowed by Congress. *See, e.g.*, *Testan*, 424 U.S. at 399; *International Custom Prods., Inc. v. United States*, 791 F.3d 1329, 1336 (Fed Cir. 2015); *Hart v. United States*, 910 F.2d 815, 817 (Fed. Cir. 1990).

Nothing in those statutes makes the government's right of offset contingent on the financial condition of the plaintiff. On the contrary, offset is required even when, as here, the claimant is insolvent. The Court of Claims' decision in *Preuss v. United States*, 412 F.2d 1293 (Ct. Cl. 1969), is instructive. There, the plaintiff—the trustee of a bankrupt contractor—opposed the government's offset on the theory that the government should be forced to pursue its setoff claim in bankruptcy court. The Court disagreed and sustained the government's claim for a "one hundred percent" offset, reasoning that it could not "relegate the government to the bankruptcy court as

a general creditor[,] where its set-off would in all probability be worth only a few cents on the dollar." *Id.* at 1304. The Court explained that the government's right of offset is "encompassed within the jurisdiction conferred on this [C]ourt by Congress" in sections 1503 and 2508, and it was "'not at liberty'" to "'limit or restrict'" it. *Id.* (quoting *Frantz Equip. Co. v. United States*, 122 Ct. Cl. 622, 630 (1952)).

2. Plaintiff has failed to show any entitlement to an award of taxpayer money. Plaintiff argues, at most, that HHS's offsets were unlawful when taken. But even if those offsets were unauthorized, it would not follow that HHS now owes Colorado Health $24.5 million more than it otherwise would. Rather, the challenged transactions would simply be undone, resuscitating the insurer's own countervailing obligations.

Plaintiff has never disputed that Colorado Health owed—and, if HHS's offsets were unwound, would again owe—at least $24.5 million in unpaid risk adjustment funds. The government thus has a valid claim for offset of that amount under 28 U.S.C. §§ 1503 and 2508. The trial court should have accounted for that offset and reduced any judgment to zero. *See, e.g.*, *Western Cas. & Sur. Co. v. United States*, 124 Ct. Cl. 156, 164 (1953) (exercising Tucker Act jurisdiction but concluding that "[s]ince [the contractor] owes the Government for unpaid taxes more than the Government owes [the contractor] for the materials purchased, the set-off exhausts the funds, and the plaintiff is not entitled to recover").

Finally, entry of a money judgment would in any event be futile. Congress has directed that "[t]he Secretary of the Treasury shall withhold paying that part of a judgment against the United States Government presented to the Secretary that is equal to a debt the plaintiff owes the Government." 31 U.S.C. § 3728(a). Nothing in that statute conditions the Secretary's duty to withhold payment on the solvency of the judgment creditor. Thus, even "if the court were to determine that plaintiff was entitled to a return of the offset funds and entered a monetary judgment against defendant, the government would then be required to apply that judgment toward" plaintiff's outstanding debt. *Greene v. United States*, 124 Fed. Cl. 636, 645 (2015). The trial court erred in imposing a judgment that plaintiff cannot collect. *See id.* (declining to enter a judgment that would be "futile" in light of 31 U.S.C. § 3728).

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

ALISA B. KLEIN
/s/ Jeffrey E. Sandberg
JEFFFREY E. SANDBERG
Attorneys, Appellate Staff
Civil Division, Room 7214
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 532-4453
jeffrey.e.sandberg@usdoj.gov

Counsel for the United States

APRIL 2020

CERTIFICATE OF SERVICE

I hereby certify that on April 27, 2020, I electronically filed the foregoing brief with the Clerk of Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Jeffrey E. Sandberg
Jeffrey E. Sandberg
Counsel for the United States

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 8,630 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Jeffrey E. Sandberg
Jeffrey E. Sandberg
Counsel for the United States

ADDENDUM

ADDENDUM CONTENTS

In the United States Court of Federal Claims

No. 18-1623
Filed: October 3, 2019

MICHAEL CONWAY, *in his capacity as Liquidator of Colorado Health Insurance Cooperative, Inc*.	)	
Plaintiff,	)	Keywords: Affordable Care Act; Reinsurance Program; Right of Offset; 42 U.S.C. § 18061; 45 C.F.R. § 156.1215.
v.	)	
THE UNITED STATES,	)	
Defendant.	)	

Stephen McBrady, Crowell & Moring LLP, Washington, D.C., for plaintiff.

Marc S. Sacks, Commercial Litigation Branch, Civil Division, U.S. Department of Justice, Washington, D.C., for defendant.

MEMORANDUM OPINION AND ORDER

***HERTLING*, Judge**

Plaintiff Michael Conway, in his capacity as Liquidator of Colorado Health Insurance Cooperative, Inc. ("the Cooperative"), sued the United States for payments that the U.S. Department of Health and Human Services' Center for Medicare and Medicaid Services ("HHS") allegedly owes the Cooperative under the Patient Protection and Affordable Care Act ("ACA"). HHS reduced or "offset" the amount of its payments to the insolvent Cooperative on account of debts allegedly owed to HHS by the Cooperative. The Liquidator argues that, under the McCarran-Ferguson Act, Colorado law governs the priority of payment of debts owed by an insurer in liquidation proceedings. Therefore, the Liquidator argues, HHS must, under Colorado insurance liquidation law, pay the amount it offset. The Liquidator requests the $24,489,799 that HHS allegedly offset, pre- and post-judgment interest, costs, attorneys' fees, and any other relief the Court deems proper and just. For the following reasons, the plaintiff's Motion for Summary Judgment is granted in part and denied in part, and HHS's Cross-Motion to Dismiss is granted in part and denied in part.

I. BACKGROUND

A. ACA Programs and the Netting Rule

In the ACA,[1] Congress created the Consumer Operated and Oriented Plan ("CO-OP") program, to ensure that states' health-benefit marketplaces were stocked with qualified insurance plans for healthcare consumers to buy. 42 U.S.C. § 18042. The CO-OP program provided loans and grants to "qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets." *Id.* It is undisputed that the Cooperative was a CO-OP program insurer.[2]

To help insurers offset the risks of providing broader coverage under the ACA's new requirements, the ACA required each state to establish certain discreet payment programs. *See, e.g.*, 42 U.S.C. § 18061(a) ("Each State shall . . . establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program . . . ."); § 18063(a) ("[E]ach State shall assess a charge on health plans and health insurance issuers . . . . [E]ach State shall provide a payment to health plans and health insurance issuers . . . ."). For the years relevant to this case, these programs included the reinsurance and risk-adjustment programs.[3]

Although the ACA allowed each state to operate its own reinsurance and risk-adjustment programs, all but two states have opted out, so HHS administers the programs for the other states. *See* 42 U.S.C. § 18041 (providing that if a state opts out or fails to establish an exchange, a reinsurance program, or a risk-adjustment program, HHS "shall establish and operate such exchange within the State and [HHS] shall take such actions as are necessary to implement" the reinsurance and risk-adjustment programs). HHS operated the reinsurance and risk-adjustment programs for Colorado at the times relevant to this case.

