No. 19-10011

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS; STATE OF WISCONSIN; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

Plaintiffs-Appellees,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

Intervenor Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Texas (No. 4:18-cv-00167-O)

BRIEF OF AMICI CURIAE ALLIANCE OF COMMUNITY HEALTH PLANS AND ASSOCIATION FOR COMMUNITY AFFILIATED PLANS IN SUPPORT OF DEFENDANT-APPELLANTS

(Counsel Listed on Inside Cover)

A. Xavier Baker
Daniel W. Wolff
CROWELL & MORING LLP
1001 Pennsylvania Ave., N.W.
Washington, D.C. 20004
(202) 624-2500
xbaker@crowell.com

Counsel for Amici Curiae

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

s/ A. Xavier Baker
A. Xavier Baker
CROWELL & MORING LLP
1001 Pennsylvania Ave., N.W.
Washington, DC 20004
(202) 624-2500
xbaker@crowell.com

Counsel for Amici Curiae

Plaintiffs-Appellees:

State of Texas, State of Wisconsin, State of Alabama, State of Arizona, State of Florida, State of Georgia, State of Indiana, State of Kansas, State of Louisiana, State of Mississippi, State of Missouri, State of Nebraska, State of North Dakota, State of South Carolina, State of South Dakota, State of Tennessee, State of Utah, State of West Virginia, State of Arkansas, Neill Hurley, and John Nantz

Defendants-Appellants:

United States of America, United States Department of Health and Human Services, Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, United States Internal Revenue Service,

and Charles P. Rettig, in his Official Capacity as Commissioner of Internal Revenue

Intervenor Defendants–Appellants:

State of California, State of Connecticut, District of Columbia, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington, and the State of Minnesota

Intervenors:

United States House of Representatives, State of Colorado, State of Iowa, State of Michigan, and the State of Nevada

Amici:

Alliance of Community Health Plans, and Association for Community Affiliated Plans

Counsel:

For Plaintiffs-Appellees:
Kyle D. Hawkins, Andrew B. Davis, Matthew H. Frederick, David J. Hacker, Darren L. McCarty, Eric A. White, and Corey F. Finkelmeyer of the State of Texas
Robert E. Henneke of Texas Policy Foundation

For Defendants-Appellants:
Brett Shumate and Martin V. Totaro

For Intervenor Defendants-Appellants:
Samuel Siegel, Kathleen Boergers, Nimrod Elias, and Neli N. Palma of the State of California
Joseph Rubin of the State of Connecticut
Caroline Van Zile of the District of Columbia
Jessica Willey of the State of Delaware

Robert Tadao Nakatsuji of the State of Hawaii
Bridet DiBattista of the State of Illinois
Steven B. Vogel of the State of Massachusetts
Matthew J. Berns and Kimberly Cahall of the State of New Jersey
Maria Rose Lenz of the State of Rhode Island
Benjamin Battles of the State of Vermont
Matthew R. McGuire of the State of Virginia
Jeffrey T. Sprung of the State of Washington
Scott H. Ikeda of the State of Minnesota

For Intervenors:
Douglas N. Letter, Kristin A. Shapiro, Todd B. Tatelman, and Brooks M. Hanner of U.S. House of Representatives
Donald B. Verrilli, Jr., Ginger Anders, Jonathan Meltzer, Rachel Miller-Ziegler, and Elaine Goldenberg of Munger, Tolles & Olson, L.L.P.
Brian R. Frazelle, Ashwin Pradyumna Phatak, Elizabeth B. Wydra, and Brian Gorod of Constitutional Accountability Center
Eric Olson of the State of Colorado
Nathanael Blake of the State of Iowa
Fadwa A. Hammoud of the State of Michigan
Heidi P. Stern of the State of Nevada

