IN THE UNITED STATES COURT OF FEDERAL CLAIMS

DOUG OMMEN, *in his capacity as Liquidator of CoOportunity Health, Inc.*, and DAN WATKINS, *in his capacity as Special Deputy Liquidator of CoOportunity Health, Inc.*,	)	
Plaintiffs,	)	
v.	)	No. 17-CV-00957-CFL Judge Charles F. Lettow
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

PLAINTIFFS' OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

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INTRODUCTION

HHS moves to dismiss all seven of the counts in CoOportunity's First Amended Complaint ("FAC"), arguing that the *Moda* opinion from the Federal Circuit largely disposes the claims. The *Moda* appeal, however, is not yet final and even if *Moda*'s petition for a writ of certiorari is denied, *Moda* would not control the outcome of the allegations in Counts III, IV, VI or VII.

With regard to counts III and IV, the FAC alleges that HHS acted without authority and contrary to federal and state law. Given the government's admission in prior proceedings that it had no statutory or regulatory authority to impose an administrative hold, the motion to dismiss must be denied.

With regard to counts VI and VII, the motion to dismiss should be denied because the issue of jurisdiction in this Court is res judicata.

QUESTIONS PRESENTED

1. Whether Counts I through IV should be dismissed based on the Federal Circuit's decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), when that appeal is not yet final and does not address all issues in Plaintiffs' First Amended Complaint?

2. Whether Counts III and IV state a claim when the government has admitted it lacked authority to impose an administrative hold and the setoff transactions it effectuated violated federal law, state law, and contract?

3. Whether the HHS's assertion that this Court lacks subject matter jurisdiction is barred by res judicata?

BACKGROUND

Plaintiffs' First Amended Complaint includes a detailed factual narrative of the background of this case, and CoOportunity will thus provide only a short summary of the factual background here. Further, this Court is well-versed in the ACA and its programs at issue in this case by virtue of the Court's work in *Land of Lincoln*. Importantly, however, there are also significant differences between the claims raised in this case and those in *Land of Lincoln*. Most significantly, HHS announced an indefinite hold on paying any funds owed to CoOportunity across the risk adjustment, risk corridors and reinsurance programs, and thereafter engaged in a series of setoff transactions to withhold payments distinct from the risk corridors funds at issue in *Moda* and *Land of Lincoln*. Those setoff transactions are the cornerstone of CoOportunity's lawsuit.

As part of the ACA, Congress created the "Consumer Operated and Oriented Plans" (the "CO-OP" program), which established non-profit insurance companies to diversify options in purchasing health insurance. *See* 42 U.S.C. § 18042(a)(1)-(2). Congress conferred authority over the CO-OP program and other relevant aspects of the ACA to the Secretary of HHS.[1] *See, e.g.*, 42 U.S.C. § 18042.

Under the ACA's CO-OP program, Congress authorized federal funding to create non-profit CO-OPs to offer qualified health insurance plans to individuals and small groups. *See* 42 U.S.C. § 18042(a)(1)-(2). In formulating regulations under which the CO-OPs would operate, HHS specifically noted that a CO-OP would be liquidated under state insolvency laws like any

[1] The Centers for Medicare & Medicaid Services ("CMS"), which is responsible for implementing the CO-OP program, is a part of HHS. *See* https://www.cms.gov/About-CMS/About-CMS.html.

other insurance company. *See* Final Rules, Responses and Comments, 45 C.F.R. 156, E.6 and F Dec. 13, 2011.

CoOportunity was one of these CO-OP entities, formed in 2012 to serve residents of Iowa and Nebraska. HHS provided start-up and solvency funding to CoOportunity pursuant to a Loan Agreement. As described in the First Amended Complaint, this was one of several contractual agreements CoOportunity entered into with HHS. FAC ¶¶ 31-74.

In the ACA, Congress "established three programs designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk: reinsurance, risk adjustment, and risk corridors." *Moda*, 892 F.3d at 1314; *see also* 42 U.S.C. §§ 18061-18063. Congress designed these programs to allow and induce insurers to offer insurance to the previously uninsured population, because the programs—in theory—would mitigate that risk.

Risk corridors was a temporary, three-year program, applying to policy years 2014, 2015, and 2016. 42 U.S.C. § 18062(a). This Court described the technical functioning of risk corridors as follows:

> When a qualified health plan issuer experiences a loss in a calendar year, such that the plan's "allowable costs" are more than 103 percent of the plan's "target amount" for that year, HHS is directed to pay the issuer a portion of that loss. 42 U.S.C. § 18062(b)(1); 45 C.F.R. § 153.510(b). Correlatively, when the issuer experiences a gain in a calendar year, such that the plan's "allowable costs" are less than 97 percent of the plan's "target amount" for that year, the issuer is directed to pay the HHS a certain amount of that gain. 42 U.S.C. § 18062(b)(2); 45 C.F.R. § 153.510(c).

Land of Lincoln, 129 Fed. Cl. at 90.

Similar to risk corridors, the reinsurance program existed for only policy years 2014-2016. All insurers are required to make payments into the reinsurance fund. 42 U.S.C. § 18061(b)(1)(A)-(B). Then, if a specific insurer's costs exceed a threshold number, individual

market issuers are eligible, up to a designated cap, for a reimbursement of funds. 42 U.S.C. § 18061(b)(1)(B).