The reinsurance program required that insurers make payments in 2014, 2015, and 2016 to one or more "reinsurance entities." 42 U.S.C. § 18061. Those entities were then required to distribute the funds to "health insurance issuers . . . that cover[ed] high risk individuals." *Id.*

[1] On March 23, 2010, Congress enacted the ACA, Pub. L. No. 111-148, 124 Stat. 119. A week later, on March 30, 2010, Congress amended the ACA through the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[2] A challenge to the constitutionality of the ACA is currently pending in the Fifth Circuit. *See State of Texas, et al. v. United States, et al.*, 5th Cir. No. 19-10011. The defendant does not argue that the outcome of that case will affect the plaintiff's claim for relief in this matter.

[3] The plaintiff has alleged in another case in this Court that it is owed $111,420,992 in payments under the ACA's risk-corridors program. *See* Notice of Lodging Certification of Class Membership, *Health Republic Insur. Co. v. United States*, No. 16-259 (Fed. Cl. June 12, 2017), ECF No. 57. That case is stayed pending Supreme Court appeal, to be argued on December 10, 2019, of other risk-corridors cases. *See* Order, *Health Republic*, No. 16-259, ECF No. 69 (staying case pending appeal of *Land of Lincoln Mut. Health Ins. Co. v. United States*, 892 F.3d 1184 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2744 (2019), and *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2743 (2019)).

The risk-adjustment program, also operated by HHS, requires that insurers whose plans bear low actuarial risk pay the state (or the federal government) a specified amount. 42 U.S.C. § 18063. That governmental entity then redistributes those payments to insurers whose plans bear high actuarial risk. *Id.*

On March 11, 2014, HHS promulgated a final rule ("the Netting Rule") explaining the method by which it would aggregate and offset monies owed by or to different insurers under these and other ACA payment programs. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,817 (Mar. 11, 2014) (codified at 45 C.F.R. § 156.1215); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,317-18 (Mar. 8, 2016) (technical amendments to March 2014 rule). The Netting Rule provides:

> (a) Netting of payments and charges for 2014. In 2014, as part of its monthly payment and collections process, HHS will net payments owed to [qualified health plan ("QHP")] issuers and their affiliates under the same taxpayer identification number against amounts due to the Federal government from the QHP issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and payment of Federally-facilitated Exchange user fees.
>
> (b) Netting of payments and charges for later years. As part of its payment and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal or State governments from the issuers and their affiliates under the same taxpayer identification number 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.
>
> (c) Determination of debt. Any amount owed to the Federal government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, including any fees for State-based Exchanges utilizing the Federal platform, risk adjustment, reinsurance, and risk corridors, after HHS nets amounts owed by the Federal government under these programs, is a determination of a debt.

45 C.F.R. § 156.1215.

B. Factual Background

In 2012, HHS approved the Cooperative's application to operate as a CO-OP program insurer and executed a loan agreement with the Cooperative.[4]

The Cooperative soon ran into financial difficulties. After an unsuccessful state-ordered supervision and rehabilitation process, in January 2016 a Colorado state court placed the Cooperative in liquidation. Liquidation is a bankruptcy-like insolvency proceeding established by state law in which an appointed "liquidator" collects any money an insolvent insurer is owed and distributes the insurer's assets to its creditors according to the priority scheme applied by the liquidation court.

In March 2016, HHS paid the Cooperative an early reinsurance payment of $14,154,424 for the previous year. Later that month, the Liquidator provided HHS a notice for creditors to submit their claims in the Cooperative's liquidation proceeding. The notice gave HHS the remainder of the calendar year to respond.

In June 2016, HHS published the amounts it owed insurers for the prior benefit year. According to HHS, it owed the Cooperative $38,644,223.02 (later amended to $38,664,334.67). To date, HHS has only paid the Cooperative $14,174,535.

According to the Liquidator, in August 2016, HHS notified him that HHS would offset $20,255,084 of the amount the agency owed the Cooperative under the reinsurance program against $21,775,432 that the Cooperative owed HHS under the risk-adjustment program. According to HHS, however, the agency executed a series of offsets between February 2017 and May 2018 to reconcile the Cooperative's various ACA program accounts.

In late December 2016, HHS responded to the Liquidator's notice. An April 2017 letter from the Liquidator requested that HHS provide additional information by June 1, 2017. Weeks after that response deadline, HHS sought an extension, and the Liquidator extended the response deadline to August 14. HHS did not respond by the August deadline.

On August 30, 2017, the Liquidator sent HHS a claims determination letter, disallowing the submitted claims and requesting the "return of all unauthorized offsets." HHS did not object to that claim determination within the 60-day limit under Colorado law. *See* Colo. Rev. Stat. § 10-3-538(1). In December 2017, on the Liquidator's motion, a Colorado court affirmed the Liquidator's claim determination.

C. Procedural Background

On October 19, 2018, the Liquidator filed a complaint in this Court, asserting two claims for relief. Count I of the complaint alleges that HHS has failed to make obligatory payments under the reinsurance program. Count II of the complaint alleges that HHS's offset of payments

[4] The facts outlined here are drawn from the complaint, whose well-pleaded allegations are accepted as true for purposes of the defendant's motion. The defendant has not otherwise contested these allegations for purposes of the plaintiff's motion for summary judgment.

it owes to the Cooperative violates Colorado law and is therefore invalid. The Liquidator later filed a Motion for Summary Judgment and HHS moved to dismiss. The motions are fully briefed, and the Court heard oral argument on September 9, 2019.

II. STANDARD OF REVIEW

Rule 12(b)(6) of the Rules of the Court of Federal Claims ("RCFC") authorizes a party to file a motion to dismiss for "failure to state a claim upon which relief can be granted." Such a motion "'is appropriate when the facts asserted by the claimant do not entitle him to a legal remedy.'" *Welty v. United States*, 926 F.3d 1319, 1323 (Fed. Cir. 2019) (quoting *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002)).

