IN THE UNITED STATES COURT OF FEDERAL CLAIMS

BLUE CROSS AND BLUE SHIELD OF NEBRASKA, and HAWAI'I MEDICAL SERVICE ASSOCIATION Plaintiffs, on behalf of themselves and all others similarly situated v. THE UNITED STATES, Defendant.	)	Case No. 18-491 C Judge Edward J. Damich

MOTION TO DISMISS

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MISCELLANEOUS

The United States moves to dismiss Count III of the Complaint, as asserted by plaintiff Blue Cross and Blue Shield of Nebraska ("BCBS-NE"),[1] for lack of subject matter jurisdiction and for failure to state a claim under Rules 12(b)(1) and 12(b)(6) of the Rules of the United States Court of Federal Claims ("RCFC").

INTRODUCTION

The risk adjustment program authorized by 42 U.S.C. § 18063 of the Affordable Care Act ("ACA") created a budget-neutral program through which insurance issuers that cover healthier-than-average enrollees in an ACA state market risk pool pay risk adjustment charges to the Secretary of Health and Human Services ("HHS"), and HHS in turn uses those funds to make risk adjustment payments to issuers that insure sicker-than-average enrollees in that state market risk pool. BCBS-NE alleges in Count III that HHS owes it more than $3 million because another issuer in BCBS-NE's state market risk pool failed to pay its risk adjustment charges. But the statute does not provide a right to money damages from the United States on this basis or for any prescribed amount of risk adjustment payment at all. Instead, the statute creates a budget-neutral program of risk adjustment for which HHS was required to develop criteria and methods to be implemented by the states, or in the absence of state administration, to be administered by HHS. Count III therefore must be dismissed for lack of subject matter jurisdiction because the statute relied upon does not impose the duty to pay that BCBS-NE alleges it does. Alternatively, Count III fails to

[1] The disposition of Counts I and II, the risk corridors claims, cannot proceed without the disposition of Count III, the risk adjustment claim, as the amount BCBS-NE receives under the risk adjustment program is part of the formula for calculating how much BCBS-NE receives under the risk corridors program. *See* Compl. ¶¶ 33-38. The United States therefore respectfully asks the Court to stay the United States' duty to respond to Counts I and II pending the resolution of Count III. The other plaintiff, Hawai'i Medical Service Association, agreed to dismiss Count III in exchange for a consensual resolution of Counts I and II. *See* ECF Nos. 19 and 22.

state a claim upon which relief may be granted, as HHS cannot violate a statutory duty that Congress did not impose.

HHS's rules and guidance likewise do not support the exercise of subject matter jurisdiction or the merits of BCBS-NE's risk adjustment claim. Pursuant to the risk adjustment statute, HHS established a methodology that ensures the amount of risk adjustment payments within a market equals the amount of risk adjustment charges in that market. This methodology has been reviewed and upheld against challenge in *New Mexico Health Connections v. U.S. Department of Health and Human Services*, 946 F.3d 1138, 1152 (10th Cir. 2019) and *Minuteman Health, Inc. v. U.S. Department of Health and Human Services*, 291 F. Supp. 3d 174, 202 (D. Mass. 2018). Under the methodology, risk adjustment payments made to issuers are limited to no more than what HHS collects in risk adjustment charges within the applicable state insurance market risk pool. As a result, and following its own guidance, HHS distributes pro-rated, interim risk adjustment payments to issuers where HHS has been unable to collect full risk adjustment charges in the applicable state market risk pool. That is precisely (and indisputably) what happened in BCBS-NE's case. Because another issuer in Nebraska has not paid its full risk adjustment assessment for 2015, BCBS-NE has not received the full risk adjustment payment it seeks. The program affords no money claim against the United States for another issuer's failure to pay full risk adjustment charges.

BCBS-NE fares no better seeking to support its contentions by relying upon 45 C.F.R. § 156.1215, a regulation promulgated by HHS specific to the ACA which provides for the offset of ACA debts owed to the United States. Under that regulation's plain text, HHS "may" net certain amounts owed under various ACA programs between an issuer and HHS, including for the risk adjustment program. However, as the Supreme Court has recognized in the context of the ACA,

"the word 'may' . . . implies discretion" unlike "the word 'shall'" which "connotes a requirement." *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1320 (2020). That HHS may not have offset another issuer's payments in the manner most preferred by BCBS-NE fails to state a money mandating claim, or alternatively a claim upon which relief may be granted. BCBS-NE's complaint in this regard must be dismissed.

STATEMENT OF THE ISSUES

1. Does the ACA obligate HHS to make risk adjustment payments to BCBS-NE in excess of collections, thus conferring jurisdiction under the Tucker Act and stating a claim on the merits, notwithstanding congressional intent to the contrary?

2. Do HHS rules and guidance obligate HHS to make risk adjustment payments to BCBS-NE in excess of collections, thus conferring jurisdiction under the Tucker Act and stating a claim on the merits, notwithstanding express language in the rules and guidance to the contrary?

3. Does 45 C.F.R. § 156.1215 (the "Netting Regulation") obligate HHS to offset amounts received from issuers in Nebraska under separate ACA programs in order to make risk adjustment payments to BCBS-NE, thus conferring jurisdiction under the Tucker Act and stating a claim on the merits, notwithstanding the discretionary nature of that regulation?