For Amici:
A. Xavier Baker and Daniel W. Wolff of Crowell & Moring LLP

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS i
TABLE OF AUTHORITIES v
INTEREST OF AMICI CURIAE 1
INTRODUCTION 2
SUMMARY OF ARGUMENT 8
ARGUMENT 11
I. THERE WAS NO BASIS FOR THE DISTRICT COURT TO CONCLUDE THAT CONGRESS WOULD HAVE PREFERRED NO ACA ABSENT THE INDIVIDUAL MANDATE. 12
II. THE ACA REMAINS OPERATIVE WITHOUT THE INDIVIDUAL MANDATE. 23
III. THE LOSS OF THE ACA WOULD HAVE DELETERIOUS CONSEQUENCES TO *AMICI CURIAE* MEMBER HEALTH PLANS. 25
IV. CONCLUSION 33
CERTIFICATE OF SERVICE
CERTIFICATE OF COMPLIANCE

TABLE OF AUTHORITIES

Page(s)

Cases

Alaska Airlines, Inc. v. Brock,
480 U.S. 678 (1987) 23

Ayotte v. Planned Parenthood of N. New England,
546 U.S. 320 (2006) 15

Denver Area Ed. Telecommunications Consortium, Inc. v. FCC,
518 U.S. 727 (1996) 15, 17

Executive Benefits Ins. Agency v. Arkinson,
573 U.S. 25 (2014) 13, 20

Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.,
130 S. Ct. 3138 (2010) 15

Marbury v. Madison,
5 U.S. 137 (1803) 14

Nat'l Federation of Indep. Business v. Sebelius,
132 S. Ct. 2566 (2012) 3, 11

Regan v. Time, Inc.,
468 U.S. 641 (1984) 13, 14, 15

Texas v. United States,
340 F. Supp. 3d 579 (N.D. Tex. 2018) 23

Texas v. United States,
352 F. Supp. 3d 665 (N.D. Tex. 2018) 16, 17, 20

United States v. Booker,
543 U.S. 220 (2005) 14, 17, 21

United States v. City & Cty. of San Francisco, 310 U.S. 16 (1940) 22

Statutes

ACA § 1302 26

ACA § 1332 26

ACA § 1401 26

ACA § 1402 26

ACA Title II, Subtitle A 26, 28

Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010) 7

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010) 7

Pub. L. No. 115-97, 131 Stat. 2054 (2017) 3, 11

Other Authorities

ACAP, Medicaid Managed Care: An ACAP Analysis (June 19, 2018) 7, 27

ACHP 2018 Annual Report 27

Bob Bryan & Zachary Tracer, *The Newest Obamacare Enrollment Numbers Prove the Health Law Is 'Far From Dead' Despite Repeated Attacks from Trump and the GOP*, Business Insider (Dec. 20, 2018) 25

CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018) 32

CBO, *Options for Reducing the Deficit: 2017 to 2026* (Dec. 2016) 24

CBO, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Nov. 2017) 24

Cunningham, Paige W., "Rubio: Defund ACA for spending deal" (July 11, 2013). 19

Juliette Cubanski, Tricia Neuman, Gretchen Jacobson, Cristina Boccuti, What are the Implications of Repealing the Affordable Care Act for Medicare Spending and Beneficiaries, Kaiser Family Foundation (Dec. 13, 2016) 31

Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer- Key Facts about Health Insurance on the Eve of Coverage Expansions* (Washington, DC: Kaiser Family Foundation), October 23, 2013. 25

Kaiser Family Foundation, Medicaid's Role for Individuals with HIV (April 18, 2017) 31

Kaiser Family Foundation State Health Facts, "Status of State Action on the Medicaid Expansion Decision," accessed February 2019 28

Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision (Feb. 13, 2019) 25

Madison Adler, Trump HIV Goal Not Possible Without Obamacare, Advocates Say, Bloomberg (Mar. 27, 2019) 30

Redhead, C. Stephen and Janet Kinzer, Congressional Research Serv., "Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act" (Feb. 5, 2016) 19

Richard C. Lindrooth, Marcelo C. Perraillon, Rose Y. Hardy, and Gregory J. Tung, Understanding the Relationship Between Medicaid Expansions and Hospital Closures, Health Affairs Vol 37, No. 1 (January 2018) 30

INTEREST OF AMICI CURIAE[1]

The Alliance of Community Health Plans ("ACHP") is a national leadership organization whose members are not-for-profit, community-based, and regional health plans or subsidiaries of not-for-profit health systems. ACHP's 24 members are non-profit, community-based plans active in 34 states and the District of Columbia, providing both private and public coverage to nearly 22 million Americans, including 2.6 million Medicare beneficiaries. Thus, ACHP members' interests will be affected by the outcome of this appeal. ACHP respectfully submits this *amicus* brief to highlight the harm its members will suffer if the district court's ruling striking the entire Affordable Care Act is upheld and to urge the Court to reverse that decision.

