[ORAL ARGUMENT REQUESTED]

No. 18-2186

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

NEW MEXICO HEALTH CONNECTIONS,

Plaintiff-Appellee,

v.

UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of New Mexico, No. 1:16-cv-00878 (Judge Browning)

REPLY BRIEF FOR APPELLANTS

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GLOSSARY

ACA	Patient Protection and Affordable Care Act
AHIP	America's Health Insurance Plans
BCBSA	Blue Cross Blue Shield Association
CMS	Centers for Medicare & Medicaid Services
GAO	Government Accountability Office
HHS	U.S. Department of Health & Human Services
NMHC	New Mexico Health Connections
SA	Plaintiff's Supplemental Appendix

INTRODUCTION AND SUMMARY

As our opening brief explained, the risk-adjustment program transfers funds each year from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees in a given State. Since the program's inception, the Department of Health & Human Services (HHS) has designed its annual methodology to be budget neutral, meaning that the charges and payments net to zero. After extensive analysis, HHS decided to use the statewide average premium as a component of the transfer formula, in part because its use results in balanced charges and payments.

The district court ruled that HHS should have explained why it decided to use a budget-neutral methodology in the first place. The court declared that HHS's "failure to explain its budget-neutral approach to the program . . . infected its decisionmaking with respect to its choice to use the statewide average premium in its formula." *New Mexico Health Connections v. U.S. Dep't of Health & Human Servs.*, 340 F. Supp. 3d 1112, 1177 (D.N.M. 2018) (*NMHC II*). For that reason, the court vacated the use of the statewide average premium in the HHS methodology for the 2014-2018 benefit years, and remanded to HHS for further explanation.

Our opening brief showed that this ruling rests on multiple legal errors. As a threshold matter, HHS had no duty to explain its budget-neutral approach because no commenter objected to it. Plaintiff does not claim that it made a timely objection to budget neutrality during the rulemaking process. Plaintiff's observation that it objected to the use of the statewide average premium on other grounds is legally

irrelevant, because the district court's judgment rests solely on HHS's asserted failure to explain why it decided to use a budget-neutral approach.

The judgment below is also wrong on the merits, as there are myriad problems with the funding approach envisioned by the district court. The court questioned why HHS did not consider using a lump sum for program management as a supplemental funding source for risk-adjustment payments. But as our opening brief explained—and plaintiff does not dispute—that discretionary lump sum was not enacted until *after* the risk-adjustment methodology was finalized for the relevant benefit year, so HHS could not have relied on it when it designed the methodology. Moreover, the lump sum was needed to administer crucial programs like Medicare and Medicaid, so HHS would not have depleted the lump sum even if it had the option to do so.

Rather than engage the substance of these points, plaintiff's brief reiterates its longstanding policy objections to the use of the statewide average premium. These policy arguments did not persuade Congress (*see* Gov. Br. 10 & n.1) or HHS, which had ample reason to reject plaintiff's preferred alternative of using each plan's own premium instead. *See Minuteman Health, Inc. v. U.S. Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 202 (D. Mass. 2018) (noting that Minuteman's analogous "proposal appears to be even less predictable" than the HHS methodology it criticized). Plaintiff's policy preferences are no basis to upset third-party expectations by retroactively vacating methodologies on which insurers relied. It was "for HHS to

weigh the options," and a court "cannot substitute its judgment for that of the agency, absent an arbitrary or irrational choice." *Id.* at 204.

ARGUMENT

I. Plaintiff Waived Any Objection to Budget Neutrality.

It is settled that "courts should not topple over administrative decisions unless the administrative body not only has erred but has erred against objection made at the time appropriate under its practice." *United States v. L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 37 (1952). This Court has explained that, "[t]o satisfy the exhaustion requirement, plaintiffs generally must structure their participation so that it alerts the agency to the parties' position and contentions, in order to allow the agency to give the issue meaningful consideration." *Forest Guardians v. U.S. Forest Serv.*, 641 F.3d 423, 430 (10th Cir. 2011) (quotation marks omitted).