STATEMENT OF THE CASE

I. Statutory and Regulatory Background of the Risk Adjustment Program

A. The ACA and Health Benefit Exchanges

Congress enacted the ACA to guarantee the availability of affordable, high-quality health insurance coverage for all Americans. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015); *see* Compl. ¶ 17. The ACA's key reforms are threefold: (1) it prohibits health insurance companies from denying coverage or setting premiums based upon health status or medical history; (2) it requires

individuals to maintain health insurance coverage or make a payment to the Internal Revenue Service;[2] and (3) it provides federal insurance subsidies in the form of premium tax credits and cost sharing reductions to make insurance more affordable to eligible consumers. *King*, 135 S. Ct. at 2486 (citing 42 U.S.C. §§ 300gg, 300gg–1(a), 18081, 18082, 18091; 26 U.S.C. §§ 5000A, & 36B); *see* Compl. ¶¶ 17-20.[3]

To implement these reforms, the ACA created Health Benefit Exchanges ("Exchanges"), virtual marketplaces in each state where individuals and small groups can purchase health insurance coverage. 42 U.S.C. §§ 18031-18041; *see* Compl. ¶ 15. The ACA contemplated that states would operate their own Exchanges but provided that HHS would establish and operate Exchanges for any state that elected not to do so. *See* 42 U.S.C. § 18041. All plans offered through an Exchange—whether state-based or federally-facilitated—must be "Qualified Health Plans" ("QHPs"), meaning that they provide "essential health benefits" and comply with other regulatory parameters such as provider network requirements, benefit design rules, and cost sharing limitations. *See* 42 U.S.C. § 18021; *see also* Compl. ¶ 16.

B. The 3Rs of the ACA

The ACA introduced millions of uninsured Americans into the insurance markets. The introduction of these individuals created business opportunities for health insurance companies electing to sell plans on the Exchanges. With those opportunities, however, came pricing

[2] Under the Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, the amount of the individual shared responsibility payment was reduced to zero for months beginning after December 31, 2018.

[3] HHS is responsible for overseeing implementation of the ACA programs and for administering certain programs under the ACA, either directly or in conjunction with other federal agencies and/or states. *See, e.g.*, 42 U.S.C. §§ 18041(a)(1)(A), (c)(1). HHS delegates many of its responsibilities under the ACA to the Centers for Medicare & Medicaid Services ("CMS"), which created the Center for Consumer Information and Insurance Oversight ("CCIIO") to oversee its implementation of the ACA insurance market programs. *See* Compl. ¶ 23.

uncertainty arising from the unknown health status of the new enrollees and the issuers' inability to charge higher premiums or deny coverage to less healthy enrollees. *See* 42 U.S.C. §§ 300gg, 300gg-1; 45 C.F.R. §§ 147.102-147.110; Compl. ¶ 22. To mitigate this risk, the ACA established three premium stabilization programs modeled on the Medicare Program. *See* Compl. ¶¶ 2, 22. Informally known as the "3Rs," these programs began with the 2014 benefit year and consist of reinsurance, risk adjustment, and risk corridors. *Id.*; *see* 42 U.S.C. §§ 18061-18063.

C. The Risk Adjustment Program: Sections 1343 and 1321 of the ACA

The 3Rs program at issue here is the risk adjustment program—a permanent program created by section 1343 of the ACA. *See* 42 U.S.C. § 18063. Under this program, monetary charges are collected from plans with healthier than average enrollees in an applicable state market risk pool, and those funds are used to make payments to plans with sicker than average enrollees in that applicable state market risk pool, thereby reducing the influence of risk selection on the premiums that plans charge. *Id.*; Compl. ¶ 45. Put another way, risk adjustment reduces incentives for issuers to avoid high-risk enrollees, and it levels the playing field for issuers that enroll sicker people, reflecting "the premise that premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population." HHS Notice of Benefit and Payment Parameters for 2014 ("2014 Final Rule"), 78 Fed. Reg. 15,410-11 (March 11, 2013); *see* Compl. ¶ 46.

The risk adjustment program has three main attributes. First, Congress designed the program to be administered by the states. Section 1343 provides that "each State shall assess a charge" on insurers if "the actuarial risk of [their] enrollees . . . for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1). Correspondingly, section 1343 provides that "each State shall provide a payment"

to insurers "if the actuarial risk of [their] enrollees . . . is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year." *Id.* § 18063(a)(2).

Second, Congress intended for risk adjustment charges and payments to be calculated using criteria and methods established by HHS. Section 1343 directs HHS to "establish criteria and methods to be used in carrying out the risk adjustment activities under this section." 42 U.S.C. § 18063(b). Section 1321 further directs HHS to work with states, the National Association of Insurance Commissioners, and health insurance issuers to establish the criteria and methods for the program. 42 U.S.C. § 18041(a). After consulting with the relevant constituent groups, HHS was required to "issue regulations setting standards for meeting the requirements under this title . . . with respect to . . . the establishment of the . . . risk adjustment program[]." 42 U.S.C. § 18041(a)(1).

Third, Congress intended for HHS to run the program on behalf of any state electing not to do so. Section 1321 provides that HHS "shall take such actions as are necessary to implement" the risk adjustment program if a State chooses not to do so. *See* 42 U.S.C. § 18041(c); Compl. ¶ 57. In practice, the only state to run its own risk adjustment program in 2014 and 2015 was Massachusetts. Compl. ¶¶ 58-62.

D. HHS's Risk Adjustment Criteria and Methods

1. The Risk Adjustment Methodology

HHS established the criteria and methods for the risk adjustment program through rules promulgated in several notice-and-comment proceedings. 45 C.F.R. § 153.320(b). The regulations define "risk adjustment methodology" as "the risk adjustment model, the calculation of plan average actuarial risk, the calculation of payments and charges, the risk adjustment data collection approach, and the schedule for the risk adjustment program." 45 C.F.R. § 153.20. The

regulations provide that "[a]ny risk adjustment methodology used by a State, or HHS on behalf of the State, must be a Federally certified risk adjustment methodology." 45 C.F.R. § 153.330(a); Compl. ¶ 64. As relevant to this case, a risk adjustment methodology may become federally certified if it is "is developed by HHS and published in the applicable annual HHS notice of benefit and payment parameters." 45 C.F.R. § 153.320(a)(1); Compl. ¶ 65.

Pursuant to these regulations, HHS detailed the risk adjustment methodology applicable to states that did not operate their own program for the 2014 benefit year in the Notice of Benefit and Payment Parameters for 2014. *See* 2014 Final Rule, 78 Fed. Reg. at 15,417-15 and 15,443; Compl. ¶ 68. The finalized parameters of the 2015 rule, which are applicable to the states where HHS operated the program for the 2015 benefit year, are substantively the same as those set forth in the 2014 Final Rule. *See* HHS Notice of Benefit and Payment Parameters for 2015 ("2015 Final Rule"), 79 Fed. Reg. 13,744, 13,753 (March 11, 2014); Compl. ¶ 69 ("Except for minor differences not relevant to this case, HHS's risk adjustment methodology was the same for the 2014 and 2015 benefit years.").