Finally, the risk adjustment program is the only permanent program of the 3Rs. This program transfers funds from "low actuarial risk plans" to "high actuarial risk plans" within the same market within each state. 42 U.S.C. § 18063. HHS determines the "actuarial risk" for each insurer. Then, HHS acts as a conduit for the incoming and outgoing required payments, which, theoretically, spread risk around the market. *Id.*; 45 C.F.R. § 153.310(a)(2).[2]

During 2014, CoOportunity experienced significant financial distress, and was eventually placed in rehabilitation, then into liquidation by the Polk County District Court in Iowa. Effective February 28, 2015, the Polk County District Court entered its Final Order of Liquidation ("Liquidation Order") for CoOportunity. The Liquidation Order expressly prohibits any "creditors [or]…other entities (including…federal government entities)…[from u]sing any self-help remedy (including, but not limited to, setting-off monies owed)…."

Despite the Liquidation Order (and several other authorities discussed below), HHS took a series of actions to set off funds that otherwise would have been paid to the CoOportunity liquidation estate. *See* FAC ¶¶ 105-08. In particular, HHS failed to make *any* risk corridor payments to CoOportunity, even the *pro rata* distributions paid to all other insurers that do not implicate the various issues implicated in *Moda* and *Land of Lincoln*. *See* FAC ¶¶ 112-41.

CoOportunity also contests HHS's implementation of the risk adjustment program. HHS challenges those claims, however, only on jurisdictional grounds. As discussed below, that issue

[2] CoOportunity asked to be excluded from the 2015 risk adjustment calculation for numerous reasons including, *inter alia*, the fact that CoOportunity operated for just two months in early 2015 at the request of HHS, after the Iowa District Court placed the company in rehabilitation on December 23, 2014. HHS's systems could not handle an abrupt year-end or mid-month liquidation, and it requested that CoOportunity be liquidated at a month-ending date, settling on February 28, 2015.

has already been litigated in federal district court in Iowa. After CoOportunity originally filed suit in federal district court, HHS convinced that court it did not have jurisdiction because all of CoOportunity's claims were only properly raised in this Court. HHS successfully pursued that conclusion to final judgment.

ARGUMENT

With respect to the majority of CoOportunity's claims, HHS moves to dismiss pursuant to RCFC 12(b)(6). Accordingly, this Court should deny HHS's motion to dismiss if CoOportunity pleads allegations that are "enough to raise a right to relief above the speculative level." *Bristol Bay Area Health Corp. v. United States*, 110 Fed. Cl. 251, 259 (2013) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 545 (2007)). "This criterion does not require the plaintiff to set out in detail the facts upon which the claim is based, but the plaintiff must allege enough facts to state a claim to relief that is plausible on its face." *Henry Hous. Ltd. P'ship v. United States*, 95 Fed. Cl. 250, 254 (2010) (internal quotation marks and citations omitted). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Martin v. United States*, 96 Fed. Cl. 627, 630 (2011).

"In ruling on a RCFC 12(b)(6) motion to dismiss, the court must accept as true the complaint's undisputed factual allegations and should construe them in a light most favorable to plaintiff." *Id.* (citing *Gould, Inc. v. United States*, 935 F.2d 1271, 1274 (Fed. Cir. 1991)).

I. CoOportunity's Counts I, II, and V Are Preserved for the Eventual Appellate Outcome of *Moda* and *Land of Lincoln*, and CoOportunity's Implied Contract Claim is Distinct from the Claims in *Moda* and *Land of Lincoln*

HHS asks this Court to dismiss Counts I (statutory right to all risk corridors payments), II (breach of contract for risk corridors payments), and V (taking) for failure to state a claim based on the Federal Circuit's recent opinions in *Moda* and *Land of Lincoln*. Of course, the parties in

Moda and *Land of Lincoln* have not yet exhausted possibilities for further appellate review. The parties' obligation to preserve claims and issues, *especially* when those exact claims and issues are currently working their way through the federal courts, is well established.[3] Once the parties in *Moda* and *Land of Lincoln* exhaust their appellate remedies, then the ultimate outcome may well control Counts I, II, and V. But until that time, HHS raises no other argument as to why Plaintiffs do not state valid claims in Counts I, II,[4] and V.

Further, with respect to CoOportunity's *implied* contract claim in Count II, *Moda*'s analysis does not govern, because the insurers at issue in *Moda* and this case are entirely different. In *Moda*, the plaintiff was a for-profit insurance company that *elected* to offer plans in the ACA marketplace. The ACA requires that any insurer wanting to sell plans in the ACA marketplace to sell "Qualified Health Plans" ("QHPs"), which include designated levels of protection and other characteristics dictated by statute and regulation. The financial disincentive associated with the QHPs (because they had to be offered to anyone, irrespective of risk profile) would be offset by the 3R programs. Thus, the ACA permitted for-profit insurance companies like *Moda* the *option* of whether to offer QHPs and participate in the ACA exchanges.

[3] Indeed, when HHS discusses opinions presently working through the appellate courts, it does not express the same bewilderment it does here. *See* HHS Br. at 40 (discussing *New Mexico Health Connections v. U.S. Dep't of Health & Human Services*, ___ F. Supp. 3d ___, 2018 WL 5112912, at *50 n.28 (D.N.M. Oct. 19, 2018), and saying "even if the opinion were to stand after the parties have exhausted their judicial remedies").

[4] To be clear, Count II alleges a breach of the QHP Agreement, which will be addressed by the eventual appellate outcomes of *Moda* and *Land of Lincoln*. As discussed further below, CoOportunity *also* asserts a breach of its Loan Agreements based on HHS's illegal set-off transactions (as part of Counts III and IV). HHS spends only a single page addressing these breaches. Doc. 23 at 36. "Loan Agreements" were never even mentioned in *Moda* or *Land of Lincoln*, nor were alleged breaches regarding improper setoff. Thus, those claims are in no way precluded by *Moda* or *Land of Lincoln.*

Unlike the for-profit insurers, CoOportunity was a "CO-OP" non-profit entity, a special type of insurance company statutorily authorized and established by the ACA to create additional providers to offer QHPs in the insurance exchanges. Congress did not give CO-OPs the choice of whether to sell QHPs; rather, CO-OPs were *required* to offer QHPs. Thus, the 3R programs—and the government's payment of monies under those programs—were essential to the very existence of CO-OP entities, as well as their initial creation.