RCFC 56 authorizes a party to file a motion for summary judgment. Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." RCFC 56(a).

III. JURISDICTION

The Tucker Act provides this Court with jurisdiction "to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." 28 U.S.C. § 1491. The Tucker Act "operate[s] to waive sovereign immunity for claims premised on other sources of law (e.g., statutes or contracts)" if that source of law "'can fairly be interpreted as mandating compensation by the Federal Government.'" *United States v. Navajo Nation*, 556 U.S. 287, 290 (2009) (quoting *United States v. Testan*, 424 U.S. 392, 400 (1976)).

The ACA's reinsurance program, when administered directly by HHS, can fairly be interpreted as mandating compensation. The pertinent provision provides that each state "shall . . . establish (or enter into contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program." 42 U.S.C. § 18061(a). The program also requires that an "applicable reinsurance entity" use the payments it collects "to make reinsurance payments to health insurance issuers." 42 U.S.C. § 18061(b). Together, these provisions require that money collected from insurers be distributed to other insurers, according to applicable formulas.

HHS's implementing regulations reinforce this conclusion. One regulation provides that "HHS will allocate and disburse to each State operating reinsurance (*and will distribute directly to issuers if HHS is operating reinsurance on behalf of a State*), reinsurance contributions collected from contributing entities." 45 C.F.R. § 153.235 (emphasis added). HHS's regulation further provides, "If a State establishes a reinsurance program, the State must ensure that the applicable reinsurance entity . . . [m]akes reinsurance payments." 45 C.F.R. § 153.240. These rules make clear that 42 U.S.C. § 18061(b) mandates distributions.

Finally, whether the disputed payment was paid directly to the Cooperative or used to offset the Cooperative's debt is irrelevant to this Court's jurisdiction. When an agency uses an offset, a plaintiff may invoke the Tucker Act to challenge the underlying debt. *See Brazos Elec. Power Co-op., Inc. v. United States*, 144 F.3d 784, 787 (Fed. Cir. 1998).

HHS argues that this Court lacks jurisdiction over Count II of the complaint because it arises under state law. Not so. The Cooperative's right to payment under the reinsurance program arises under 42 U.S.C. § 18061. The reason that state law is potentially relevant is that the ACA's non-preemption clause, 42 U.S.C. 18041(d), acknowledges the applicability of nonconflicting state law, and the McCarran-Ferguson Act generally instructs that the insurance business "shall be subject to the laws of the several states." 15 U.S.C. § 1012. If McCarran-Ferguson applies, the question of the Cooperative's right to payment under 42 U.S.C. § 18061 necessarily encompasses the question of whether HHS's offset was permissible under Colorado law, but that question arises solely because of the money-mandating elements of the relevant ACA provision and its interplay with other federal laws.

IV. DISCUSSION

A. Count I

Count I of the Complaint alleges that HHS's offset violated the ACA. The Liquidator argues that the ACA and HHS regulations require timely payment to plan issuers and HHS's offset reduced the amount paid and violated this payment requirement. HHS responds that it has the inherent authority to employ offset among different ACA programs. HHS argues that it both put insurers on notice that it might use its offset authority in the context of the ACA by promulgating the Netting Rule, and then in fact used its offset authority to reconcile the Cooperative's accounts on several occasions. HHS concludes that because it had the power to do what it did, and because an offset constitutes the payment of money, the Cooperative received all the money it was owed.

The general right of 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 Maryland v. Strumpf*, 516 U.S. 16, 18 (1995) (quoting *Studley v. Boylston Nat'l Bank*, 229 U.S. 523, 528 (1913)). The federal government has the same offset rights as other creditors. *See United States v. Munsey Tr. Co. of Washington, D.C.*, 332 U.S. 234, 239 (1947).

The Court analyzes below whether the ACA or other applicable law authorized HHS's offset. As a threshold matter however, the Court holds that the ACA does not *prohibit* offset otherwise allowed under federal common law or state law. Count I of the complaint does not provide an independent basis for relief, and accordingly it is dismissed.

B. Count II

Count II of the Complaint alleges that the offset HHS made under the Netting Rule after the Cooperative entered liquidation was invalid under Colorado's insurance liquidation priority scheme, and that the ACA itself and the McCarran-Ferguson Act prevents HHS's Netting Rule from preempting Colorado's insurance liquidation priority scheme. HHS relies on the Netting Rule as the authority for its offset. It argues that because the ACA is an act of Congress relating specifically to insurance, HHS's Netting Rule implementing the ACA preempts even conflicting state insurance laws that would otherwise apply by virtue of the McCarran-Ferguson Act.

Further, HHS argues, federal law should govern HHS's property rights "arising under nationwide federal programs."

The Court holds that HHS's offset was invalid under Colorado's insurance liquidation priority scheme. Because neither the ACA nor another statute authorizes the Netting Rule's application in the insurance liquidation context, HHS must have taken its offset in its capacity as a creditor. Although federal law governs HHS's rights as a creditor in implementing the nationwide reinsurance and risk-adjustment programs, its interest in uniformity is insufficient to warrant this Court creating a federal common law rule to displace Colorado's insurance liquidation priority scheme.

1. No Statutory Authority for the Netting Rule

The ACA preempts state laws that prevent the application of its provisions, but HHS's Netting Rule does not likewise preempt state law because it is not required or authorized by the ACA or another statute. The title of the ACA that provides for the reinsurance and risk-adjustment programs includes a clause defining the extent to which the ACA preempts state law:

> NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

Pub. L. No. 111-148, § 1321(d), 124 Stat. 119, 187 (codified as 42 U.S.C. § 18041(d)).

The Eighth Circuit interpreted this clause as disclaiming any ACA preemption over the entire field of health insurance. *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) (quoting Black's Law Dictionary 1226 (8th ed. 2004)) ("This preemption clause is a narrow one, and only those state laws that 'hinder or impede' the implementation of the ACA run afoul of the Supremacy Clause."); *accord UnitedHealthcare of New York, Inc. v. Vullo*, 323 F. Supp. 3d 470, 481 (S.D.N.Y. 2018) (holding that the ACA does not preempt the field of health insurance), *appeal argued*, No. 18-2583 (2d Cir. Feb. 8, 2019). Despite its narrow reading of the clause, that court held invalid several state law limits on what healthcare plan counselors could tell consumers because it found the limits incompatible with HHS's ACA regulations. *St. Louis Effort for AIDS*, 782 F.3d at 1022, 1024-27.