The Association for Community Affiliated Plans ("ACAP") is a national trade association representing 64 not-for-profit and community-based health plans in 28 states that provide health

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than *amici* or their counsel made a monetary contribution for preparation or submission of this brief. All parties have consented to the filing of this brief.

coverage to more than 20 million people through Medicaid, Medicare, and Marketplace plans, and other public health coverage programs. Many enrollees are among the nation's poorest and sickest people who lack access to other health insurance. In contrast to many other insurers, ACAP health plans primarily participate in the low-margin Medicaid market and rarely participate in the higher-margin large group employer market. Further, as community-based plans committed to serving vulnerable people, ACAP member plans are integral parts of their community's fragile "safety net." With ACHP, ACAP submits this *amicus* brief to highlight the harm its members will suffer if the district court's decision striking the Affordable Care Act is permitted to stand.

INTRODUCTION

The irony of this case punctuates the legal flaws in the district court's holding. Seeking to facilitate broader individual participation in the health insurance market in order to spread risk among a broader pool of insureds and keep premium costs relatively low, Congress included as part of the 2010 Affordable Care Act a requirement that individuals purchase insurance if not otherwise

covered under a group plan (*e.g.*, an employer-offered health insurance plan). To enforce the individual mandate, Congress also created a monetary penalty for non-compliance, enforced by the Internal Revenue Service based on annual tax returns.

The mandate was challenged in court on grounds of congressional overreach; that it impinged on individual rights reserved to the People under our Constitution. The case eventually reached the Supreme Court, which upheld the individual mandate in combination with the penalty for non-compliance (the so-called "shared-responsibility payment") under Congress' taxing powers. *See Nat'l Federation of Indep. Business v. Sebelius*, 132 S. Ct. 2566 (2012).

In 2017, Congress zeroed out the penalty, *i.e.*, it kept the mandate and the tax penalty provision, but it reduced the tax to $0. Pub. L. No. 115-97, 131 Stat. 2054 (2017). That modification effectively repealed the penalty and thus neutralized the burden of the individual mandate.

According to the plaintiffs, the 2017 tax legislation also undercut the basis for the result in *Sebelius*, which is why, in this case, the individual mandate is challenged for precisely the opposite reason: the

plaintiffs say that because the penalty has been eliminated, the mandate can no longer be justified under Congress' taxing powers. What is more, the plaintiffs say, the entire ACA must fall with the mandate because Congress never would have intended an ACA without the mandate.

Below, despite the lack of empirical evidence that any plaintiff is actually harmed by Congress eliminating the tax for non-compliance with the individual mandate, the court held that plaintiffs had standing to file their suit. The court then agreed that since the tax was zeroed out by the 2017 tax law, the basis for the *Sebelius* Court's decision upholding the constitutionality of the individual mandate no longer existed, meaning the mandate was no longer constitutional. Finally, focusing largely on the importance of the individual mandate to the *effectiveness* of the ACA, the district court agreed with the plaintiffs that Congress would not have intended the ACA to exist absent the mandate. It held, therefore, that the individual mandate could not be severed from the ACA without rendering the entire law invalid. And because the mandate was unconstitutional, the entire ACA must fail.

The district court erred in almost every facet of its decision. This brief focuses on its flawed severability analysis. It also focuses on the harms that the decision will have to *amici*.