The "risk adjustment methodology" for benefit years 2014 and 2015 is an enrollee-data driven process involving three steps:

Measuring enrollee risk: first, the methodology measures the actuarial risk of each plan enrollee—that is, it measures the predicted relative cost of insuring each enrollee as compared to other enrollees. 2014 Final Rule, 78 Fed. Reg. at 15,419. The methodology does so through metal-level differentiated "risk adjustment models" based on demographic data (age and sex) and diagnostic data (health conditions such as diabetes, asthma, and so on). *Id.*

Plan risk score: second, the methodology aggregates the risk scores for each enrollee in each plan to determine an overall plan risk score—a prediction of how much healthier (or sicker)

than average a plan's enrollees are as a whole, and so how much cheaper (or more expensive) they will be to insure relative to a plan of average actuarial risk in the same state market risk pool. *Id.* at 15,431.

Payment transfer formula: third, the methodology assigns monetary transfers that counteract the cost burden of insuring a sicker-than-average population (or the cost benefit of insuring a healthier-than-average population). *Id.* The methodology does this through a complicated "transfer formula" that compares the predicted costs for a plan based on its risk score to the predicted costs of a plan based on the average actuarial risk in that state's market risk pool, using an adjusted weighted average of all premiums in the applicable state market risk pool as a measure of cost. *Id*.

For some plans, this comparison yields a risk adjustment assessment (also called a "charge"), because their predicted costs are lower than the state average. For others, this comparison yields a risk adjustment payment, because their predicted costs are greater than the state average. In deciding to use the statewide average premium in the transfer formula, HHS explained that, among other benefits, its use results in balanced charges and payments, *i.e.*, charges and payments that net to zero. *See* HHS Notice of Benefit and Payment Parameters for 2014 ("2014 Proposed Rule"), 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) (explaining that "transfers net to zero when the State average premium is used as the basis for calculating transfers").

2. The Program's Budget Neutral Design

HHS designed the risk adjustment program to be a budget-neutral redistribution of revenue among issuers in a given state market risk pool. Compl. ¶ 71. The program therefore does not require the states or HHS expend additional resources—beyond what it collects from issuers in risk adjustment charges—to make transfers under the program. The 2014 Final Rule describes the

risk adjustment program as a "budget-neutral revenue redistribution among issuers," and explained that its methodology addresses "the need for inter-plan transfers that net to zero." 2014 Final Rule, 78 Fed. Reg. at 15,417 and 15,441; Compl. ¶ 71.[4]

HHS's risk adjustment bulletin, incorporated by reference in the 2014 Final Rule, outlined HHS's "intended approach to implementing risk adjustment when [HHS] operates risk adjustment on behalf of a State." 2014 Final Rule, 78 Fed. Reg. at 15,414. According to the bulletin, if HHS is unable to collect all risk adjustment charges from issuers in a given state, HHS could provide pro-rata interim payments to the other issuers in the State until it was able to collect the full charge amounts due. Specifically:

> To ensure proper balancing between payments and charges, **all of the [risk adjustment] payments made to issuers must be completely funded through the [risk adjustment] charges** assessed to other issuers within the same market in the same State. Consequently, charges will be invoiced prior to processing issuer payments. . . . HHS will not offset charges for an issuer for one State based on payments due to that same issuer in another State. **HHS will only be able to pay issuers in a State the amount they are owed after receipt of funds owed by issuers in that State. If full charges are not received from issuers in that State, HHS could determine to issue interim payments that are pro-rated across issuers in a State based on the total charges remitted to date. After the remaining charges have been collected, HHS will remit the remainder of outstanding payment balances**.[5]

[4] By contrast, the 2014 Final Rule indicated that the risk *corridors* program was "not statutorily required to be budget neutral," thus "[r]egardless of the balance of payments and receipts, HHS [would] remit [risk corridors] payments as required under section 1342 of the Affordable Care Act." 2014 Final Rule, 78 Fed. Reg. at 15,473.

[5] Appendix Ex. 1 (A1), CMS, *Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services*, at 4-5 (May 1, 2012), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/pfm-risk-adj-bul.pdf (emphasis added).

HHS's public presentations likewise indicated that the risk adjustment program would not require HHS to fund any shortfall arising from non-payment of charges. Its presentation, dated May 8, 2012, stated that "HHS would not remit [risk adjustment] payments to issuers until after receipt of charges owed by issuers in that State," and, consequently, "**HHS may adjust payments based on receipt of funds to ensure that payments and charges remain balanced**."[6]

Later agency publications reiterated that the program does not require additional government funding, and HHS would address any shortfall by making pro-rata interim payments. For example, on August 14, 2015, HHS responded to a question on how issuers in a state would be affected if HHS was unable to collect all risk adjustment payments in that state. The agency answered:

> **To the extent CMS is not able to fully collect 2014 benefit year risk adjustment charges in a risk pool in a market in a state, 2014 benefit year risk adjustment payments for that risk pool will be adjusted on a pro rata basis to reflect the under collection**. Risk adjustment charges for other issuers in the risk pool would not be affected.
>
> If CMS is unable to collect full risk adjustment charges in a state and market, **the issuer can reflect this reduction in payment on the following year's risk corridors and medical loss ratio (MLR) filing**.[7]

Thus, although an issuer may receive a pro-rated risk adjustment payment for the year, the issuer is not without recourse: it can adjust its MLR the following year, potentially reducing or eliminating the annual rebates owed by the issuer to its enrollees. A smaller risk adjustment

[6] Appendix Ex. 2 (A13), CMS, *Risk Adjustment Program: HHS Operations*, at 9 (May 8, 2012), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/fm-2a-fed-ra-ov-dv.pdf (emphasis added); *see also* Appendix Ex. 3 (A37), CMS, *Risk Adjustment Program: HHS Operations*, at 7 (May 21-23, 2012) (same), available at https://www.cms.gov/CCIIO/Resources/Presentations/Downloads/hie-risk-adjustment-methodology.pdf.