Whether an agency-promulgated rule preempts state law raises two separate questions. *See New York v. F.E.R.C.*, 535 U.S. 1,18 (2002). First, is the agency's regulation authorized by federal statute? If so, second, does the state law conflict with the agency's regulation? *St. Louis Effort for AIDS* only addressed the latter question.

Here, the Netting Rule does not preempt Colorado's insurance liquidation priority scheme because neither the ACA nor another statute require or authorize HHS to issue a rule offsetting among different ACA programs payments HHS owes to an insurer in liquidation proceedings and contributions HHS is owed. The Netting Rule provides operational convenience but its application of offset in an insolvency proceeding is not vital to the application of the ACA's provisions.

As HHS repeatedly noted in oral argument, the Netting Rule was the product of notice-and-comment rulemaking. HHS's 116-page notice of proposed rulemaking cites the ACA sections requiring establishment of the reinsurance and risk-adjustment programs as authority, but does not offer a more specific basis for the Netting Rule other than greater efficiency. *See* HHS Notice, 78 Fed. Reg. 72322-01 (proposed Dec. 2, 2013); HHS Notice, 79 Fed. Reg. at 13,817 (final rule) ("This process will permit HHS to calculate amounts owed each month, and pay or collect those amounts from issuers more efficiently. . . . We believe that this process will enable HHS to operate a monthly payment cycle that will be efficient for both issuers and HHS."). *Cf. id.* at 13,746 (asserting HHS authority to collect user fees for exchanges it operates, citing the ACA provision requiring HHS to operate an exchange when a state does not and separately citing "31 U.S.C. § 9701 [which] permits a Federal agency to establish a charge for a service provided by the agency.").

Although the ACA required HHS to "take such actions as are necessary to implement" the reinsurance and risk-adjustment programs whenever a state did not, the Court will not infer from the ACA's requirements or structure that applying the Netting Rule's combined accounting regime in state insurance liquidation proceedings is necessary to implement the reinsurance and risk-adjustment programs.

The ACA did not require that HHS administer both programs for a state. Indeed, it is not clear that Congress contemplated that HHS would wind up administering both programs for *nearly all* of the states.

To the contrary, HHS admits that it does not operate a single accounting regime covering the reinsurance, risk-adjustment, and risk-corridor programs for all 50 states. States can administer one of the three programs and choose to have HHS administer the other two. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 Fed. Reg. 10,750, 10,758–9 (Feb. 27, 2015) (noting that Connecticut administers its own reinsurance program and Massachusetts administers its own risk-adjustment program). That HHS can administer each program for any state that wanted it to without also administering that state's other programs undermines HHS's argument that the reinsurance and risk-adjustment programs are so integrated that netting is required as part of the ACA's structure.

As for other statutes, the Netting Rule, its rulemaking notices, and HHS's filings in this case do not claim that the Netting Rule was an implementation of the 1982 Debt Collection Act. *Cf. McCall Stock Farms, Inc. v. United States*, 14 F.3d 1562, 1565-67 (Fed. Cir. 1993). The Debt Collection Act authorized agencies to issue regulations with procedures for taking administrative offsets to collect debts and was "intended to supplement, and not displace, the government's pre-existing offset rights under the common law." *Id.* at 1566 (citing General Accounting Office, Federal Claims Collection Standards, 49 Fed. Reg. 8891 (1984) (final rule)).

2. The McCarran-Ferguson Act is Inapplicable

The McCarran-Ferguson Act does not directly affect the Netting Rule's preemptive effect because neither the Netting Rule nor any offset authority the Netting Rule exercises qualifies as an "Act of Congress." The McCarran-Ferguson Act generally prevents federal law from preempting state insurance law. It provides "[t]he business of insurance . . . shall be subject to

the laws of the several States which relate to the regulation . . . of such business." 15 U.S.C. § 1012. The McCarran-Ferguson Act further provides, "[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 business of insurance . . . unless such Act [of Congress] specifically relates to the business of insurance." *Id.*

The Courts of Appeals have consistently held McCarran-Ferguson inapplicable to non-statutory sources of federal law. Three circuits have excluded treaties from McCarran-Ferguson's reference to an "Act of Congress." *See Safety Nat'l Cas. Corp. v. Certain Underwriters At Lloyd's, London*, 587 F.3d 714, 718 (5th Cir. 2009) (*en banc*) (holding a treaty is not an "Act of Congress" under McCarren-Ferguson with dissenters only disagreeing as to whether the court was construing the treaty or its implementing legislation); *ESAB Grp., Inc. v. Zurich Ins. PLC*, 685 F.3d 376, 390 (4th Cir. 2012) (citing *Am. Ins. Ass'n v. Garamendi*, 539 U.S. 396, 428 (2003)) (limiting "Act of Congress" to "domestic commerce legislation"). The Second Circuit has held that federal common law—even when later codified by statute—is not an "Act of Congress" to which McCarran-Ferguson applies. *Stephens v. Nat'l Distillers and Chem. Corp.*, 69 F.3d 1226, 1234 (2d Cir. 1995), *amended* (Jan. 11, 1996) ("[T]he McCarran–Ferguson Act did not by its terms or in its history purport to overturn any pre-existing international or common law. To bring the McCarran–Ferguson Act into play simply because Congress chose to codify that pre-existing law would truly defy common sense.")

Because no "Act of Congress" authorizes the Netting Rule, McCarran-Ferguson does not affect whether the Netting Rule preempts Colorado law prohibiting offset in insurance liquidation proceedings.

3. HHS's Offset Right as a Creditor

The inherent collection and payment authority HHS exercises includes its rights as a creditor which are not specifically enlarged by the ACA's provisions. Without statutory authority from the ACA to implement an offset rule in its capacity as a regulator, HHS could only have promulgated the Netting Rule as notice of its intent to exercise whatever offset authority it normally enjoys as a creditor.

Federal common law defining the rights of federal agency-creditors in the government contracts context recognizes a broad right of offset. Colorado law, however, prohibits creditors from using offset to circumvent its insurance liquidation priority scheme.

a. Offset Under Federal Common Law

The federal government has the same offset rights as other creditors. *Munsey Tr.*, 332 U.S. at 239. The federal courts have repeatedly recognized a general right of offset when determining the rights of agency creditors and government contractor debtors as a matter of federal common law.