Amici curiae are the Alliance of Community Health Plans ("ACHP"),[2] a national leadership organization whose members are non-profit, community-based, and regional health plans or subsidiaries of non-profit health systems; and the Association for Community Affiliated Plans ("ACAP")[3], a national trade association

---

[2] ACHP's members include: Aultcare (OH), AvMed (FL), Capital District Physicians' Health Plan (NY), Capital Health Plan (FL), CareOregon (OR), CommunityCare (OK), Dean Health Plan (WI), Fallon Health (MA), Geisinger Health Plan (PA), Group Health Cooperative of South Central Wisconsin (WI), Harvard Pilgrim Health Care (MA), Health Alliance (IL), Health Alliance Plan (MI), HealthPartners (MN), Independent Health Plan (NY), Kaiser Foundation Health Plan, Permanente Federation, Martin's Point Health Care (ME), Pacific Source Health Plans (OR), Presbyterian Health Plan (NM), Priority Health (MI), Scott and White Health Plan (TX), Security Health Plan (WI), SelectHealth (UT), UCare (WI), and UPMC Health Plan (PA).

[3] Health plans represented by ACAP include: Affinity Health Plan (N.Y.), Alameda Alliance for Health (Calif.), Alliance Health (N.C.), AlohaCare (Hawaii), AmeriHealth Caritas Louisiana (La.), AmeriHealth Caritas Pennsylvania (Penn.), Amida Care (N.Y.), Banner University Health Plans (Ariz.), Boston Medical Center HealthNet Plan (Mass.), CalOptima (Calif.), Cardinal Innovations Healthcare (N.C.), CareOregon (Ore.), CareSource Ohio (Ohio), CenCal Health (Calif.), Central California Alliance For Health (Calif.), Children's Community Health Plan (Wisc.), Children's Medical Center Health Plan (Texas),
(Continued…)

representing not-for-profit community health plans. Together, ACHP and ACAP member plans deliver affordable, high-quality coverage and care for more than 40 million Americans in 39 states and the District of Columbia. As mission-driven organizations, member plans have been a strong and stable presence in their communities and states, some for decades.

Commonwealth Care Alliance (Mass.), Community Care Plan (Fla.), Community Health Choice (Texas), Community Health Group (Calif.), Community Health Network of Connecticut (Conn.), Community Health Plan of Washington (Wash.), Contra Costa Health Plan (Calif.), Cook Children's Health Plan (Texas), CountyCare (Ill.), Denver Health (Colo.), Driscoll Health Plan (Texas), El Paso First Health Plans (Texas), Elderplan | HomeFirst (N.Y.), Gateway Health Plan (Penn.), Geisinger Health Plan (Penn.), Gold Coast Health Plan (Calif.), Health Partners Plans (Penn.), Health Plan of San Joaquin (Calif.), Health Plan of San Mateo (Calif.), Health Services for Children with Special Needs (D.C.), Hennepin Health (Minn.), Horizon NJ Health (N.J.), Inland Empire Health Plan (Calif.), Kern Family Health Care (Calif.), L.A. Care Health Plan (Calif.), Maryland Community Health System (Md.), MDwise (Ind.), Montana Health CO-OP (Mont.), My Choice Family Care (Wisc.), Nascentia Health (N.Y.), Neighborhood Health Plan of Rhode Island (R.I.), Parkland Community Health Plan (Texas), Partnership Health Plan of California (Calif.), Passport Health Plan (Ky.), Prestige Health Choice (Fla.), Priority Partners (Md.), San Francisco Health Plan (Calif.), Santa Clara Family Health Plan (Calif.), Sendero Health Plans (Texas), Texas Children's Health Plan (Texas), University of Utah Health Plans (Utah), UPMC for You (Penn.), VillageCareMAX (N.Y.), Virginia Premier Health Plan (Va.), VNSNY CHOICE Health Plans (N.Y.), Well Sense Health Plan (N.H.), YourCare Health Plan (N.Y.),

ACHP's and ACAP's members began offering qualified health plans ("QHPs") in 2014 on the health exchanges that the Patient Protection and Affordable Care Act ("ACA")[4] established throughout the country. Likewise, ACHP's and ACAP's members insured newly eligible persons under the ACA's expansion of Medicaid benefits, covering approximately 50% of Medicaid beneficiaries (expansion or otherwise)[5], helping previously uninsured persons access healthcare—many for the first time. The ACA also enabled ACHP and ACAP members to provide more Medicare benefits with lower costs to enrollees. In short, the ACA empowered ACHP and ACAP members to realize their core mission: providing cost-effective, comprehensive health care to their communities.