[7] Appendix Ex. 4 (A66), CMS, *FAQ: Risk Adjustment Charges* (Aug. 14, 2015) (emphasis added).

payment also increases an issuer's "allowable costs" and thus potentially increases the amount it could receive through the risk corridors program for the years that program was in operation (i.e., the 2014, 2015, and 2016 benefit years). *See* 42 U.S.C. § 18062(c)(1); Compl. ¶¶ 35-37.

Similarly, a 2016 HHS white paper, quoted and cited in the Complaint (at ¶ 47), stated that the program would not require "government sources" or "accumulate a surplus":

> **By construction, risk adjustment payments and charges will be budget neutral**, meaning the total amount of risk adjustment charges collected from issuers will equal the total amount of risk adjustment payments made. **This is a key objective of the [payment] transfer formula, and it ensures that risk adjustment will neither require government sources of funding nor accumulate a surplus**.[8]

The Congressional Budget Office ("CBO") also issued a report, cited in the Complaint (at ¶ 85), consistent with HHS's above guidance on the risk adjustment program. The CBO report provided that "[b]y law" the risk adjustment program "can have no net effect on the budget deficit." Specifically:

> **By law**, risk adjustment payments and reinsurance payments will be offset by collections from health insurance plans of equal magnitudes; those collections will be recorded as revenues. **As a result, those payments and collections can have no net effect on the budget deficit**.
> . . .
> The risk adjustment system is facilitated by the federal government, but, by law, **essentially entails transfers between insurance companies with no net budgetary effect**.
> . . .

[8] Compl., Ex. B, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting, Discussion Paper*, at 91 (March 24, 2016) (emphasis added); *id.* at 79 ("[R]isk adjustment transfers must meet the requirement of being budget neutral, which means that the payments and charges across an entire risk pool within a market within a State must sum to zero."); *id.* at 80 (stating that payment formula must "[b]alance payments and charges across the entire Statewide market risk pool"; thus, "[t]o remain budget neutral, the sum of all charges imposed on low-risk plans should equal the payments made to high-risk plans").

> As in the case of the risk adjustment process, the payments to and from the government are specified to be equal and so will have **no net budgetary effect over the course of the program**.[9]

In sum, the risk adjustment program, as created by Congress, designed by HHS, and further explained by the CBO, does not require HHS to pay issuers above what it collects. Rather, the program requires HHS, to the extent it operates the program on behalf of a state, to make pro-rata distribution payments to issuers until the agency is able to collect all charges in a given state market risk pool.

E. The Netting Regulation

To streamline its payment and collection process for the 3Rs programs and other enumerated ACA programs, HHS promulgated a regulation providing that it "may" net amounts owed by issuers against amounts HHS owes to the issuers under those programs. *See* 45 C.F.R. § 156.1215 (the "Netting Regulation"); HHS Notice of Benefit and Payment Parameters for 2015 ("2015 Proposed Rule"), 78 Fed. Reg. 72,322, 72,370-71 (Dec. 2, 2013) (explaining that netting will "permit HHS to calculate amounts owed each month, and pay or collect those amounts from issuers more efficiently"). Specifically:

> HHS **may net payments** owed to issuers . . . against amounts due to the Federal or State governments from the issuers . . . for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, payment of any fees for State-based

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[9] Compl., Ex. D, CBO, *The Budget and Economic Outlook: 2014 to 2024*, at 59, 110 (Feb. 2014), available at https://www.cbo.gov/publication/45010 (emphasis added).

Although the CBO describes the collections and payments as "essentially" transfers "between insurance companies," the state or HHS, as applicable, is responsible for the collection of charges and distribution of payments. Accordingly, the CBO treats all such collections and payments by HHS as revenues and outlays. *See* Appendix Ex. 5 (A67), CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, at 9 (April 2014) ("CBO treats the [3Rs] payments as outlays and the collections as revenues"), available at https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45231-ACA_Estimates_OneColumn.pdf.

> Exchanges utilizing the Federal platform, and risk adjustment, reinsurance, and risk corridors payments and charges.

45 C.F.R. § 156.1215 (emphasis added). The use of netting in its monthly payments and collections cycle allows HHS to distribute timely payments to insurers that are due funds under the 3Rs programs and for advance payment of premium tax credits and cost sharing reductions. 2015 Proposed Rule, 78 Fed. Reg. at 72,370.

II. HHS's Administration of the Risk Adjustment Program

HHS operated the risk adjustment program on behalf of Nebraska according to the rules and guidance described above. For the 2015 benefit year, the applicable year here, the agency assessed risk adjustment charges and collected risk adjustment payments from numerous issuers participating in the Nebraska individual and small group markets. Only one issuer, CoOportunity Health ("CoOportunity"), did not (and has not yet) paid the full risk adjustment charges owed to HHS for the 2015 benefit year in that state. Compl. ¶ 181. This issuer still owes approximately $7 million for the individual and small group market risk pools. *Id.*[10]

Because this $7 million payment remains outstanding, BCBS-NE received a pro-rated, interim payment for the 2015 benefit year. *See* Compl. ¶¶ 161, 183. Consistent with the program's design and the payment transfer formula, the total risk adjustment payments provided to Nebraska issuers equals the total risk adjustment charges collected from Nebraska issuers in the applicable state market risk pool. For the 2015 benefit year, BCBS-NE has received $11,731,627.27 for the individual market risk pools and $2,962,123.68 for the small group market risk pool—totaling

[10] The United States and CoOportunity are mediating issues related to CoOportunity's obligations under the ACA pursuant to an ADR referral by the presiding judge. *See Ommen v. United States*, No. 17-957C (Ct. Fed. Cl.), ECF No. 49 (order staying case until the conclusion of ADR proceedings). A disposition of that case may moot Count III of the BCBS-NE complaint.