The district court ruled that HHS should have explained why it adopted a methodology that was budget neutral, *i.e.*, that ensured that charges and payments would net to zero. Plaintiff does not claim that it (or any other commenter) raised a timely objection to budget neutrality or identified an extrinsic source of funding during the rulemaking process. Nor does plaintiff defend the district court's conclusion that HHS's passing references to budget neutrality during the rulemakings bring this case within the narrow exception to the exhaustion requirement that applies when an agency considers an issue on its own initiative. *See NMHC II*, 340 F. Supp. 3d at 1168 (citing *Garcia-Carbajal v. Holder*, 625 F.3d 1233, 1238 (10th Cir. 2010)

(Gorsuch, J.)). As our opening brief explained, that "rare exception" to the waiver rule does not apply unless "three preconditions" are met. *Garcia-Carbajal*, 625 F.3d at 1238. The agency must: "(1) clearly identify a claim, issue, or argument not presented by the petitioner; (2) demonstrate that the agency chose to exercise its discretion to entertain that matter; and (3) explicitly decide that matter in a full explanatory opinion or substantive discussion." *Id.* at 1238-39. None of those conditions was fulfilled with respect to the issue of budget neutrality or the availability of the lump sum.

Accordingly, the judgment below should be reversed on waiver grounds alone. To satisfy the exhaustion requirement, plaintiff was required to alert HHS to its "position and contentions, in order to allow the agency to give the issue meaningful consideration." *Forest Guardians*, 641 F.3d at 430. "Claims not properly raised before an agency are waived, unless the problems underlying the claim are 'obvious' or otherwise brought to the agency's attention." *Id.*

Instead of coming to grips with this Court's precedent, plaintiff relies on cases from other circuits that suggest that certain "key assumptions" may be challenged in court even if they were never challenged before the agency. *See* Pl. Br. 40. Plaintiff makes no attempt to reconcile that reasoning with this Court's precedent, which treats claims not raised before the agency as waived "unless the problems underlying the claim are 'obvious' or otherwise brought to the agency's attention." *Forest Guardians*, 641 F.3d at 430. "Permitting the parties to hide trumps up their sleeve for appeal can

only exalt endless gamesmanship over fair play and finality of judgment." *Id.* at 431 n.6 (citation omitted).

Plaintiff cannot plausibly contend that there is an "obvious" problem with HHS's budget-neutral approach, given that plaintiff contemporaneously endorsed budget neutrality in comments to the agency. Plaintiff's brief explains that plaintiff, Minuteman, and five other insurers formed the CHOICES coalition in order to present their views on risk adjustment to HHS. *See* Pl. Br. 13; *see also* SA 124 (identifying members of the CHOICES coalition). In November 2015, shortly before the proposed rule for the 2017 benefit year was issued, *see* 80 Fed. Reg. 75,488 (Dec. 2, 2015), the CHOICES coalition submitted a white paper to HHS that objected to various aspects of the risk-adjustment methodology, *see* SA 123-38, most of which are not relevant to this appeal.

Page 5 of the white paper addressed the use of the statewide average premium in the transfer formula. *See* SA 133 ("Technical Issue #6"). The CHOICES coalition argued that, for certain insurers, use of the statewide average premium produces an estimation error that would be eliminated if the plan's actual average premium were used instead. *See id.* The CHOICES coalition recognized that the statewide average premium was used "in significant part because it simplifies the calculations and automatically results in plan payments and charges that sum to zero." *Id.* And the CHOICES coalition explicitly acknowledged that if its preferred approach were used, budget neutrality would have to be achieved through another mechanism: "[I]t would

be necessary to adjust the aggregate 'payments' to receiving plans and/or 'charges' to other plans *to achieve overall balance among the transfers*." *Id.* at n.9 (emphasis added).

In other words, the CHOICES coalition's white paper—joined by plaintiff here—affirmatively embraced the need for budget neutrality. The coalition simply proposed a different way of achieving it (one that would have been more financially advantageous for its members).

Similarly, in April 2016, the CHOICES coalition again urged HHS to make changes to the risk-adjustment methodology. *See* SA 146-49. As relevant here, the CHOICES coalition proposed that state regulators be given authority to reduce transfer amounts by a fixed percentage, such as 50%. *See* SA 149. In describing the "Benefits" of this "Proposed Solution," the CHOICES coalition emphasized that it "[m]aintains budget neutrality." *Id.* Thus, even after the rule for the 2017 year was finalized, *see* 81 Fed. Reg. 12,204 (Mar. 8, 2016), the CHOICES coalition continued to recognize the need for budget neutrality in the risk-adjustment methodology.