Although Land of Lincoln was also a CO-OP entity, this argument was never raised in the course of its proceedings. And, as this Court accurately stated, the "meeting of the minds" necessary to form an implied contract "is inferred from the conduct of the parties and the surrounding circumstances." *Land of Lincoln Mut. Health Ins. Co. v. United States,* 129 Fed. Cl. 81, 111 (2016) (citing *Night Vision Corp. v. United States*, 469 F.3d 1369, 1375 (Fed. Cir. 2006)). The CO-OPs' statutory and contractual obligation to offer QHPs is a critical fact for this Court to consider in determining whether there was a meeting of the minds between CO-OP entities and the federal government such that risk corridors monies would be paid. In distinguishing *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957) (finding an implied contract with the government), the *Moda* court repeatedly described risk corridors as an "incentive program" that was "designed to encourage the provision of affordable health care to third parties without a risk premium to account for the unreliability of data relating to participation of the exchanges—not the traditional *quid pro quo* contemplated in *Radium Mines*." *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1330 (Fed. Cir. 2018). Not so with respect to CO-OPs, whose entire business and viability was dependent on—not merely incentivized by—risk corridors payments.

This critical distinction with respect to CO-OP entities establishes, at the very least, that CoOportunity has stated a plausible claim for the existence of an implied contract, at least such that the case should proceed past the pleading stage.

II. CoOportunity States a Claim for Relief Regarding HHS's "Administrative Hold" and its Application of Setoff

The entirety of HHS's motion to dismiss Counts III and IV argues against a strawman—that the government has no right to use setoff transactions to collect funds it is owed. CoOportunity has never made such an argument. Instead, CoOportunity's Counts III and IV seek relief because of the improper *method* used by HHS to achieve the setoffs. First, HHS invented an indefinite "administrative hold" to keep any funds owed to CoOportunity for a *future possibility* of setoff. *See, e.g.*, FAC ¶¶ 106-07, 197-201. Further, Plaintiffs allege HHS failed to properly calculate and implement setoffs to account for all mutual debts and obligations. *See, e.g.*, FAC ¶¶ 237-38. CoOportunity sufficiently pleads that HHS violated both of these principles. FAC ¶¶ 196-241. HHS's abstract right to use setoff transactions is not at issue in this lawsuit; its process and procedure for effectuating the transactions is.

Plaintiffs allege that HHS treated CoOportunity differently than other insurers. *See* FAC ¶¶ 105. The risk corridors program was first set to apply to policy year 2014, with payment to be made from HHS to eligible insurers in late 2015. *See Land of Lincoln*, 129 Fed. Cl. at 89-91. From the inception of the ACA until shortly before HHS was set to make these payments, HHS maintained[5]—consistent with the statutory mandate that it "shall pay" the amounts prescribed by

[5] *See, e.g.*, 78 FR 15409, 15473 (Mar. 11, 2013) ("The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act."); HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,829 (Mar. 11, 2014) (nothing that the "risk corridors program is likely to be budget neutral or, will result in net revenue to the Federal government."); *Letter from Sylvia M. Burwell, Secretary, HHS, to U.S. Senator Jeff Sessions* (June 18, 2014) ("As established in statute … [QHP] plans with allowable costs at least

the statute—that it would make the full risk corridors payments irrespective of the amount of money brought in through the risk corridors program. *See Moda*, 892 F.3d at 1316.

In April 2014, HHS switched course by announcing its intention to instead make payments in a budget-neutral fashion. *See Moda*, 892 F.3d at 1317-18. In other words, HHS would pay the policy year 2014 outlays from risk corridors funds received for policy year 2014. In the event inflows were insufficient to cover the required 2014 payments, the 2015 inflows would first be applied to 2014 balances, and the same for 2016 inflows. Even as HHS made this announcement, however, HHS still maintained the risk corridors inflows would be sufficient. In the *very same announcement* where it articulated the policy change, HHS stated: "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments." *See id.*

HHS miscalculated the amount of money it would collect from risk corridors for policy year 2014. *Id.* at 1319 ("Specifically, [HHS] expected payments in of approximately $362 million but noted requests for payments out totaling $2.87 billion.").[6] HHS was able to pay carriers only 12.6% of the statutorily required payments. *Id.* On October 1, 2015, HHS issued its official notice stating that payments to issuers would be reduced on a *pro rata* basis, and each carrier eligible to receive risk corridors funds for policy year 2014 would receive only 12.6% of

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three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses.").

[6] "A report from CMS shows that the total amount of payments in collected for the 2014-2016 benefit years fell short of the total amount of payments out calculated according to the agency's formula by more than $12 billion." *Moda*, 892 F.3d at 1319 (citing CMS, *Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year* (November 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf).

the amount due and owing.[7] Prior to this announcement, CoOportunity was otherwise expecting to receive approximately $130 million in risk corridors for policy year 2014. FAC ¶ 114. At a minimum, CoOportunity should have received approximately $16.38 million under the *pro rata* formula.