The Federal Circuit has followed the Supreme Court's holding in *Strumpf* that a valid offset requires "(i) a decision to effectuate a setoff, (ii) some action accomplishing the setoff, and (iii) a recording of the setoff." *Applied Cos. v. United States*, 144 F.3d 1470, 1474 (Fed. Cir.

1998) (quoting *Strumpf*, 516 U.S. at 19); *see also Johnson v. All-State Const., Inc.*, 329 F.3d 848, 854 (Fed. Cir. 2003) (applying *Strumpf*'s three-part test).

Here, all three requirements for a procedurally valid offset under the federal common law of contracts were met. The parties agree that HHS decided to effectuate an offset of the Cooperative's accounts, provided notice to that effect, and modified its debt records accordingly. Consequently, HHS's use of offset would have been procedurally valid if only federal common law controlled the Cooperative's right to payment.

Cases like *All-State Construction* recognize a right to use offset when the parties' contract rights are governed primarily by federal common law. *See* 329 F.3d at 852. These cases, however, do not answer the question of whether an agency-creditor has a right to use offset when the rights of the parties are not primarily defined by federal common law, like in state-law insurance liquidation proceedings.

b. Offset Under Colorado Law

Analyzed under Colorado law, HHS's offset violates Colorado's insurance liquidation priority scheme by leap-frogging claimants with higher priority. *See* Colo. Rev. Stat. § 10-3-541. Seeking to avoid this problem, HHS invokes Colorado's offset statute, which provides:

> 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, and the balance only shall be allowed or paid, except as provided in subsections (2) and (4) of this section and section 10-3-532.

Colo. Rev. Stat. § 10-3-529(1).

The parties disagree about the meaning of Colorado's offset statute. The Liquidator argues that it does not cover HHS's offset because (1) the statute only applies to "contracts;" (2) the Cooperative and HHS's debts are not "mutual;" and (3) HHS is a net debtor with respect to the Cooperative, so HHS's offset exceeds the permitted offset amount that the statute refers to as "the balance."

To interpret the Colorado offset statute, the Court looks to the Colorado Supreme Court's rules of statutory interpretation. The Colorado Supreme Court has explained that the "primary purpose" of statutory interpretation is "to ascertain and give effect to the legislature's intent." *McCoy v. People*, 442 P.3d 379, 389 (Colo. 2019). Courts should "look first to the language of the statute, giving its words and phrases their plain and ordinary meanings." *Id.* Courts should also "read statutory words and phrases in context, and . . . construe them according to the rules of grammar and common usage." *Id.*

The Liquidator argues that the Colorado offset statute only applies to "contracts between the insurer and another person in connection with any action or proceeding under this part 5."[5] The relevant clause of the statute—the one beginning with "whether" and set off by commas—modifies those "mutual debts or mutual credits" that "shall be set off." The apparent purpose of the clause is to clarify that "mutual debts or mutual credits" may be set off even if multiple contracts, *i.e.*, "one or more contracts," are involved. The clause does not, however, appear to address whether mutual debts or mutual credits other than those arising from contracts may also be set off. In other words, it is not clear from the plain language of the provision whether the clause is restrictive or non-restrictive.

Context supplies the answer. "The legislature is presumed to intend that the various parts of a comprehensive scheme are consistent with and apply to each other, without having to incorporate each by express reference in the other statutory provisions." *Martinez v. People*, 69 P.3d 1029, 1033 (Colo. 2003) (citation omitted). Subsection 5 of the offset statute permits certain offsets that are otherwise barred when "the contracts" meet certain requirements. Colo. Rev. Stat. § 10-3-529(5). Moreover, Subsection 6 provides:

> This section shall be effective January 1, 1993, and shall apply to all *contracts* entered into, renewed, extended, or amended on or after said date and to debts or credits arising from any business written or transactions occurring after January 1, 1993, pursuant to any *contract* including those in existence prior to January 1, 1993, and shall supersede any agreements or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer. For purposes of this section, any change in the terms of, or consideration for, any *such contract* shall be deemed an amendment.

Colo. Rev. Stat. § 10-3-529(6) (emphasis added).

These neighboring provisions are highly suggestive that in the context of the entire statute the Colorado legislature did not intend for Subsection 1 to authorize offset beyond the realm of insurance contracts. In the absence of a superior contrary argument, the Court finds that the relevant Colorado statute applies only to offset involving a contract. Because HHS does not argue that it offset any contract it had with the Cooperative, it may not invoke Colo. Rev. Stat. § 10-3-529 to bypass the priority scheme set forth in Colo. Rev. Stat. § 10-3-541.

HHS urges that there is no reason for the offset statute to be limited to contracts. This argument rests on an assumption that, under Colorado law, a broad right of offset is the default in insurance liquidation. In fact, the Colorado Supreme Court has suggested that the opposite is true; the priority scheme set forth in Colo. Rev. Stat. § 10-3-541 is the default, and any statutory rights of offset constitute exceptions to that general policy. *See Bluewater Ins. Ltd. v. Balzano*,

[5] "Part 5" appears to be a reference to "Part 5: Insurers' Rehabilitation and Liquidation," the section of the Colorado Revised Statutes in which the quoted section appears. Colo. Rev. Stat. § 10-3-529(5).

823 P.2d 1365, 1374 (Colo. 1992) ("The general intent of the liquidation act was to protect the public and to establish uniformity in liquidations of insurance companies."). Whatever the merits of HHS's policy argument about the precise contours of the Colorado offset statute, the Court is of the opinion that the better course is to hew to the plain language of the Colorado statute, bolstered by its statutory context.

HHS also responds that the presence of commas indicates that the "whether" phrase is non-restrictive. While stylists recommend that restrictive clauses not be placed between commas, the presence of commas does not categorically rule out the possibility of a restrictive clause. *Cf.* Bryan Garner, *The Redbook* § 1.6 (3d ed. 2013) (noting the recommended rule). Nonetheless, the statutory context in which the provision is found offers strong evidence that HHS's reading, while grammatically preferable, is not what the Colorado legislature had in mind when it enacted the relevant statutory scheme.