If plaintiff actually believed that budget neutrality was unwarranted, then plaintiff should have spoken up in a timely fashion and thus alerted the agency to its position. Instead, plaintiff's separate comments incorporated by reference the CHOICES white paper, which expressly recognized the need for budget neutrality. *See* SA 172 (plaintiff's comment on the proposed rule for 2017, relying on the "White Paper developed by CHOICES").

Rather than reckoning with this administrative history, plaintiff argues that the exhaustion requirement was satisfied because the CHOICES coalition challenged the use of the statewide average premium on various policy grounds—such as by arguing that "risk transfer amounts are biased against effective plans," Pl. Br. 13—and "HHS actually considered whether to use the statewide average premium instead of an issuer's own premium," Pl. Br. 38. Those arguments are beside the point, because the only issue on which the district court ruled was HHS's decision to adopt a methodology that is budget neutral, which the court believed "infected" the choice of the statewide average premium. *NMHC II*, 340 F. Supp. 3d at 1177. On that issue, HHS and CHOICES both agreed that budget neutrality was necessary. Plaintiff cannot adopt a different position now.

II. The District Court's Reasoning Was Also Wrong on the Merits.

A. HHS Adequately Addressed Plaintiff's Belated Objection to Budget Neutrality.

During the rulemaking for the 2018 benefit year, plaintiff and Minuteman asserted for the first time that "there is no requirement in Section 1343 that Risk Adjustment be budget neutral; no requirement that payments collected from one set of issuers be used to make full and complete payments to another set of issuers." Aplt. App. 25 (plaintiff's comment); Aplt. App. 44-45 (Minuteman comment). However, neither comment identified any potential funding source other than the amounts collected from insurers. Accordingly, when HHS responded to those

comments, it explained: "In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner[.]" 81 Fed. Reg. 94,058, 94,101 (Dec. 22, 2016).

That explanation was sufficient to address the terse comments submitted. Although the Patient Protection and Affordable Care Act (ACA) appropriated funds for certain of its programs—such as by enacting a permanent appropriation for the premium tax credits authorized under Section 1401 of the Act—the ACA did not appropriate any extrinsic funding for the risk-adjustment payments. No comment identified any other source of potential funding.

B. The Timing of the Lump-Sum Appropriation Meant That HHS Could Not Have Relied on It When HHS Designed Its Risk-Adjustment Methodology for a Given Benefit Year.

The district court in its Rule 59(e) opinion suggested that HHS should have considered using a lump sum for program management as a supplemental funding source for risk-adjustment payments. *See NMHC II*, 340 F. Supp. 3d at 1174. As our opening brief explained, however, the lump sum was not appropriated until *after* HHS finalized its risk-adjustment methodology for the applicable benefit year, so HHS could not have relied on the lump sum even if it had wished to do so. *See* Gov. Br. 27-31.

Although plaintiff asserts that "An Alleged Lack of Appropriation Does Not Necessitate Budget Neutrality," Pl. Br. 29, it is a bedrock principle of appropriations law that "[a]gencies may not spend, or commit themselves to spend, in advance of . . .

appropriations." Government Accountability Office (GAO), *Principles of Federal Appropriations Law*, at 1-8 (4th ed. 2016 rev.). The Anti-Deficiency Act makes it unlawful for an officer or employee of the federal government to incur an obligation for the payment of money "before an appropriation is made." 31 U.S.C. § 1341(a)(1)(B).

Without apparent irony, plaintiff urges this Court to disregard what plaintiff describes as the "*post hoc* justifications concocted by litigation counsel." Pl. Br. 29. It bears repeating that, during the rulemakings, neither plaintiff nor any other commenter proposed that HHS draw upon the lump sum, so HHS had no reason to address the issue. In any event, the Anti-Deficiency Act is a legal constraint on Executive Branch spending that applies whether or not an agency explicitly cites the statute in a rulemaking.

C. The Substantive Limits on the Lump-Sum Appropriation Meant That the Lump Sum Was Not Available for Risk-Adjustment Payments.