Rather than paying CoOportunity its *pro rata* share, HHS did not pay *any* risk corridors funds to CoOportunity. *See, e.g.*, FAC ¶ 105. Instead, HHS announced in late 2015 an "administrative hold" on all payments due to CoOportunity, so that it could evaluate CoOportunity's status and have funds to pay itself—*i.e.*, to setoff—amounts HHS *subsequently* decided CoOportunity should pay. Based on the chance that there *might* be a debt HHS would like to set off in the *future*, HHS withheld all payments to CoOportunity. FAC ¶¶ 106-07. There is no legal authority for the indefinite administrative hold, which has the impact of circumventing the Iowa liquidation proceeding and priority interests of other creditors. *See, e.g.*, FAC ¶¶ 198-201.

Eventually, HHS determined there was a debt that could offset the risk corridors payment owed to CoOportunity, and HHS to setoff that payment accordingly. FAC ¶ 105. HHS then continued to engage in several more setoff transactions throughout 2015 and 2016, all of which were made possible by the "administrative hold" and all of which failed to properly calculate the outstanding balances between the parties. FAC ¶¶ 105-110.

As discussed below, these facts sufficiently establish a valid claim to survive a motion to dismiss. CoOportunity sufficiently pleads that the "administrative hold" and the manner in which HHS implemented its setoff transactions were illegal.

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[7] *See* CMS, *Risk Corridors Payment Proration Rate for* 2014 (Oct. 1, 2015), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProration Ratefor2014.pdf.

A. HHS states a valid claim against HHS's "administrative hold."

Given the deferential standard at this procedural stage—as well as HHS's prior *admission* that it has no authority to implement an administrative hold—CoOportunity states a claim, and HHS's motion should be denied. From the time CoOportunity first became aware that HHS implemented an "administrative hold" on all funds due to CoOportunity, it has asked the Government to provide a legal basis or authority for the "hold." HHS never provided an explanation. There is no authority to implement an administrative hold found in the text of the ACA, no federal regulation attendant to the ACA confers this power, and the contract language in the QHP and loan agreements between the parties does not recognize an administrative-hold authority.

Eventually, CoOportunity's liquidators sued HHS in the United States District Court for the Southern District of Iowa, alleging, *inter alia*, that the administrative hold was improper and sought an injunction barring its further use. HHS moved to dismiss that suit for lack of subject matter jurisdiction, asserting that CoOportunity's claims were *de facto* claims for money damages that only this Court has jurisdiction to resolve.

The district court eventually granted that motion, which led to this case being filed in this Court. But, prior to doing so, the district court held a hearing on the Government's motion to dismiss. There, as stated in CoOportunity's First Amended Complaint ¶ 110, the Government admitted it had no authority for the administrative hold it imposed:

> THE COURT: Can you point me to the statutory authority for your administrative hold?
>
> [COUNSEL]: There is no statutory authority for the hold.

App.[8] 8:22-25. After the Government then explained that the "administrative hold" is set up specifically to protect HHS against an insolvency process, the Court again pressed the Government on the functions it implements as part of this administrative hold:

> THE COURT: Those functions have to be explained somewhere. I asked you for the statutory authority. Are there any regulations about administrative holds that you can point me to?
>
> [COUNSEL]: No, not as far as I know.
>
> THE COURT: So there's no statutory authority and no regulations. When you just said there's 30 percent that goes to the Department of Treasury and that this is why this administrative hold exists, what -- where do we find that?
>
> [COUNSEL]: There are Treasury regulations, and I believe those would be in 31 CFR –
>
> THE COURT: I understand the Treasury regulations and the -- I understand that. Once it is referred there are regulations that govern that and -- but when you are holding it, what regulations do I look to to see that it is being held properly?
>
> [COUNSEL]: There are none that I am aware of.

App. 10:11 – App. 11:2.

This admission that HHS had no authority for the hold is alone sufficient to establish *at least* that CoOportunity has stated a claim that is "plausible on its face." Because HHS had no legal authority to withhold CoOportunity's payment for the 2014 risk corridors, that payment of $16.38 million should have been directly and promptly paid to CoOportunity's liquidation estate in December 2015, along with the payments that went to all of the other QHP insurers.

HHS now cites two "authorities" it claims support the use of an "administrative hold." *See* Doc. 23 at 39 (citing *Citizens Bank of Md. v. Strumpf*, 516 U.S. 16, 18 (1995); *Johnson v.*

[8] "App." denotes a citation to Plaintiff's Appendix attached to this brief pursuant to RCFC 5.4(a)(2)(G).

All-State Constr., Inc., 329 F.3d 848 (Fed. Cir. 2003)). Neither of these cases comes anywhere near permitting an administrative hold merely *in anticipation* of a future setoff possibility; yet that is precisely what HHS implemented here. While *Strumpf* and *Johnson* recognize the federal government's general ability to effectuate a setoff, they do not consider, much less approve of, the administrative hold used here.

Because CoOportunity was in the midst of a liquidation process in Iowa state court, HHS knew that if it followed the law and paid funds to the CoOportunity estate, then later had a debt come due from CoOportunity, it would be more difficult to get money out of the liquidation estate, because the Government did not have priority there over policyholder claims.[9] *See, e.g.*, FAC ¶¶ 106-07; 197-201. So, HHS unilaterally decided to "hold" the funds (without authority), and then simply adjust an accounting entry at the U.S. Treasury in the event an amount became due from CoOportunity. FAC ¶ 107. While this may have been easy and efficient for HHS, this is precisely the type of self-help measure that the Liquidation Order makes illegal, because these exact funds were rightly the property of the liquidation estate (and the other creditors), not HHS. FAC ¶¶ 197-201.