$14,693,750.95. *See generally* Compl. ¶¶ 161-65. If HHS is able to collect CoOportunity's remaining risk adjustment balance, HHS will be able to distribute the final risk adjustment payment for the 2015 benefit year of $2,887,975.62 to BCBS-NE.[11]

LEGAL STANDARDS

A motion to dismiss for lack of subject matter jurisdiction is governed by RCFC 12(b)(1). The Tucker Act confers subject matter jurisdiction on the Court where a claim is 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 . . . in cases not sounding in tort." 28 U.S.C. § 1491(a)(1). This means that a claimant must be able to identify a "money-mandating" provision of law, regulation, or contract "affording it a right to money damages." *Terran v. U.S. Dep't Health & Human Servs.*, 195 F.3d 1302, 1309 (Fed. Cir. 1999). Where a plaintiff has identified a "money-mandating source" and has made "a nonfrivolous allegation that it is within the class of plaintiffs entitled to recover under the money-mandating source," this Court has jurisdiction. *Jan's Helicopter*, 525 F.3d at 1308. That said, where a movant challenges the

[11] BCBS-NE alleges in conclusory fashion that HHS collected but withheld risk adjustment charges that it received from issuers in Nebraska. *See* Compl. ¶¶ 184-91. But, consistent with BCBS-NE's cited exhibit (Compl. ¶ 186), HHS has distributed all risk adjustment charges it has collected from issuers in Nebraska—via offset or otherwise—for the 2015 benefit year. *See* Compl., Ex. R, Decl. of Jeffrey Grant, CCIIO Director, at ¶¶ 6-7 (describing how HHS will distribute all the collected funds, including the $9.4 million charge from CoOportunity, to issuers entitled to receive risk adjustment payments). BCBS-NE's factual and unsupported inferences to the contrary should be rejected. *See Bradley v. Chiron Corp.*, 136 F.3d 1317, 1322 (Fed. Cir. 1998) (holding that, under Rule 12(b)(6), "unwarranted inferences of fact do not suffice to support a claim"); *see also Jan's Helicopter Serv. v. FAA*, 525 F.3d 1299, 1308 (Fed. Cir. 2008) (holding that jurisdiction under the Tucker Act must be supported by "a nonfrivolous allegation that [the plaintiff] is within the class of plaintiffs entitled to recover under the money-mandating source"). Likewise, HHS accepts as true that the risk adjustment balance for BCBS-NE was $3,332,054.15 when the Complaint was filed on April 3, 2018. This amount, however, is not the current balance on BCBS-NE's risk adjustment payee statement. Since April 2018, HHS has made additional risk adjustment payments to BCBS-NE, resulting in a new outstanding balance of $2,887,975.62.

jurisdictional facts alleged in the complaint, "[t]he plaintiff cannot rely solely on allegations in the complaint, but must bring forth relevant, adequate proof to establish jurisdiction." *Widtfeldt v. United States*, 122 Fed. Cl. 158, 162 (2015). The burden of proving that the Court possesses subject matter jurisdiction lies, at all times, with the plaintiff. *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 176-77 (2009). If the court determines that the plaintiff has not met its burden, the court "cannot proceed at all in any cause" and must dismiss the action. *Ex parte McCardle*, 74 U.S. (7 Wall.) 506, 514 (1868); RCFC 12(h)(3).

A motion to dismiss for failure to state a claim upon which relief may be granted is governed by RCFC 12(b)(6). "In determining whether it should grant a 12(b)(6) motion, the court 'must accept as true all the factual allegations in the complaint' and make 'all reasonable inferences in favor of the non-movant.'" *Bowers Inv. Co., LLC v. United States*, 104 Fed. Cl. 246, 253 (2011) (quoting *Sommers Oil Co. v. United States*, 241 F.3d 1375, 1378 (Fed. Cir. 2001)). Even with these inferences, however, "[t]he purpose behind Rule 12(b)(6) 'is to allow the court to eliminate actions that are fatally flawed in their legal premises and destined to fail, and thus to spare litigants the burdens of unnecessary pretrial and trial activity.'" *Id.* (quoting *Advanced Cardiovascular Sys., Inc. v. SciMed Life Sys., Inc.*, 988 F.2d 1157, 1160 (Fed. Cir. 1993)). "Conclusory allegations of law and unwarranted inferences of fact do not suffice to support a claim." *Bradley*, 136 F.3d at 1322. Accordingly, "[a] failure to state a claim upon which relief can be granted warrants a judgment on the merits." *Id.*

ARGUMENT

BCBS-NE alleges in Count III that HHS "failed to fulfill its statutory and regulatory obligation to make full risk adjustment payments to BCBS-NE." Compl. ¶ 287. Because HHS does not have any such money-mandating obligation under the ACA or the applicable regulatory

scheme, and because the Netting Regulation does not *require* HHS to collect risk adjustment charges from issuers via offset, Count III should be dismissed for lack of jurisdiction under the Tucker Act or, in the alternative, for failure to state a claim upon which relief may be granted.

I. The ACA Does Not Obligate HHS to Pay Any Risk Adjustment Shortfall

Contrary to BCBS-NE's allegations (at ¶ 287), neither section 1343 nor section 1321 of the ACA require HHS to make "full" risk adjustment payments in the event that HHS (or the state, as applicable) is unable to collect the full amount due under the program. "The starting point in every case involving construction of a statute is the language itself." *Wyeth v. Kappos*, 591 F.3d 1364, 1369 (Fed. Cir. 2010) (citation omitted). The statutory language is "the best indication of Congress's intent." *Mission Critical Sols. v. United States*, 91 Fed. Cl. 386, 407 (2010) (citation omitted). "Only a most extraordinary showing of contrary intentions by Congress justifies a departure from the plain language of a statute." *Id.* (internal quotation marks and citation omitted).