In the alternative, HHS argues that Colorado recognizes a common law right of offset broader than its offset statute. In support, HHS relies on *Bluewater*, but that reliance is misplaced. *Bluewater* addressed a reinsurer's right, if any, to offset an insurer's unpaid premiums against its own contractual liabilities. The Colorado Supreme Court concluded that the insurance commissioner had acted properly in interpreting then-governing state law to prohibit reinsurers from exercising an equitable right of offset. *Bluewater*, 823 P.2d at 1373. The Court assumed without deciding that "an equitable right to offset does obtain in the reinsurance context," and concluded that the legislature had abrogated any such right. *Id.*

Then, in dicta, the Court addressed whether a common law right of offset was implicit in the insurance liquidation priority statute. It answered that question in the negative, writing: "In practice, the relief prayed for by the reinsurers, predicated on the existence of an equitable right to offset, would favor their private interest over the interest of policyholders, contrary to law." *Id.* at 1374. "A common law base line," the Court remarked, "is inapposite and serves only to deflect attention from the regulated character of the insurance business in general and of reinsurance contracts in particular." *Id.*

Read together, the relevant discussion by the Colorado Supreme Court suggests that whatever common law right of offset does exist in Colorado may not be exercised in such a manner as to contravene the priority statute. HHS's observation that most of the statements cited herein are dicta is well-taken, but dicta by a state's highest court is suggestive and can be persuasive, especially for a non-expert federal court seeking to interpret Colorado law. HHS does not identify any other basis that might undercut the dicta to support its broad assertion that it may bypass the priority statute using the common law. For these reasons, HHS's offset redirecting the Cooperative's 2015 reinsurance payments to its outstanding debts violates Colorado's insurance liquidation priority scheme. The Court must still determine whether this Colorado law provides the rule of decision in this case.

4. Colorado Law as the Federal Rule of Decision

Colorado insurance liquidation law applies here to prohibit HHS's offset because federal interests do not require a uniform, federal rule. Arguing for the Netting Rule's preemptive force, HHS asserts that federal law should govern the property rights of the United States arising under

this "nationwide federal program[]." Gov't Mot. at 15 (quoting *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 726 (1979)).

HHS is partially correct. Under *Clearfield Trust Co. v. United States*, and *United States v. Kimbell Foods*, federal law may govern the United States' property interests arising from a nationwide federal program. 318 U.S. 363, 366 (1943); 440 U.S. at 727. Even when federal law governs a federal agency's property interests, however, a federal court must still "fashion the governing rule of law according to [its] own standards." *State of Montana v. United States*, 124 F.3d 1269, 1274 (Fed. Cir. 1997) (quoting *Clearfield Trust,* 318 U.S. at 367).

This principle, "however, does not necessarily mean that federal courts should *create* the controlling law." *Am. Elec. Power Co. v. Connecticut*, 564 U.S. 410, 422 (2011) (emphasis added). "Absent a demonstrated need for a federal rule of decision, the [Supreme] Court has taken 'the prudent course' of 'adopt[ing] the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation.'" *Id*. (alterations in original) (quoting *Kimbell Foods, Inc.,* 440 U.S. at 740).

Federal law governs HHS's rights here. HHS's collection from and payments to insurers under the ACA's programs "perform[] a federal function," and HHS's authority to collect these contributions and issue these payments (although not its authority to use offset) "derive[s] . . . from [a] specific Act[] of Congress passed in the exercise of a 'constitutional function or power,'" the ACA. *Kimbell Foods*, 440 U.S. at 726 (quoting *Clearfield Trust Co.*, 318 U.S. at 366). These activities "arise from and bear heavily upon a federal program." *Id.* (alterations omitted). "In such contexts, federal interests are sufficiently implicated to warrant the protection of federal law." *Id.; see also State of Montana*, 124 F.3d at 1274 ("[For a] federal administrative agency congressionally authorized to implement a federal lending program, *Clearfield Trust* and *Kimbell Foods* require that federal law preempt state law and govern [the] case.").

Having decided that federal law governs, next "the court must determine if federal statutes provide a rule. If they do, then that rule must be applied." *State of Montana*, 124 F.3d at 1274 (citing *Kimbell Foods,* 440 U.S. at 727). "[I]f no federal statute supplies the rule of law, the court must determine whether to create federal common law or to incorporate state law as the rule of decision." *Id.*

Here, no federal statute provides an insurance liquidation priority scheme or other rule that would determine the priority of HHS's offset within a state's existing insurance liquidation scheme.[6] This case differs from *State of Montana*, in which a federal loan program's statute and regulations explicitly provided that inconsistent state regulatory laws "shall not be applicable" to the loan program contracts and the regulations set forth a contract term providing that "No liens

[6] The federal priority statute, 31 U.S.C. § 3713, "accords first priority to the United States with respect to a bankrupt debtor's obligations," *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 493 (1993). It cannot, however, be the source for a rule here. The McCarran-Ferguson Act, 15 U.S.C. § 1012, prohibits this Court from construing the federal priority statute—or any other statute not specifically related to the business of insurance—to supersede Colorado law's placement of insurance policy-holder claims ahead of HHS's claim. *Fabe*, 508 U.S. at 493.

or encumbrances shall be placed on the [the collateral] after the loan is approved." *Id.* at 1275. Unlike that loan program, the provisions creating the reinsurance and risk-adjustment programs are silent on insurance liquidation priority.

Without a statutory rule to apply, the Court must choose between formulating a uniform rule or adopting the otherwise applicable state-law rule of decision. The *Kimbell Foods* court considered three factors to answer this question: "(1) the need for national uniformity, (2) whether state law would 'frustrate specific objectives' of the federal program; and (3) the extent to which federal rules might 'disrupt commercial relationships predicated upon state law.'" *Id.* at 1274 (quoting *Kimbell Foods,* 440 U.S. at 728–29). Here, all three factors favor applying the state-law rule of decision.

a. Uniformity

"[F]ederal programs that 'by their nature are and must be uniform in character throughout the Nation' necessitate formulation of controlling federal rules." *Kimbell Foods*, 440 U.S. at 728 (quoting *United States v. Yazell*, 382 U.S. 341, 354 (1966)). "Conversely, when there is little need for a nationally uniform body of law, state law may be incorporated as the federal rule of decision." *Id.*