Finally, HHS's argument that the illegal hold is "moot" because of the later setoff (Doc. 23 at 39) is simply wrong. The timing of these actions is critical: had HHS followed the law, the $16.38 million from the risk corridors payments (as well as all other monies HHS held via the "administrative hold") would have been paid *into the liquidation estate*, and HHS would then

[9] Iowa liquidation laws, like all state insurance-company insolvency statutes, give priority to policyholder-level claims over other creditors—including the federal government. *See* Iowa Code § 507C.42. Here, most of those claims are held by "guaranty associations" established by statute in Iowa and Nebraska. The guaranty-association statutory protection of policyholders provides that, in the event of an insurance company liquidation, the guaranty associations will immediately step in and pay all policyholder claims so that insureds and healthcare providers are made whole. *See* Iowa Code § 508C.2. By statute, the guaranty associations then step into the policyholders' shoes in the liquidation proceeding. *See* Iowa Code § 507C.42.

have had to abide by the Iowa creditor-priority scheme governing the liquidation to get those funds back out. HHS has no right, and had no right, to effectuate its incorrect view of the law through unilateral self-help.

None of HHS's arguments in support of the administrative hold are valid, nor do they come close to establishing that CoOportunity has not state a plausible claim for relief.

B. CoOportunity states a sufficient claim that HHS's setoffs were illegal under federal law, state law, and contract.

For all of the time HHS spends in its motion to dismiss discussing the Federal Circuit's decision in *Moda,* the absence of any substantive discussion of *Moda* with respect to HHS's setoffs is telling. *Moda* supports CoOportunity's claims for improper setoff, as it makes clear that the full risk corridors payments are "owed" to CoOportunity (even if the lack of an appropriation means there are no funds available to pay the obligation) and should therefore be accounted for in any HHS setoff.

Under *any* potentially relevant authority—federal law, Iowa law, and contract—HHS applied the entire concept of setoff incorrectly. The concept of "setoff" or "netting" is a relatively simple one; when two parties have multiple debits and credits flowing between one another, they total up all of the mutual outstanding debits and credits and calculate a single "net" figure to be paid. Essential to this concept is that the parties include *all* debits and credits that are subject to setoff in this calculation. But HHS failed to account for the full $130 million it owed to CoOportunity under the risk corridors program. Had that amount been included, HHS would have owed substantially more to CoOportunity than was due from CoOportunity and, accordingly, HHS would not have been able to impose any setoff, under federal or state law. As discussed below, HHS's justification (i.e., that it has no risk corridors obligation beyond program

inflows due to lack of Congressional appropriation) has now been rejected by the Federal Circuit.

1. CoOportunity states a valid claim for wrongful setoff applying federal law.

HHS claims that it had the authority to impose setoffs through the federal Netting Regulation promulgated under the ACA. The plain language of that regulation illustrates that HHS is incorrect. The regulation states:

> (b) Netting of payments and charges for later years. In 2015 and later years, as part of its payment and collections process, HHS may net *payments owed to issuers . . . against amounts due to the Federal government* 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, and risk adjustment, reinsurance, and *risk corridors payments and charges*.

45 C.F.R. § 156.1215(b) (emphasis added). This provision establishes two important things. First, when calculating a netting or setoff, HHS is supposed to include all payments "*owed* to issuers" and set those off against "amounts *due* to the Federal government from the issuers." Second, these amounts should include "risk corridors payments."

Accordingly, when it came time for HHS to try and calculate a setoff, HHS was supposed to include on its side of the ledger all risk-corridors payments "owed" to CoOportunity, an amount that was over $130 million. Instead of doing that, however, HHS only included the 12.6% (or $16.38 million) as being owed to CoOportunity. This is consistent with HHS's prior position in *Moda* that the lack of a Congressional appropriation absolved it of *any* obligation to pay the full risk-corridors amount, such that it no longer "owed" it to CoOportunity.

This justification does not hold up to scrutiny under *Moda*. There, the Federal Circuit described the statutory risk-corridors payment obligation as "unambiguously mandatory." *Moda*, 892 F.3d at 1320.

> It provides that "[t]he Secretary *shall* establish and administer" a risk corridors program pursuant to which "[t]he Secretary *shall* provide" under the program that "the Secretary *shall* pay" an amount according to a statutory formula. 42 U.S.C. § 18062 (emphases added). Nothing in section 1342 indicates that the payment methodology is somehow limited by payments in.

Id. (alterations and emphasis in original). The court went on to reject all of HHS's arguments that the statute required the risk-corridors program to be operated in a budget-neutral manner, holding that HHS's decision to operate the program in that manner did nothing to absolve the government of its obligation. *See id.* at 1321-22.

Additionally, the court rejected HHS's argument that Congress's failure to provide budgetary authority to make payments in excess of receipts (or identify another source to fund the payments) relieved the government's obligation. The court relied on *United States v. Langston*, 118 U.S. 389 (1886), which established the proposition that "the government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation." *Moda*, 892 F.3d at 1321; *see also id.* ("Our predecessor court noted long ago that '[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties.'" (quoting *Ferris v. United States*, 27 Ct. Cl. 542, 546, 1800 WL 2022 (1892)). Similarly, the court rejected HHS's contention that the Anti-Deficiency Act had any effect on the government's obligation, noting that "the Supreme Court has rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government." *Id.* at 1322 (citing *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 197 (2012)).

Simply put, "the obligation is created by the statute itself, not by the agency." *Id.* HHS has no discretion to alter a statutory obligation created by Congress, which is why the court

ultimately concluded that the risk-corridors statute "created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program." *Id.*

The Court then turned its attention to specific riders Congress placed in its appropriations bills for Fiscal Years 2015 and 2016, which dictated that funds outside of risk-corridors collections could not be used to pay risk-corridors amounts due. Even when considering those riders, the court held that they acted only as temporary suspensions of the payments; the government's statutory obligation remained intact. *See id.* at 1325. In fact, the dissenting opinion criticized the majority, claiming that the holding resulted in a de facto rescission of the government's obligation; the majority rejected this criticism:

> We do not "ratif[y] an 'indefinite suspension' of payment," dissent at 1333, or a "permanent postponement," *id.* at 1333. We hold only that Congress effected a suspension applicable to the fiscal years covered by each appropriations bill containing the rider, which corresponded to each fiscal year in which risk-corridor payments came due.