---

[4] The Affordable Care Act (the "Act" or the "ACA") is actually comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010).

[5] ACAP, Medicaid Managed Care: An ACAP Analysis (June 19, 2018) *available at* https://www.communityplans.net/wp-content/uploads/2019/03/MMC-Enrollment-Infographic-061918.pdf.

SUMMARY OF ARGUMENT

For the reasons raised by State Defendants and Intervenor House of Representatives, the complaint below should have been dismissed on grounds that the plaintiffs all lack standing—the plaintiffs were not injured by the elimination of the shared-responsibility payment. The district court also stumbled on the merits, failing to recognize that the elimination of the penalty did not eliminate any constitutional basis for the individual mandate—because the mandate no longer imposes a burden on Americans, it no longer impinges on any individual liberties, privileges, or immunities that might put it crosswise with the Constitution.

But even assuming the district court was not wrong about those issues, its severability analysis falls far short under Supreme Court precedent. The linchpin to conventional severability analysis is whether Congress would have intended the balance of a law to remain in effect where a specific provision within the law is held by a court to be unconstitutional. The question is not what Congress originally intended—obviously, Congress' original intent is the law that it enacted, unconstitutional provisions and all. The question is more

speculative—what would Congress have intended if it had known a provision would not withstand constitutional scrutiny.

Below, the court gave outsized weight to what Congress wanted in 2010. That was wrong because, obviously, *in 2010*, Congress wanted an enforceable and effective individual mandate. And there is no doubt the individual mandate was thought to be key to the ACA achieving its maximum potential. But reviewing what Congress enacted, and the many statements in support of the importance of the individual mandate, as the district court did, avoids the question required for conventional severability analysis: would Congress have still wanted the balance of the ACA even if it could not have the individual mandate. The district court's flawed reasoning is even starker in this case because Congress itself answered the question *in 2017* by *keeping the balance of the ACA intact* even while zeroing out the shared-responsibility penalty and thereby rendering the compulsive effect of the individual mandate nugatory. In other words, this is an easier case than most severability cases because Congress, in eliminating the individual mandate in practical terms, nonetheless kept the remainder of the law. Thus, by 2017, Congress no longer intended the ACA to have an enforceable and

effective individual mandate: it changed its mind, as is its right. That answers the severability question.

In addition to this showing of actual intent, there is also empirical evidence that the rest of the law still functions without the individual mandate. Notwithstanding the elimination of the penalty, millions of Americans enrolled for health care insurance through the ACA exchanges for coverage in 2019—they did so not because they otherwise would have faced a tax, but because the ACA still provides the infrastructure for health insurance that would otherwise be lacking. The very fact of its continued existence belies the district court's belief that the ACA would be doomed without the mandate.

Finally, the court's decision does a huge disservice to the many Americans who rely not only on coverage under the ACA, and the plans—including *amici curiae*'s member plans—that provide that coverage. It also ignores the many provisions of the ACA that have no relationship to the individual mandate and never depended on the mandate in order to operate. The decision makes bad law by ignoring Supreme Court precedent, and in the process it will wreak terrible consequences for society. This Court should reverse.

ARGUMENT

For the reasons raised by State Defendants (at 25-27) and Intervenor House of Representatives (at 20-35), the plaintiffs lack standing. In 2012, critics of the ACA challenged the individual mandate as unconstitutional. The Supreme Court disagreed and upheld the mandate because, in combination with the share-responsibility payment for non-compliance, it represented a lawful exercise of Congress' power to tax. *See Sebelius*, 132 S. Ct. at 2600. In 2017, tracking the plaintiffs who lost in *Sebelius*, Congress eliminated the penalty, which effectively neutralized any practical effect of the individual mandate. Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054 (2017). It cannot credibly be found that the effective elimination of the individual mandate gives rise to a cognizable injury for purposes of standing to challenge the rest of the ACA.