The reinsurance and risk-adjustment programs do not require a uniform rule regarding offset in insurance liquidation. Supreme Court precedent makes clear that federal programs adapted to state law do not require a uniform rule. In *United States v. Yazell*, the Supreme Court rejected arguments for a uniform rule applied to Small Business Administration ("SBA") loan contracts that would displace state coverture rules. 382 U.S. 341 (1966). Finding that the SBA's operations were "specifically and in great detail adapted to state law" and that the SBA individually negotiated in detail each loan transaction, the Supreme Court held that "there was no 'federal interest'" that justified supplanting loan agreements that were "important and carefully evolved state arrangements designed to serve multiple purposes." *Yazell*, 382 U.S. at 345-46, 353, 357. The Supreme Court came to a similar conclusion in *Kimbell Foods*, in which it found that Farmers Home Administration ("FHA") and SBA loan-processing procedures were adapted to state law and thus did not have, or require, uniform federal rules. *Kimbell Foods*, 440 U.S. at 733. Accordingly, the Supreme Court adopted the "readymade body of state law as the federal rule of decision" and held that "absent a congressional directive, the relative priority of private liens and consensual liens arising from [FHA] lending programs is to be determined under nondiscriminatory state laws." *Id.* at 739.

The reinsurance and risk-adjustment programs need not "by [their] nature . . . be uniform in character through the Nation." Even more than the SBA program in *Yazell*, the ACA's provision for separate exchanges, reinsurance, and risk-adjustment programs in all 50 states demonstrates that the ACA creates no requirement that could not be met by each state operating its own programs, presumably applying its own insurance liquidation priority scheme. Like the FHA loan-processing procedures in *Kimbell Foods* or the SBA loan program in *Yazell*, the ACA does not require that HHS's obligations to reinsurance and risk-adjustment program participants issue forth as "nationwide act[s] of the Federal Government, emanating in a single form from a single source." *Kimbell Foods*, 440 U.S. at 733 (quoting *Yazell*, 382 U.S. at 348). Although the reinsurance and risk-adjustment programs' requirements might not be adapted on an insurer-by-

insurer basis in the same way as the individually-negotiated loan contracts in *Yazell*, nothing suggests that the ACA programs' requirements could not have been adapted on a state-by-state basis to account for variations in insurance liquidation priority.

The adaptability of the reinsurance and risk-adjustment programs, evident on the face of the statute creating them and from the fact that states like Connecticut and Massachusetts may operate both or one of them, suggest that Colorado's insurance liquidation priority scheme is the appropriate federal rule of decision here.

b. Frustrating Specific Objectives of Federal Programs

HHS argues that without a uniform rule allowing offset in this context, the reinsurance and risk-adjustment programs will not be financially viable.

In *Kimbell Foods*, the Supreme Court rejected the proposition that ensuring funding for a nationwide program justifies displacing state law with a federal rule, noting that whatever obstacle treating the United States "like any other lender" creates, it does not undermine federal interests sufficiently to justify unrestricted federal priority—even in an area as "important to the Nation's stability as taxation." *Id.* at 738.

More generally, the Supreme Court has "repeatedly emphasized that 'in fashioning federal [common law] principles to govern areas left open by Congress, our function is to effectuate congressional policy.'" *Jesner v. Arab Bank, PLC*, 138 S. Ct. 1386, 1410 (2018) (quoting *Kimbell Foods,* 440 U.S. at 738). Although the ACA does not authorize or determine the preemptive effect of HHS's offset, *see* IV.B.1 *supra*, the ACA's non-preemption clause suggests that the ACA does not authorize HHS to pursue the reinsurance and risk-adjustment programs' objectives whatever the cost to state regulatory authority. The ACA non-preemption clause's title alone—"No Interference with State Regulatory Authority"— suggests that the reinsurance and risk-adjustment programs can be properly implemented in the face of potentially less favorable, but not outright incompatible state insurance liquidation law, like Colorado's priority scheme.

HHS's inability under Colorado's insurance liquidation priority scheme to collect some funds from insolvent insurers that an alternate rule would otherwise allow it to collect does not frustrate "specific objective[s]" of the reinsurance and risk-adjustment programs. HHS's notices proposing and publishing the Netting Rule justify it as an efficiency measure, not a funding measure. The other rules implementing these programs are replete with variables affecting the programs' financial viability. When HHS's own fees and formulas determine what insurers must pay HHS and what HHS must pay insurers to balance each program, it is unclear why HHS must also preempt state insurance liquidation law to ensure the programs' financial viability. This Court will not infer on this record, as a matter of preemptive federal common law, that it is necessary to give HHS super-priority in state insurance liquidation proceedings in order to carry out either the programs' specific objectives or their broad policy goals.

c. Disruption of Commercial Relationships

A uniform rule allowing HHS's offset in insurance liquidation and preempting Colorado's insurance liquidation priority scheme would disrupt the expectations of the

Cooperative's other creditors, including its policyholders. Colorado's insurance liquidation law dictates the "priority of distribution of claims from the insurer's estate." Colo. Rev. Stat. § 10-3-541. The priority statute provides that "[e]very 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." *Id.* It generally treats policyholders as Class 2 claims. *Id.* And it defines most "claims of the federal government" as Class 3 claims. *Id.* HHS offsetting amounts it owed to the Cooperative effectively elevated HHS's Class 3 claims above all other classes of creditors, contrary to Colorado's priority scheme.

Moreover, although the McCarran-Ferguson Act does not control here because the authority for HHS's offset was not an "Act of Congress," *see* IV.B.2 above, adoption of a uniform rule allowing HHS's offset would be at odds with, and perhaps even inconsistent with, the federal policy expressed by McCarran-Ferguson as applied in *United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 509 (1993) (holding that Ohio law governs the priority of claims brought by the United States in a liquidation proceeding when the priority scheme places policyholder claims above the United States' claims). Formulating a uniform rule that disrupts the expectations of policyholders whose interests a state has chosen to protect for the sake of a federal agency's administrative efficiency runs counter to McCarran-Ferguson's statutory policy statement that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012.

* * *

The ACA's state-by-state structure, the ACA's own non-preemption provision, and the role Congress assigned to HHS in administering the reinsurance and risk-adjustment programs on behalf of states undermine HHS's argument that federal interests require a uniform rule. HHS's argument that Colorado's prohibition of offset in insurance liquidation threatens the reinsurance and risk-adjustment programs' financial viability is too general of an interest to support the creation of a preemptive federal rule displacing unfavorable priority schemes. The federal policy expressed by the McCarran-Ferguson act and its application to priority schemes that protect policyholders' commercial expectations weigh against displacing Colorado's policyholder-protecting priority scheme with a uniform federal rule of administrative efficiency. Therefore, the Court applies Colorado's insurance liquidation priority scheme as the federal rule of decision. Under Colorado's priority scheme, HHS's offset was invalid.