Id. (alterations in original). As the majority thus makes apparent, the government always owed, and continues to owe, the full risk-corridors amount required by statute.

Further, the court's description of this "suspension" of payments occurring *from year to year* based specifically on *each year's appropriations rider* is critically important for the analysis of this case. Indeed, when HHS made the decision to effectuate this setoff in 2015, it had *no idea* what Congress's appropriations riders would say for FY2016, much less FY2017. And this is precisely the point made in *Moda*: HHS has an ongoing and continuing obligation for the statutory payments it owes under the ACA, and Congress's annual appropriations riders speak—on a year-to-year basis—to whether HHS pays those debts or continues to owe them into the next year.

The conclusion that HHS should have included all amounts it owes CoOportunity is reinforced by additional federal authority. Indeed, the very next provision of the ACA's Netting Regulation states:

> (c) Determination of debt. Any amount owed to the Federal government by an issuer . . . for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, 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(c) (emphasis added). As this text also establishes, HHS is supposed to net all "amounts owed by the Federal Government under these programs," which includes risk corridors.[10] HHS simply chose not to follow its own regulation. If it had done so, of course, it would not have been able to take *any* setoff at *any* time because the $130 million HHS owes to CoOportunity dwarfs any charge that ever became due from CoOportunity to the federal government.

HHS's invocation of federal law is thus insufficient to require dismissal of CoOportunity's claim on the pleadings alone. *Moda* firmly establishes that CoOportunity has a plausible claim, and this Court should allow the case to proceed for CoOportunity to determine—through discovery—how HHS calculated and executed its setoff transactions.

2. CoOportunity states a valid claim for wrongful setoff applying Iowa law.

HHS argues that federal law and regulations govern its setoff actions against CoOportunity while in liquidation, but Congress and HHS have consistently stated—in statute,

[10] Similarly, the federal bankruptcy code "authorizes the setoff of all mutual debts and credits, between the estate of a [debtor] and a creditor, and provides that the account shall be stated and one debt set off against the other; and that only the balance shall be allowed and paid." *Inter-State Nat'l Bank of Kansas City v. Luther*, 221 F.2d 382, 390 (10th Cir. 1955) (emphasis added); *see also Tyler v. Marine Midland Trust Co. of New York*, 128 F.2d 927, 928 (2nd Cir. 1942) (the Bankruptcy Act "allows setoff of all mutual debts and credits….").

regulation, guidance, and contract—that State insurance laws govern any CO-OP entity in liquidation. *See, e.g.*, 42 U.S.C. § 18041(d) (stating, in a section titled "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."); Proposed Rules, 45 C.F.R. Part 156, 76 Fed. Reg. 43237-01 (July 20, 2011) ("State law establishes a variety of required regulatory actions if an insurer's RBC [risk-based capital] falls below established levels or percent of RBC. These regulatory interventions can range from a corrective action plan to liquidation of the insurer if it is insolvent. Solvency and the financial health of insurers is historically a State-regulated function."); Final Rules, Responses and Comments, 45 C.F.R. Part 156, 76 Fed. Reg. 77392-01 at E.6 and F, Dec. 13, 2011 ("In the potential case of insurer financial distress, a CO-OP follows the same process as traditional insurers and must comply with all applicable State laws and regulations."); Loan Agreement ¶ 15.3(c) (noting that in the event of default: "Borrower must immediately repay any unused Loan Funds to *Lender following the resolution of any outstanding debts and run out of outstanding claim obligations, consistent with State Insurance Laws*." (emphasis added)). Iowa law should govern this analysis because it controls CoOportunity's liquidation, and all of HHS's relevant actions (the administrative hold and the setoffs) occurred after CoOportunity was under the jurisdiction of the Iowa Liquidation Court.

The question of whether HHS's setoffs were proper under Iowa law is relatively simple, because CoOportunity's liquidation began with a Liquidation Order entered by the Iowa state court, which spelled out, among other things, what actions creditors could—and could not—take. As relevant here, the order provided:

> No lender, bank, or other institution (including any State or Federal governmental entity), person, or other entity shall exercise any form of set-off, alleged set-off,

> lien, any form of self-help whatsoever or refuse to transfer any funds or assets to the Liquidator's or Special Deputy's control without further order of this Court.

Doc. 20-6, ¶ 45.[11] Despite having notice of the contents of this order, *both before and after it was entered*, HHS ignored it. Time and time again, before this litigation and in this litigation, HHS has thumbed its nose at this Order, claiming that it is not required to follow Iowa liquidation law and the Court's attendant orders. If HHS believed that a hold or a setoff of funds owed to CoOportunity was warranted under the law, all HHS needed to do was notify the Polk County Court and request permission for the transaction. Instead, HHS/CMS selectively engaged in self-help, with no notice to the Polk County District Court and direct damage to the other creditors of the estate.

Further, even if the Iowa Liquidation Court would have approved a setoff, Iowa law—just like federal law—would have required HHS to include *all* of its mutual debits and credits, including the full amount of its risk-corridors debt owed to CoOportunity. *See* Iowa Code § 507C.30 (allowing setoff of "mutual debts or mutual credits" in which case "the balance only shall be allowed or paid"). Thus, no matter how it is analyzed—via the binding Order or statutory authority on setoffs) CoOportunity states a claim for wrongful setoff in the event Iowa law provides HHS's supposed "justification" for its actions.