Furthermore, for the reasons stated in the briefs of the State Defendants (at 27-33) and Intervenor U.S. House of Representatives (at 35-40), the district court erred in holding that the individual mandate is unconstitutional. Given that the penalty for non-compliance has been

eliminated, the fact of the matter is that the individual mandate now has no impact on individual rights or liberties. As such, it cannot offend any individual rights, liberties, privileges, or immunities otherwise reserved to the People under the Constitution.

But even assuming for the sake of argument that plaintiffs have standing and that the district court's determination that the individual mandate is unconstitutional was correct, its follow-on conclusion that the ACA must, as a result, be stricken in its entirety finds absolutely no support in Supreme Court precedent. Indeed, empirical evidence about the operability of the ACA even in the absence of the mandate proves the fallacy of the lower court's decision. Furthermore, there are strong policy reasons that compel reversal.

I. There Was No Basis For The District Court To Conclude That Congress Would Have Preferred No ACA Absent The Individual Mandate.

The district court determined that the individual mandate was no longer a tax, and therefore no longer a constitutional exercise of congressional authority, after the 2017 Tax Cuts and Jobs Act removed the individual mandate penalty. The court then found that the individual mandate was not severable from the rest of the ACA, rendering the entire ACA invalid.

The district court's severability analysis finds no support in the Supreme Court precedent the court purported to apply. The usual rule, oft repeated, is that the courts should do as little damage to a statutory scheme as possible, and thus presume that Congress would prefer a statute to stand subject to excision of its unconstitutional provisions rather than see the entire statute fail. *See generally Executive Benefits Ins. Agency v. Arkinson*, 573 U.S. 25, 36-37 (2014); *accord Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (recognizing a presumption in favor of severability).

> In exercising its power to review the constitutionality of a legislative Act, a federal court should act cautiously. A ruling of unconstitutionality frustrates the intent of the elected representatives of the people. Therefore, a court should refrain from invalidating more of the statute than is necessary. As this Court has observed, 'whenever an act of Congress contains unobjectionable provisions separable from those found to be unconstitutional, it is the duty of the court to so declare, and to maintain the act in so far as it is valid.'

Regan, 468 U.S. at 652 (quoting *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909)).

In the usual case, the analysis inevitably requires some guesswork on the part of the courts to discern what Congress would have intended.

See id. It is guesswork because, as stated in *Regan*, the most obvious intent is the one the court rejects: the statute as written, voted on, presented to the President, and enacted into law. But inasmuch as it is the role of the judiciary to say what the law is, *Marbury v. Madison*, 5 U.S. 137, 177 (1803), when a court holds a statutory provision to be unconstitutional, it must choose for the remainder of the law between two remedies neither of which Congress could possibly have actually intended: (1) no statute at all; or (2) a statute excised of its unconstitutional parts.[6] The court must therefore discern (*i.e.*, guess) what Congress would have done had it had the benefit of the court's holding that the offending provision is unconstitutional. *See United States v. Booker*, 543 U.S. 220, 265 (2005) (describing the inquiry as focused on the "likely intent" of Congress "in light of" the court's

[6] In *United States v. Booker*, 543 U.S. 220 (2005), the Court considered a third alternative: engrafting a new, judicially imposed, requirement on to the statute to salvage the constitutionality of all of the original provisions. The majority opted to excise the unconstitutional provision rather than neutralize it with a judicially superimposed requirement which Congress never considered. *See* 543 U.S. at 246-47, 252. Either approach to saving some semblance of the statute, the Court acknowledged, "would significantly alter the system that Congress designed." *Id.* at 246.

decision). Left with those two choices, "the presumption is in favor of severability." *Regan*, 468 U.S. at 653.