No such extraordinary showing exists here. Under section 1343, HHS "shall establish criteria and methods to be used in carrying out the risk adjustment activities." 42 U.S.C. § 18063(b). States—"[u]sing the criteria and methods developed [by HHS]"—"shall assess a charge on health plans and health issuers" if the plan's actuarial risk is lower than the state's average risk. *Id.* § 18063(a)(1). Conversely, states—"[u]sing the criteria and methods developed [by HHS]"—"shall provide a payment to health plans and health issuers" if the plan's actuarial risk is higher than the state's average risk. *Id.* § 18063(a)(2). Nothing in this section requires HHS to pay any particular sum of money. Under section 1321, HHS "shall . . . issue regulations setting standards for meeting the requirements under this title . . . with respect to . . . the establishment of the . . . risk adjustment program[]." *Id.* § 18041(a)(1)(C). If a state does not elect to operate the risk adjustment program, HHS "shall take such actions as are necessary to

implement" the program on behalf of the state. *Id.* Nothing in this section requires HHS to pay anything. Taken together, these sections (at most) require HHS to create "criteria and methods" so that the state (or HHS on its behalf, as applicable) can assess risk adjustment charges and provide risk adjustment payments to participating issuers. Neither section provides the amount of those payments nor any formula for calculating them.

The provision adjacent to section 1343 underscores the United States' reading of the statute. "'[S]tatutory language cannot be construed in a vacuum.'" *In re Affinity Labs of Tex., LLC*, 856 F.3d 883, 891 (Fed. Cir. 2017) (quoting *Davis v. Mich. Dep't of Treasury*, 489 U.S. 803, 809 (1989)). "It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.'" *Id.* (quoting *Davis v. Mich. Dep't of Treasury*, 489 U.S. 803, 809 (1989)). Likewise, "when Congress includes particular language in one section of a statute but omits it in another, Congress intended a difference in meaning." *Me. Cmty. Health Options*, 140 S. Ct. at 1323 (internal quotation marks and citation omitted). Section 1342, which governs the risk *corridors* program, provides that HHS "shall pay" eligible unprofitable plans according to the formula provided by Congress in the statute. 42 U.S.C. § 18062(b)(1). Given this plain language, the Supreme Court concluded that the "Government 'shall pay' the sum that § 1342 prescribes." *Me. Cmty. Health Options*, 140 S. Ct. at 1321. Section 1343, on the other hand, does not use the words "the Secretary shall pay," nor does it provide a payment formula. The absence of such language reflects Congress's intent *not* to mandate HHS to pay participating issuers a pre-determined amount of risk adjustment money.

BCBS-NE's statutory interpretation should also be rejected under the doctrine of constitutional avoidance. "Where a possible construction of a statute would render the statute unconstitutional, courts must construe the statute 'to avoid such problems unless such construction

is plainly contrary to the intent of Congress.'" *Consolidation Coal Co. v. United States*, 528 F.3d 1344, 1347 (Fed. Cir. 2008) (quoting *Edward J. DeBartolo Corp. v. Fla. Gulf Bldg & Constr. Trades Council*, 485 U.S. 568, 575 (1988)). "'The elementary rule is that every reasonable construction must be resorted to, in order to save the statute from unconstitutionality.'" *Id.* (quoting *Hooper v. California*, 155 U.S. 648, 657 (1895)). BCBS-NE's construction of the ACA breaks this elementary rule. The Tenth Amendment of the U.S. Constitution provides, "[T]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST., AMEND. X. Under this Amendment, the federal government cannot force states "to use their own money to fund a federal program." *Minuteman Health*, 291 F. Supp. 3d at 202; *see Printz v. United States*, 521 U.S. 898, 929-30 (1997) ("the Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs").[12]

To avoid violating these tenets of federalism, the ACA must be read to allow HHS to implement a budget-neutral, self-funded risk adjustment program. Section 1343 provides that the States—not the federal government—"shall assess a charge" and "shall provide a payment." 42 U.S.C. § 18063(a)(1)-(2). While states may elect for HHS to run the program under section 1321 by declining to operate the program themselves, nothing in the ACA suggests that HHS's implementation of the program would operate any differently than the states' implementation of the program. Had Congress intended the states to cover any shortfall, the ACA would run afoul

[12] *See also New York v. United States*, 505 U.S. 144, 149 (1992) ("[W]hile Congress has substantial power under the Constitution to encourage the States to provide for the disposal of the radioactive waste generated within their borders, the Constitution does not confer upon Congress the ability simply to compel the States to do so."); *Connecticut v. Physicians Health Servs. of Conn., Inc.*, 287 F.3d 110, 122 (2d Cir. 2002) (holding that the federal government cannot require states "to enact and administer federal programs").

of longstanding Tenth Amendment precedent. The U.S. District Court for the District of Massachusetts reached the same conclusion. It held,

> [T]he risk-adjustment program was meant to be run by the states. Congress could not, under the Constitution, require the states to use their own money to fund a federal program. It therefore stands to reason that absent any appropriation, Congress expected the states to run budget-neutral risk-adjustment programs, and for HHS to set its federal regulations to allow it to certify such programs.

Minuteman, 291 F. Supp. 3d at 202 (citing *Printz*, 521 U.S. at 929-30, and *New York*, 505 U.S. at 175-76). Based on this reasonable and constitutionally permissible interpretation of the ACA, Congress did not intend for states to subsidize the federal risk adjustment program; nor did Congress intend for the states to run a self-funded program while HHS ran a government-funded program. BCBS-NE's risk adjustment allegations therefore cannot support the "money mandating" requirement of the Tucker Act nor state a claim upon which relief may be granted under RCFC 12(b)(6).

II. HHS Rules and Guidance Do Not Obligate the Agency to Pay More than What It Collects under the Risk Adjustment Program

BCBS-NE does not allege that HHS's criteria and methods for the risk adjustment program are arbitrary or capricious.[13] Rather, it alleges that HHS violated its "regulatory obligation" by failing to make "full risk adjustment payments," *see* Compl. ¶ 287, as determined by the "federally certified methodology." *Id.* ¶ 73. But, under the regulatory authority cited in the complaint and additional rules and guidance published by HHS and the CBO, HHS has no such obligation.

[13] Nor would BCBS-NE be successful if it did, as multiple courts have upheld the HHS risk adjustment methodology as reasonable and not arbitrary under the Administrative Procedure Act ("APA"). *See N.M. Health Connections*, 946 F.3d at 1152; *Minuteman Health Inc.*, 291 F. Supp. 3d at 214.