[11] In its motion to dismiss, HHS argues that sovereign immunity prevents this Liquidation Order from binding the federal government. Doc. 23 at 33-35. The federal government, however, *affirmatively submitted* a proof of claim in the liquidation proceeding, thereby consenting to the jurisdiction and disposition of that court. *See* FAC ¶ 105(c). And, in any event, sovereign immunity operates only to bar suits or other actions taken *against* the government. *See* 14 Wright and Miller, Fed. Practice and Procedure § 3654 (4th ed. 2015); *see also United States v. Brosnan*, 363 U.S. 237, 250 (1960). Here, the Iowa liquidation proceeding does not seek to cause an affirmative action on behalf of the government; rather, it is a setting to resolve claims *against CoOportunity*. *See Brosnan*, 363 U.S. at 251; *United States v. Rural Elec. Convenience Co-op Co.*, 922 F.3d 429, 436 (7th Cir. 1991).

3. CoOportunity states a sufficient claim that HHS breached the Loan Agreement by taking the setoffs in the manner it did.

HHS also argues that CoOportunity's claims for breach of the Loan Agreement with respect to setoff should be dismissed. Doc. 23 at 36. HHS claims that dismissal is warranted under Sections 19.12, 4.4, and 3.4 of the Loan Agreement. With respect to each provision, HHS is incorrect.

Section 19.12. HHS once again misdirects the inquiry as to whether it had some abstract power to setoff and not on the relevant question of whether it used any such authority appropriately. While HHS may have had the *general* right to use setoff, it still must do so in a legal manner. That much is made clear by the portion of the Loan Agreement § 19.12 *omitted from* HHS's block quote, which references "applicable Treasury regulations" and other authorities on which HHS can rely as remedies. As CoOportunity explains above, all such forms of setoff require the same basic tenets—that *all* amounts owed are used in the calculation. HHS did not do so, and Section 19.12 does nothing to absolve it of that requirement.

Section 4.4. This section of the Loan Agreement provides that CoOportunity is obligated to make its loan payments "subject to its ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements." This language is problematic for HHS, because HHS admits that it has used setoff to effectuate payment of the $14.7 million start-up loan *after* CoOportunity was in liquidation and was, of course, not in compliance with the Iowa reserve requirements. Any such payment would therefore be a violation of this provision of the Loan Agreement unless HHS found a way around it.

HSS attempts to do so by arguing that this language only applies "unless Lender terminates this Agreement for cause under Section 16.3 below." HHS then states that such a termination: "indisputably occurred here." Doc. 23 at 36. However, HHS's *own termination*

letter expressly states that it terminated the contract "pursuant to ***Section 15.3***." App. 1 (emphasis added).[12] Section 15.3 provides various remedies available to the Lender (HHS) in the event of a default on the terms of the Loan. Section 16.3 is not even referenced in HHS's termination notice. And, tellingly, HHS conceded in the termination notice that its debts would be resolved through the Iowa state-law liquidation process: "We of course realize that *the debts in question* are otherwise subject to disposition under relevant provisions of Iowa law concerning liquidation proceedings." *Id.* (emphasis added). In any event, because HHS did not terminate the agreement pursuant to Section 16.3, the operative language of Section 4.4 *still applied* when HHS made the unilateral decision to effectuate payment of the start-up loan in clear violation of the Loan Agreement's terms.

Of course, had HHS followed the law and its obligations under the Loan Agreement by paying the funds to CoOportunity's Liquidation Estate instead of setting them off, those funds would then reside within the estate. And HHS was well aware that Iowa Liquidation law places payment of policyholder claims *before* claims by the federal government in its priority scheme. *See* Iowa Code § 507C.42. While utilizing unilateral and illegal self-help to avoid Iowa's priority scheme was assuredly more expedient for the government, it does not make it legal. HHS unilaterally effectuated payment of the start-up loan at a time when CoOportunity was not solvent under its state's reserve requirements, and doing so was an express breach of the Loan Agreement.

Section 3.4. Iowa law is not the only source of authority for placing obligations of policyholder claims above those of the federal government. Indeed, the Loan Agreement does the very same thing:

[12] This termination letter was referenced and quoted in CoOportunity's Amended Complaint. *See* Doc. 21, ¶¶ 84-85.

> The Loans and other Obligations will be general obligations of Borrower. Because the intent of the Loans, and the Solvency Loan in particular, is to provide financing to Borrower that meets the definition of "risk based capital" for State Insurance Laws purposes, the Loans will have a claim on cash flow and reserves of Borrower that is subordinate to (a) claims payments, (b) Basic Operating Expenses, and (c) maintenance of required reserve funds while Borrower is operating as a CO-OP under State Insurance Laws.

Doc. 20-1, § 3.4. Because the CoOportunity estate unquestionably had "claims payments" outstanding at the time HHS took its setoff, the setoff was a clear violation of the Loan Agreement.

Without quoting the entirety of Section 3.4, HHS attempts to argue that the limitation found in Subsection (c)—"while Borrower is operating as a CO-OP under State Insurance Laws"—applied *also* to Subsections (a) and (b). This Court should not yield to HHS's illogical construction of this term. There is no indication whatsoever—even by a comma preceding the word "while"—that this limitation applies to anything other than Subsection (c). When drafting this document, HHS was perfectly able to break up the operative terms in each subsection with individual letters (a, b, and c) to denote the relevant breaks. Had HHS desired to have the limitation apply to all three subsections, there were plenty of drafting options to effectuate such a result. HHS chose none of them, and this Court should not condone the grammatical gymnastics HHS now employs in an attempt to avoid its contractual obligations.