Independent of the problem of timing just described, the district court was also incorrect to conclude, as a substantive matter, that the lump sum was available for risk-adjustment payments. For the fiscal years at issue here, the annual appropriations acts stated that "except as otherwise provided," the lump sum was available for carrying out enumerated programs such as Medicaid and Medicare, and other responsibilities of the Centers for Medicare & Medicaid Services (CMS). *See, e.g.*, Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235,

div. G, title II, 128 Stat. 2130, 2477 (Dec. 16, 2014). Just as Congress "otherwise provided" for Medicare and Medicaid benefits through separate appropriations, Congress "otherwise provided" for risk-adjustment payments by allowing the amounts collected from insurers to be used to fund those payments. Thus, the lump sum could not have been used for risk-adjustment payments.

In arguing that Congress did not "otherwise provide" for risk-adjustment payments, plaintiff mistakenly assumes that the authority to distribute amounts collected under the risk-adjustment program comes from the program management appropriation for "user fees." Pl. Br. 31-32. In reality, the amounts collected under the risk-adjustment program are distributed under the authority of the ACA itself. Section 1343 of the ACA directs each State to assess risk-adjustment charges and make payments, and Section 1321 of the ACA directs HHS to act on behalf of a State that opted not to do so. In combination, these ACA provisions establish a special fund for risk adjustment that does not flow through the program management account and is not classified as a user fee.[1] Plaintiff's reliance on a GAO opinion addressing a different ACA program—the temporary risk-corridors program—is thus misplaced, because the amounts collected under that three-year program were user fees distributed under the authority of the program management appropriation. *See*

[1] *See, e.g.*, Office of Management and Budget, Fiscal Year 2016 Appendix: Budget of the U.S. Government 473, https://go.usa.gov/xmHCY (identifying risk-adjustment collections as special fund receipts).

Dep't of Health and Human Servs.—Risk Corridors Program, B-325630, 2014 WL 4825237, at *3-5 (Comp. Gen. Sept. 30, 2014) (noting the GAO's agreement with HHS's conclusion that risk-corridors collections are user fees that may be distributed pursuant to the program management appropriation).

D. The Risk-Adjustment Program Was Meant To Be Administered by States, Which Could Not Have Drawn on the Lump Sum for CMS Program Management.

Our opening brief identified a further problem with the funding approach envisioned by the district court: Congress designed the risk-adjustment program to be administered by States. *See* Gov. Br. 32-34. States, of course, cannot avail themselves of the lump-sum appropriation for CMS program management. So it would have made no sense for HHS to "establish criteria and methods to be used in carrying out" the risk-adjustment program that were not usable by the States. 42 U.S.C. § 18063(b).

Plaintiff admits that Massachusetts operated its risk-adjustment program for the 2014, 2015, and 2016 benefit years, but emphasizes that no State is currently choosing to do so. *See* Pl. Br. 37. Insofar as this case involves the 2014-2016 years (as well as 2017-2018), it is puzzling that plaintiff regards the Massachusetts-run program as irrelevant. More generally, HHS explained at the outset that it was developing a methodology that any State would be able to use if it opts to run its own risk-adjustment program. 77 Fed. Reg. 17,220, 17,232-33 (Mar. 23, 2012). That approach was well within HHS's discretion, particularly given the burdens associated with

developing a risk-adjustment methodology. *See id.* at 17,230 ("Developing a risk adjustment program is methodologically and operationally complex.").

E. Plaintiff's Policy Arguments Are Unavailing.

Plaintiff does not advance its position by reiterating the policy objections to the HHS risk-adjustment methodology that were raised unsuccessfully before Congress. Plaintiff and other CO-OPs—which were new entrants to insurance markets that received subsidized federal loans—attributed the failure of many CO-OPs to the risk-adjustment and risk-corridors programs. In testimony before Congress, the trade representative for CO-OPs claimed that the HHS risk-adjustment methodology favored large, pre-existing insurers over new entrants; that restrictions on funding for risk-corridors payments threatened the solvency of many CO-OPs; and that additional support for CO-OPs would enhance competition.[2]

Congress not only declined to intervene, however, but repeatedly re-enacted the same funding restrictions on risk-corridors payments to which the CO-OPs objected. *See Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1319-20, 1325 (Fed. Cir. 2018).