HHS designed the risk adjustment program to be "budget-neutral." That much is undisputed. *See* Compl. ¶ 71 ("the 'risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers.'") (quoting 2014 Final Rule, 78 Fed. Reg. at 15,441). Under HHS's rules and guidance, "budget-neutral" means that risk adjustment payments *made* to issuers must equal risk adjustment payments *collected* from issuers. In a 2012 bulletin, incorporated into the 2014 Final Rule, HHS states that "all of the [risk adjustment] payments made to issuers **must be completely funded through the [risk adjustment] charges** assessed to other issuers within the same market in the same State."[14] As a result, HHS explains, the agency will distribute risk adjustment payments only "**after** receipt of funds owed by issuers in that State."[15] In the event that "full charges are not received from issuers in that State," HHS may "issue **interim payments that are pro-rated across issuers** in a State based on the total charges remitted to date."[16] Once HHS collects the "remaining charges," HHS "will remit the remainder of outstanding payment balances."[17]

Other HHS publications, issued before and after the 2014 Final Rule, reinforce HHS's stated approach to the collection-payment process. In a May 8, 2012 presentation, HHS states that the agency "**may adjust payments based on receipt of funds to ensure that payments and**

[14] Appendix Ex. 1 (A1), CMS, *Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services*, at 4-5 (May 1, 2012), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/ppfm-risk-adj-bul.pdf (emphasis added).

[15] *Id.*

[16] *Id.*

[17] *Id.*

charges remain balanced."[18] On August 14, 2015, in addressing what would happen if HHS could not collect all risk adjustment charges, HHS states that "**risk adjustment payments for that risk pool will be adjusted on a pro rata basis to reflect the under collection**."[19] In a 2016 white paper, HHS further explains that budget-neutrality is a "key objective" of the payment transfer formula because it "ensures that risk adjustment **will neither require government sources of funding nor accumulate a surplus**."[20] The CBO likewise understood that "[t]he risk adjustment system is facilitated by the federal government, but, by law, essentially entails transfers between insurance companies **with no net budgetary effect over the course of the program**."[21]

Moreover, to the extent "budget-neutral" in the context of the risk adjustment program is ambiguous, HHS's interpretation of the term is entitled to deference. "Deference to an agency's interpretation of its own regulations is broader than deference to the agency's construction of a statute, because in the latter case the agency is addressing Congress's intentions, while in the former it is addressing its own." *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d

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[18] Appendix Ex. 2 (A13), CMS, *Risk Adjustment Program: HHS Operations*, at 9 (May 8, 2012), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/fm-2a-fed-ra-ov-dv.pdf; *see also* Appendix Ex. 3 (A37), CMS, *Risk Adjustment Program: HHS Operations*, at 7 (May 21-23, 2012) (same).

[19] Appendix Ex. 4 (A66), CMS, *Risk Adjustment Charges* (Aug. 14, 2015) (emphasis added).

[20] Compl., Ex. B, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting, Discussion Paper*, at 91 (March 24, 2016) (emphasis added); *id.* at 79 ("[R]isk adjustment transfers must meet the requirement of being budget neutral, which means that the payments and charges across an entire risk pool within a market within a State must sum to zero."); *id.* at 80 (stating that payment formula must "[b]alance payments and charges across the entire Statewide market risk pool"; thus, "[t]o remain budget neutral, the sum of all charges imposed on low-risk plans should equal the payments made to high-risk plans").

[21] Compl., Ex. D, CBO, *The Budget and Economic Outlook: 2014 to 2024*, at 59, 110 (Feb. 2014), available at https://www.cbo.gov/publication/45010 (emphasis added).

1352, 1363-64 (Fed. Cir. 2005) (citation omitted). Thus, "the agency's construction of its own regulations is 'of controlling weight unless it is plainly erroneous or inconsistent with the regulation.'" *Id.* (quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)). As the Supreme Court recently clarified in *Kisor v. Wilkie*, 139 S. Ct. 2400, 2415-18 (2019), a court should afford such deference where the regulation is "genuinely ambiguous," the agency's interpretation is reasonable, and the interpretation reflects the agency's fair and considered judgment.

The term "budget-neutral" in the context of the risk adjustment program is not ambiguous. It means the program should not impact states' budgets (or HHS's budget) in either a negative or positive way, thus requiring the state (or HHS) to distribute to issuers only what it receives under the program. There is no need to go any further. The regulation, and the final rule promulgated under it, "just means what [they] mean[]—and the court must give [them] effect, as the court would any law." *Kisor v. Wilkie*, 139 S. Ct. at 2415. But to the extent the Court finds any genuine ambiguity, it should be resolved in HHS's favor. The regulation at issue, 45 C.F.R. § 153.320, requires HHS to develop and publish its risk adjustment methodology, including the "calculation of payments and charges," in "an annual HHS notice of benefit and payment parameters." HHS did that. The 2014 Final Rule, and those published thereafter, outline a detailed methodology that requires payments made *by* issuers in a given state market risk pool to equal charges collected *from* issuers in a given state market risk pool. Consistent with this methodology, the 2014 Final Rule and those published thereafter require the program to be a "budget-neutral revenue redistribution among issuers." 2014 Final Rule, 78 Fed. Reg. at 15,441. As interpreted by HHS, "budget-neutral" means the program will be self-funding—"risk adjustment will neither require

government sources of funding nor accumulate a surplus."[22] This interpretation came after multiple public meetings, white papers, and notice and comment periods. *See* 2014 Final Rule, 78 Fed. Reg. at 15,414 (describing the public meetings and publications issued prior to arriving at the final rule). To the extent "budget-neutral" is ambiguous, HHS's interpretation of the term is reasonable and the result of a fair and considered judgment. BCBS-NE has not (and cannot) establish that the interpretation is "plainly erroneous or inconsistent" with the regulation or the rules themselves.