HHS's invocation of Sections 19.12, 3.4, and 4.4 hurt HHS more than they help. Further, the only question at issue in this motion is whether CoOportunity has stated a plausible claim for relief. These contractual provisions—as explained in the First Amended Complaint—establish that CoOportunity has stated a plausible claim, and HHS's motion should be denied.

III. Res Judicata Bars HHS From Arguing That This Court Lacks Jurisdiction Over The Risk Adjustment Claims.

HHS's argument that this Court lacks jurisdiction over CoOportunity's risk adjustment APA claims without a single mention of this case's procedural history is especially interesting, because the parties have already litigated this very issue—to final judgment—once before.

CoOportunity originally filed its claims in the United States District Court for the Southern District of Iowa on May 3, 2016. *See Ommen v. Dep't of Health & Human Servs.*, No. 4:16-cv-00151-RGE-CFB, Doc. 1 (S.D. Iowa) (hereinafter "*Iowa Case*"). CoOportunity filed an amended complaint on July 26, 2016. App. 56-91. In that case, CoOportunity raised a series of APA challenges to HHS's actions, specifically including HHS's methodology for calculating risk adjustment figures in 2015 and CoOportunity's inclusion in the risk adjustment program for 2015.[13] *See, e.g.*, App. 84-87, ¶¶ 145(f); 146; 151(e). HHS moved to dismiss, arguing, *inter alia*, that CoOportunity's APA claims were actually requests for money judgments, that an adequate forum for the claims existed in the Court of Federal Claims, and that all of CoOportunity's claims should be dismissed for lack of jurisdiction because the claims could only be brought before this Court. *See Iowa Case*, Docs. 62, 64. CoOportunity filed an opposition, and HHS replied. *See Iowa Case*, Docs. 71, 74.

The district court held oral argument on the motion to dismiss on December 15, 2016. App. 3-55. In fact, during oral argument, HHS's attorney specifically addressed the jurisdictional issue as it related to CoOportunity's risk-adjustment claims:

> Moving to the risk adjustment claim, because this claim ostensibly challenges HHS's methodology as arbitrary and capricious, in ordinary circumstances this is the type of claim that might be entertained under the APA prior to the money being collected by HHS; but there are two unique facts that remove this claim from the Court's APA jurisdiction.

[13] These are the same risk-adjustment claims asserted in this case. *See* Doc. 20 at 46-48.

App. 20:16-21. Counsel then went on to explain to the Court that because the government had already collected some of the funds at issue, and because HHS had amended the risk-adjustment methodology for future years (that did not apply to CoOportunity), CoOportunity's claim is nothing more than a damages claim, and "it is one that is fully redressable in the Court of Federal Claims." App. 20:22 – App. 21:21. Because there was no prospective relief sought, HHS's counsel argued that CoOportunity's claims properly fit within this Court's jurisdiction as articulated by the Federal Circuit's precedents. App. 21:22 – App. 22:10.

HHS's arguments were successful; on March 16, 2017, the district court entered an order dismissing CoOportunity's claims—including the risk adjustment claims—for a lack of jurisdiction. App. 92-111. In fact, the district court separately analyzed the risk adjustment claims in particular, distinguishing them from other risk adjustment claims dismissed by this Court because CoOportunity's claims challenged specific items about a year of the program that had already passed, and CoOportunity would not be participating in the program in the future. App. 106-08. The court held that a "money judgment in favor of the CoOportunity estate would adequately address" the claim and that the Court of Claims could provide "adequate relief." *Id.* at 107. Ultimately, the court concluded: "Therefore this Court does not have jurisdiction over the Liquidators' risk adjustment claim because an adequate remedy exists in the Court of Federal Claims." *Id.* at 108.

HHS did not challenge this decision through a motion for reconsideration, a motion to clarify, an appeal, or otherwise. HHS is now bound by this decision, and this Court should reject HHS's attempt to relitigate the same issue.

"Res judicata, or claim preclusion, 'prevents a party from relitigating the same claims that were or could have been raised before.'" *Watson v. United States*, 86 Fed. Cl. 399, 401

(2009) (quoting *Case, Inc. v. United States*, 88 F.3d 1004, 1011 (Fed. Cir. 1996)). "Dismissals for lack of jurisdiction may be given res judicata effect as to the jurisdictional issue." *Id.* at 402 (internal quotation marks, citations, and alteration omitted). Res judicata applies if "(1) the parties are identical or in privity; (2) the first suit proceeded to a final judgment on the merits; and (3) the second claim is based on the same set of transactional facts as the first." *Id.* at 401 (quoting *Ammex, Inc. v. United States*, 334 F.3d 1052, 1055 (Fed. Cir. 2003)).

Here, the parties are identical. The Iowa district court's judgment was final. *See, e.g.*, *Verdone v. United States*, No. 04-801C, 2005 WL 6112626, at *3 (Fed. Cl. May 31, 2005) ("The judgments were valid in that every court has the jurisdiction to determine its own jurisdiction, . . . and unless a decision finding no jurisdiction is successfully appealed or otherwise set aside pursuant to the rules of the court, the judgment remains valid."). And the claims and jurisdictional facts remain the same as in the *Iowa case*. Indeed, CoOportunity still raises APA challenges exclusively to past applications of the risk adjustment program, and there is no future regulatory activity at issue. Res judicata bars HHS's jurisdictional argument.

CONCLUSION

WHEREFORE, for the reasons set forth above, CoOportunity asks the Court to deny HHS's motion to dismiss and for all other relief deemed just and appropriate.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on December 14, 2018, I filed a copy of the foregoing Notice of Voluntary Dismissal Without Prejudice via the Court's ECF system, which provided electronic notice to all counsel of record.

/s/ DOUGLAS J. SCHMIDT