The question of intent usually requires focusing on the enacting Congress and asking (speculatively) what it would have done had it been aware of the constitutional infirmity. *See*, *e.g.*, *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006); *Denver Area Ed. Telecommunications Consortium, Inc. v. FCC*, 518 U.S. 727, 767 (1996). This inquiry is imperfect because, obviously, Congress could not have actually intended a statute in a form it did not actually enact. *See Ayotte*, 546 U.S. at 329 (recognizing that a "ruling of unconstitutionality frustrates the intent of the elected representatives of the people").

Fortunately, in this instance, this Court should find the guesswork far less uncomfortable than in the normal "what-would-Congress-have-intended" case because Congress itself has already provided a huge clue about what it would prefer: by zeroing out in the 2017 tax law the tax upheld in *Sebelius* (and thus neutralizing the individual mandate as a practical, if not legal, matter) while *leaving the*

rest of the ACA intact, Congress has directly signaled what it intends—keep the rest of the statute.

The district court fumbled this analysis, both (i) by placing outsized weight on the 2010 Congress that enacted the ACA instead of the 2017 Congress that amended the ACA in relevant part, and (ii) in emphasizing the *original* intent of Congress in enacting the ACA at the expense of discerning the *likely* intent of Congress had it been aware of the constitutional infirmity.

In evaluating what Congress would have intended, the district court focused its attention on what Congress *wanted at the time it passed the ACA*.[7] To this end, the court focused on various statements and pronouncements—in the legislation itself and in the copious opinions from the two key Supreme Court decisions passing on other aspects of the ACA—indicating the central importance of the individual mandate to the ACA as its creators envisioned. *See Texas v. United*

[7] The court purported to consider intent both as of the time of original enactment (2010) and as of the 2017 amendment. But it emphasized the intent of the 2010 Congress and dismissed the intent of the 2017 Congress. As explained here and in the opening briefs of State Defendants and Intervenor U.S. House of Representatives, that analysis was flawed.

States, 352 F. Supp. 3d 665, 685–86 (N.D. Tex. 2018). Given the centrality of the individual mandate to the ACA as a whole, the district court concluded that if the individual mandate must fall, so must the rest of the statute. *See id*.

The shortcoming to the court's analysis is that it focused on the wrong measure of intent and the wrong point in time. In addressing "intent" as part of a severability analysis, the question is not what Congress actually intended when it enacted the legislation at issue—the statute as enacted will *always* answer that question. Rather, the target of the inquiry is a more fictional intent, namely "Congress' likely intent *in light of*" the court's holding that a portion of the statute is unconstitutional. *Booker*, 543 U.S. at 265 (emphasis in original). *See also Denver Area Ed. Telecommunications Consortium*, 518 U.S. at 767. In other words, what would Congress intend *now*, in light of the court finding the individual mandate unconstitutional? Thus, the requisite intent cannot be found in the legislation as originally enacted. And it certainly cannot be found in the dicta of Supreme Court opinions.

Nor is the intent of the 2010 Congress the correct reference point in this case since it was not the 2010 Congress that zeroed out the

penalty for not buying individual coverage. In this case, the legislation that drives the "intent" analysis is the ACA as modified by the 2017 tax law. Accordingly, it is the intent of that later Congress which provides the more logical frame of reference for discerning the "likely" intent of Congress. After all, Congress in 2017 effectively eliminated the legal impact of the individual mandate yet chose not to modify the ACA in other regards, much less repeal it altogether. That is powerful, if not dispositive, evidence that Congress did in fact intend for the ACA to exist even in the absence of the mandate.

It is no answer to this recent legislative history to say, as the district court did, that Congress focused narrowly on the penalty in the 2017 tax law only because the House was operating pursuant to budget reconciliation rules and could not, by those rules, touch the substance of the law. That misses the forest through the trees.