Additional HHS explanation of the reasons for budget neutrality would not redress the grievances that the CO-OPs brought to Congress's attention. Nor are

[2] *See* Testimony of Peter Beilenson, MD, MPH, CEO and President, Evergreen Health Cooperative, and Board Member, National Alliance of State Health CO-OPs Before the House Committee on Energy and Commerce Subcommittee on Oversight & Investigations (Nov. 5, 2015), https://go.usa.gov/xmHC8.

plaintiff's criticisms of the HHS risk-adjustment methodology a basis to affirm the judgment below, which rested on the narrow ground that additional explanation for budget neutrality was warranted. The district court did not otherwise question the substance of the agency's chosen methodology.

In any event, the CO-OPs' assertion that the HHS risk-adjustment methodology was responsible for their failures is a "very-much-disputed" claim. *Minuteman Health, Inc. v. U.S. Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 195 (D. Mass. 2018). For example, although plaintiff insists that the HHS risk-adjustment methodology is "inherently unpredictable," Pl. Br. 34, its view is contradicted by national associations that—unlike plaintiff—represent "companies on both sides of the risk adjustment ledger." AHIP/BCBSA Amicus Br. 11. Amici explain that the advance publication of HHS's annual risk-adjustment methodology "has allowed health plans, in reliance on this regulatory regime, to account for transfer payments when making business decisions, including rate-setting for plan premiums." AHIP/BCBSA Amicus Br. 4. By contrast, the Milliman paper on which plaintiff relies, *see* Pl. Br. 33-34, was simply a retrospective analysis of the program's first year, when "there were no official market-wide risk score metrics available that would help issuers estimate what transfer payment their own experience might produce." SA 141. Nothing in the record supports plaintiff's pronouncement that risk-adjustment payments are still as unpredictable as it claims.

Similarly, although plaintiff asserts that the relatively low premiums offered by various CO-OPs were attributable to efficient operations, that was just the CO-OPs' own characterization. Indeed, Minuteman admitted that it excluded high-priced hospital systems from its network, *see Minuteman*, 291 F. Supp. 3d at 189, which is one of the practices that risk adjustment is meant to rectify and deter, *see* Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20 KAN. J.L. & PUB. POL'Y 222, 224 (2011) (explaining that a plan could offer lower premiums by excluding from its provider networks specialty hospitals that treat high-cost conditions). Plaintiff quotes Evergreen Health's CEO for the proposition that "[t]he risk adjustment program administered by [HHS] destroyed Evergreen" because "Evergreen was unable to predict" its risk-adjustment charge for the 2015 calendar year." Pl. Br. 54 (quoting the Beilenson Decl.). However, an independent account concluded that Evergreen underpriced its premiums in an effort to gain market share from its competitor. *See* Sarah Gantz, *Evergreen Health is undercutting Carefirst's exchange premium prices to gain market share*, Baltimore Business Journal, Aug. 26, 2014, https://www.bizjournals.com/baltimore/news/2014/08/26/evergreen-health-is-undercutting-carefirsts.html.

The *Minuteman* court correctly recognized that its role was not to arbiter such disputes over policy, which are matters for Congress and the agency to resolve. *See Minuteman*, 291 F. Supp. 3d at 179 ("[T]he role of this Court is not to sit in judgment on the wisdom of the law, nor is it to judge the actions of HHS with the benefit of

hindsight."). As the *Minuteman* court noted, the approach that plaintiff and other CO-OPs preferred—using a plan's own premium in the transfer formula instead of the statewide average premium—would have increased uncertainty in the risk-adjustment program. *See id.* at 202-03 ("[C]ompared to any of the other methodologies HHS was considering, using the statewide average premium appeared to be at least somewhat predictable"). "There were documented advantages and disadvantages to both options, and it was rational for HHS to decide that the increased predictability of the statewide average premium outweighed any harm to very low-cost plans." *Id.* at 204. It is "for HHS to weigh the options," and a court "cannot substitute its judgment for that of the agency, absent an arbitrary or irrational choice." *Id.*

III. The District Court Should Have Granted the Rule 59(e) Motion or, at a Minimum, Tailored Any Relief to Plaintiff's Injury.

For the reasons discussed above, the district court erred in its initial decision when it ruled that additional explanation for HHS's budget neutral approach was needed. In any event, HHS provided such additional explanation during the summer of 2018, while the government's Rule 59(e) motion was pending. Therefore, the district court should have granted that motion or—at a minimum—tailored its remedy to plaintiff's injury.