This conclusion is further supported by two recent federal court decisions. In *New Mexico Health Connections*, the Tenth Circuit rejected an APA challenge to the payment transfer formula. In doing so, the court understood the formula's "budget-neutral" application to mean that "HHS would not provide any additional funds to pay for the transfers." 946 F.3d at 1152. Likewise, in *Minuteman Health*, the U.S. District Court for the District of Massachusetts rejected an APA challenge to the risk adjustment methodology. 291 F. Supp. 3d at 202. It held that HHS's "attempt to design the program to pay for itself, as opposed to exposing its own general appropriations to float the program for any state that chose not to run its own program" was not "unreasonable or arbitrary." *Id.*

To be clear, BCBS-NE does not challenge HHS's payment transfer formula or its interpretation of "budget-neutral" under the APA. *See* Compl. ¶¶ 272-88. Rather, BCBS-NE

[22] Compl., Ex. B, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting, Discussion Paper,* at 91 (March 24, 2016); *id.* at 79 ("[R]isk adjustment transfers must meet the requirement of being budget neutral, which means that the payments and charges across an entire risk pool within a market within a State must sum to zero."); *id.* at 80 (stating that payment formula must "[b]alance payments and charges across the entire Statewide market risk pool"; thus, "[t]o remain budget neutral, the sum of all charges imposed on low-risk plans should equal the payments made to high-risk plans").

alleges that HHS's rules and related guidance *expressly require* HHS to cover any risk adjustment shortfall resulting from under-collection. *See, e.g.*, Compl. ¶¶ 70, 73-74, 287. This reading of the rules and guidance is wrong. As supported by multiple sources quoted above, HHS has no express (or implied) obligation to pay BCBS-NE any more than its share of what the agency is able to collect from issuers in the applicable Nebraska market risk pools. Thus, while the regulatory scheme may be "money-mandating" for those issuers in Nebraska that did not receive their pro-rated share of payments, it is not "money-mandating" for BCBS-NE, as the issuer received everything owed to it to date under the program. *See* note 11 *supra*. The Court therefore lacks subject matter jurisdiction under the Tucker Act, as BCBS-NE is not within "the class of plaintiffs entitled to recover under the money-mandating source." *Jan's Helicopter*, 525 F.3d at 1309. And, for these same reasons, Count III fails to state a claim upon which relief may be granted under RCFC 12(b)(6), as HHS cannot violate a regulatory duty it does not have.

III. The Netting Regulation Does Not Confer Jurisdiction under the Tucker Act, Nor Does It Save BCBS-NE's Risk Adjustment Claim on the Merits

BCBS-NE reads the Netting Regulation wrong too. BCBS-NE alleges that HHS violated the Netting Regulation by (1) failing to offset amounts that CoOportunity might owe to HHS under the risk adjustment program with a $14.7 million payment collected from CoOportunity under a separate start-up loan program, *see* Compl. ¶¶ 192-98; and (2) paying CoOportunity $274,447 in connection with the risk corridors program without offsetting amounts owed by CoOportunity under the risk adjustment program, *see* Compl. ¶¶ 199-200, 202-03.

These claims ignore the plain text of the Netting Regulation. Under 45 C.F.R. § 156.1215(b):

> HHS **may net payments** owed to issuers . . . against amounts due to the Federal or State governments from the issuers . . . for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment

> of Federally-facilitated Exchange user fees, payment of any fees for State-based Exchanges utilizing the Federal platform, and risk adjustment, reinsurance, and risk corridors payments and charges.

(Emphasis added). The key term here is "may." As acknowledged by the Supreme Court, "the word 'may'" in the context of the ACA "implies discretion" unlike "the word 'shall'" which "connotes a requirement." *Me. Cmty. Health Options*, 140 S. Ct. at 1320. The fact that HHS, in its discretion, chose not to use a $14.7 million loan payment collected from CoOportunity to make a risk adjustment payment to BCBS-NE does not violate the Netting Regulation. Likewise, the fact that HHS, in its discretion, chose not to withhold a $274,447 risk *corridors* payment in order to make a risk adjustment payment to BCBS-NE does not violate the Netting Regulation.

This reading of the Netting Regulation is also consistent with the offset doctrine generally. As recognized by the Supreme Court, "[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.*, 332 U.S. 234, 239 (1947) (internal quotation marks and citations omitted). That right "allows"—but does not force—"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). The same is true for the Netting Regulation. It allows, but does not require, HHS to offset money it owes an issuer as a way to collect money that issuer owes HHS under the 3Rs programs. For this reason, the Netting Regulation neither provides for subject matter jurisdiction under the Tucker Act nor supports a claim upon which relief may be granted under RCFC 12(b)(6).[23] BCBS-NE's allegations to the contrary should be rejected.

[23] As stated in note 11 *supra*, BCBS-NE alleges that HHS failed to pay issuers "all the risk adjustment funds that HHS actually collected from CoOportunity," *see* Compl. ¶¶ 184-91, and that

CONCLUSION

For the foregoing reasons, the United States respectfully asks the Court to dismiss Count III of BCBS-NE's Complaint for lack of subject matter jurisdiction under the Tucker Act or, in the alternative, for failure to state a claim upon which relief may be granted.

Dated: September 14, 2020

Respectfully submitted,

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the shortfall of risk adjustment payments due to BCBS-NE totals something other than $2,887,975.62, *see id.* ¶ 284. These allegations are wrong, as demonstrated by BCBS-NE's own exhibit (Compl., Ex. R ¶¶ 6-7), and should be rejected under the Tucker Act and the Rule 12(b)(6) standard. *See Bradley*, 136 F.3d at 1322 (holding that, under Rule 12(b)(6), "unwarranted inferences of fact do not suffice to support a claim"); *see also Jan's Helicopter*, 525 F.3d at 1307 (holding that jurisdiction under the Tucker Act must be supported by "a nonfrivolous allegation that [the plaintiff] is within the class of plaintiffs entitled to recover under the money-mandating source").

CERTIFICATE OF SERVICE

I hereby certify that on September 14, 2020, I electronically filed the foregoing MOTION TO DISMISS with the Clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to all CM/ECF participants.

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