C. Damages

The record before the Court is not adequate to grant the Liquidator's Motion for Summary Judgment on the amount of damages. Although the parties do not appear to dispute the damage amounts at stake in this case for purposes of the motion to dismiss, the accounting records attached to HHS's Motion to Dismiss contradict the allegation in the complaint that a single offset in the amount of $20,255,084 took place on August 23, 2016. Under the circumstances, a genuine dispute of material fact may yet exist with respect to the amount of money the Cooperative is due under the 2015 reinsurance program. Accordingly, further proceedings regarding that amount are necessary.

V. CONCLUSION

For the reasons set forth above, the plaintiff's Motion for Summary Judgment is **GRANTED IN PART** and **DENIED IN PART**. The defendant's Cross-Motion to Dismiss is **GRANTED IN PART** and **DENIED IN PART**. Count I of the Complaint is **DISMISSED**.

The parties are directed to confer in order to resolve the issue of the amount owed to the plaintiff under Count II of the Complaint.

The parties shall file by October 18, 2019, a Joint Stipulation proposing the amount and form of a final judgment in the event they are able to resolve the issue of the amount owed to the plaintiff. If the parties are unable to resolve that issue by October 18, 2019, they shall file no later than that date a Joint Status Report proposing a process and a schedule by which the Court may resolve the issue of damages and any other pending issues.

Either the Joint Stipulation or the Joint Status Report, whichever the parties file, should include a list of any remaining unresolved issues that would prevent entry of a final judgment for the plaintiff.

It is so **ORDERED.**

s/ Richard A. Hertling
Richard A. Hertling
Judge

In the United States Court of Federal Claims

No. 18-1623C
(Filed: October 18, 2019)

MICHAEL CONWAY,	)
	)
Plaintiff	)
	)
v.	)
	)
UNITED STATES,	)
	)
Defendant.	)
	)
	)

ORDER

Pursuant to the Court's Memorandum Opinion and Order of October 3, 2019 (ECF 20), the parties have this day filed a Joint Stipulation (ECF 21) in which they advise the Court that they have agreed on the amount owed to the plaintiff.

Accordingly, and pursuant to the Joint Stipulation, the defendant shall pay to the plaintiff $24,489,799 in full satisfaction of the plaintiff's claims.

The Clerk is directed to enter judgment in favor of the plaintiff in the amount of $24,489,799.

Costs are awarded to the plaintiff.

It is so **ORDERED.**

s/ Richard A. Hertling
Richard A. Hertling
Judge

In the United States Court of Federal Claims

No. 18-1623 C
Filed: October 21, 2019

MICHAEL CONWAY, in his capacity as Liquidator of Colorado Health Insurance Cooperative, Inc.

JUDGMENT

v.

THE UNITED STATES

Pursuant to the court's Memorandum Opinion and Order, filed October 3, 2019, granting in part and denying in part plaintiff's motion for summary judgment and granting in part and denying in part defendant's cross-motion for summary judgment; the parties' stipulation, filed October 18, 2019; and the court's Order, filed October 18, 2019,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that plaintiff recover of and from the United States, the sum of $24,489,799.00. Costs are awarded to plaintiff.

Lisa L. Reyes
Clerk of Court

By: s/ Debra L. Samler

Deputy Clerk

NOTE: As to appeal to the United States Court of Appeals for the Federal Circuit, 60 days from this date, see RCFC 58.1, re number of copies and listing of all plaintiffs. Filing fee is $505.00.

28 U.S.C. § 1503. Set-offs.

The United States Court of Federal Claims shall have jurisdiction to render judgment upon any set-off or demand by the United States against any plaintiff in such court.

---

28 U.S.C. § 2508. Counterclaim or set-off; registration of judgment.

Upon the trial of any suit in the United States Court of Federal Claims in which any setoff, counterclaim, claim for damages, or other demand is set up on the part of the United States against any plaintiff making claim against the United States in said court, the court shall hear and determine such claim or demand both for and against the United States and plaintiff.

If upon the whole case it finds that the plaintiff is indebted to the United States it shall render judgment to that effect, and such judgment shall be final and reviewable.

The transcript of such judgment, filed in the clerk's office of any district court, shall be entered upon the records and shall be enforceable as other judgments.

---

31 U.S.C. § 3728. Setoff against judgment.

(a) The Secretary of the Treasury shall withhold paying that part of a judgment against the United States Government presented to the Secretary that is equal to a debt the plaintiff owes the Government.

(b) The Secretary shall—

(1) discharge the debt if the plaintiff agrees to the setoff and discharges a part of the judgment equal to the debt; or

(2)

(A) withhold payment of an additional amount the Secretary decides will cover legal costs of bringing a civil action for the debt if the plaintiff denies the debt or does not agree to the setoff; and

(B) have a civil action brought if one has not already been brought.

(c) If the Government loses a civil action to recover a debt or recovers less than the amount the Secretary withholds under this section, the Secretary shall pay the plaintiff the balance and interest of 6 percent for the time the money is withheld.

42 U.S.C. § 18041. State flexibility in operation and enforcement of Exchanges and related requirements.

(a) ESTABLISHMENT OF STANDARDS

(1) IN GENERAL The Secretary shall, as soon as practicable after March 23, 2010, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part E; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) CONSULTATION

In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) STATE ACTION Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS

(1) IN GENERAL If—

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) ENFORCEMENT AUTHORITY

The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY

Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES

(1) IN GENERAL

In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) PROCESS

The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

45 C.F.R. § 156.1215. Payment and collections processes.

(a) *Netting of payments and charges for 2014.* In 2014, as part of its monthly payment and collections process, HHS will net payments owed to QHP issuers and their affiliates under the same taxpayer identification number against amounts due to the Federal government from the QHP issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and payment of Federally-facilitated Exchange user fees.

(b) *Netting of payments and charges for later years.* As part of its payment and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal or State governments from the issuers and their affiliates under the same taxpayer identification number 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.

(c) *Determination of debt.* Any amount owed to the Federal government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, including any fees for State-based Exchanges utilizing the Federal platform, risk adjustment, reinsurance, and risk corridors, after HHS nets amounts owed by the Federal government under these programs, is a determination of a debt.