As our opening brief explained, the district court announced in June 2018 that it would not be in a position to rule on the pending Rule 59(e) motion until Labor Day—a delay that would have impaired the impending collection and distribution of

$5 billion. To prevent a crisis in the insurance markets, HHS reissued its previously published 2017 methodology on an emergency basis, and reissued its previously published 2018 methodology after notice and comment. *See* Gov. Br. 12-14. Thus, the worst harms anticipated in the Wu declaration were averted by extraordinary agency efforts.

In both of those rulemakings, HHS set forth in detail its reasons for using a budget-neutral approach and the statewide average premium. *See* 83 Fed. Reg. 36,456, 36,457-59 (July 30, 2018); 83 Fed. Reg. 39,644, 39,646-48 (Aug. 10, 2018). The government called that additional explanation to the attention of the district court, in support of the pending Rule 59(e) motion. *See* Dkt. Nos. 81, 84. The district court refused to consider the additional explanation, however, because it was not given contemporaneously with the original issuance of the rules. *See NMHC II*, 340 F. Supp. 3d at 1179 (declaring that the court "does not appreciate HHS attempting to rationalize budget neutrality only now when it should have provided a conscious explanation when it proposed the formula in the first instance"). Echoing that reasoning, plaintiff asserts that the additional explanation should be ignored because it was not part of the administrative record for the original rules. *See* Pl. Br. 44-45.

That makes no sense. When a court remands to an agency for further explanation, it is inevitable that the additional explanation will postdate the original agency action. An agency cannot go back in time. The point of the district court's original remand order was to give HHS the opportunity to provide additional

explanation for its budget-neutral approach, which is exactly what HHS did. Contrary to plaintiff's contention, HHS's additional explanation did not "moot" the controversy. Pl. Br. 45. The additional explanation satisfied the original judgment and thus made relief under Rule 59(e) appropriate.

The district court compounded its errors by making its relief applicable nationwide, rather than tailoring it to plaintiff's injury. The Supreme Court has repeatedly admonished that a "plaintiff's remedy must be tailored to redress the plaintiff's particular injury." *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018). NMHC is the only plaintiff in this case. The application of the risk-adjustment methodology to NMHC is thus the proper subject of review, *see Lujan v. National Wildlife Fed'n*, 497 U.S. 871, 891 (1990), and the outer limit of any relief.

Moreover, although NMHC now asserts that the risk-adjustment methodology "was not specific to New Mexico," the CHOICES coalition previously recognized that the HHS risk-adjustment program operates on a State-by-State basis. *See* SA 148 ("Since the Risk Adjustment transfers are determined within each state's 'market rating areas,' any change adopted in a given state would not affect the Risk Adjustment transfers in any other state."). Indeed, HHS recently formalized a process by which a State may "request to reduce risk-adjustment transfers" based on "State-specific factors." 45 C.F.R. § 153.320(d).

It is especially difficult to fathom how a district court in New Mexico could effectively reverse the decision in *Minuteman*, which rejected the same arguments that

plaintiff makes here. If Minuteman had wished to challenge that adverse judgment, its recourse was to appeal to the First Circuit.[3] NMHC cannot properly seek relief on behalf of Minuteman or any other insurer.

CONCLUSION

The judgment of the district court should be reversed.

Respectfully submitted,

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[3] Although plaintiff suggests that Minuteman could not have appealed because it was put into receivership, *see* Pl. Br. 28 n.8, Minuteman was already in receivership during the district court litigation, *see Minuteman*, 291 F. Supp. 3d at 179. It is not unusual for the receiver of a defunct CO-OP to pursue litigation, as illustrated by the litigation in *Ommen v. United States*, No. 17-957C, 2017 WL 3882006 (Fed. Cl. Sept. 5, 2017), which plaintiff cites in its brief, *see* Pl. Br. 14 n.4.

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 4,311 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

s/ Joshua Revesz
Joshua Revesz

CERTIFICATE OF DIGITAL SUBMISSION

I hereby certify that (1) all required privacy redactions have been made; (2) any paper copies of this document submitted to the Court are exact copies of the version filed electronically; and (3) the electronic submission was scanned for viruses and found to be virus-free.

s/ Joshua Revesz
Joshua Revesz

CERTIFICATE OF SERVICE

I hereby certify that on June 3, 2019, I electronically filed the foregoing reply brief with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Joshua Revesz
Joshua Revesz