If anything, the fact that Congress was only able to modify the ACA through reconciliation augments the point that Congress did not intend any larger dismantling of the ACA—if nothing else, it did not have the votes. It need hardly be pointed out that the ACA has been the focus of heavily splintered opinion, in Congress and beyond, since even

before the exchanges went into effect in 2014.[8] Bills introduced to repeal the ACA number in the dozens.[9] Nonetheless, and despite the recent two-year period of one-party rule (January 2017-January 2019) by a party that has been openly and notoriously hostile to the ACA from the outset, Congress never repealed the ACA.[10] Through the bicameral legislative process, it accomplished a far more modest modification: the effective repeal of the shared-responsibility payment, in turn neutralizing the individual mandate. Accordingly, Congress actively expressed its most recent intent by leaving the balance of the ACA intact.[11]

---

[8] *See*, *e.g.*, Cunningham, Paige W., "Rubio: Defund ACA for spending deal" (July 11, 2013), *available at* http://www.allsides.com/news/2013-07-11-1202/marco-rubio-says-he-wont-back-spending-deal-without-obamacare-cut (describing Republican pledge that "I will not vote for a continuing resolution unless it defunds Obamacare").

[9] *See* Redhead, C. Stephen and Janet Kinzer, Congressional Research Serv., "Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act" (Feb. 5, 2016), *available at* https://fas.org/sgp/crs/misc/R43289.pdf. *See generally* Brief of U.S. House of Representatives at 7-8 & nn. 1&2.

[10] *See generally* State Defendants' Brief at 11 (citing multiple recent repeal efforts).

[11] *Accord* State Defendants' Br. at 40 (citing views of legislators affirming that the 2017 tax law did nothing more than eliminate the penalty). *Accord* Brief of U.S. House of Representatives at 8.

In light of this recent and actual legislative history, as compared to the district court's examination of the history associated with the law as originally enacted, it was plainly erroneous for the district court to conclude that Congress would have, *in light of the district court's holding regarding the unconstitutionality of the individual mandate*, "preferred no statute at all"[12] to the very statute it left standing in 2017 and has continued to leave standing to the present.[13]

Booker is a helpful comparison. That case concerned the federal sentencing guidelines ("Guidelines"), which Congress made binding on

---

[12] *See Exec. Benefits Ins. Agency v. Arkison,* 134 S. Ct. 2165, 2173, 189 L. Ed. 2d 83 (2014).

[13] The district court called it a "fool's errand" to look to the 2017 Congress for the relevant "intent," and stressed that even the 2017 Congress only zeroed out the penalty and did not eliminate the individual mandate. *Texas v. United States*, 340 F. Supp. 3d, 579, 616 (N.D. Tex. 2018), *stay granted*, 352 F. Supp. 3d 665 (Dec. 30, 2018), *appeal docketed*, No. 19-10011 (Jan. 7, 2019). That again misses the point. While it is perhaps a fool's errand for a court *ever* to try to discern congressional intent, especially in a context in which the question is hypothetical—*What would Congress "likely" have done had it known what the court is now saying?*—here the question is far less hypothetical: the 2017 Congress provides recent and relevant historical context. By eliminating the shared-responsibility penalty, which it knew would neutralize the mandate, while never touching any other aspect of the ACA, the 2017 Congress (leaving the ACA largely intact) offers reliable, and perhaps even dispositive, perspective on what the otherwise fictional Congress (the post-decisional Congress with clarity on the constitutional infirmity) would have intended.

federal district court judges under the Sentencing Reform Act of 1984. The Court held that the statutory provision making the Guidelines mandatory (along with one other provision) had to be severed, but that the remainder of the Guidelines could be salvaged. 543 U.S. at 245. Dissenting from that portion of the holding, Justice Stevens criticized the majority for upsetting "Congress' unmistakable commitment to a binding Guidelines system." *Id.* at 784 (Stevens, J., dissenting in part). Responding, the majority did not disagree with Justice Stevens that it was disrupting what Congress originally intended: "We do not doubt that Congress, when it wrote the Sentencing Act, intended to create a form of mandatory Guidelines system." *Id.* at 767. The point to the inquiry, however, stressed the majority, was "to determine Congress' likely intent *in light of today's holding*." *Id.* at 767-68.

So, too, with the ACA. The district court was no doubt correct in concluding that Congress, in 2010, saw the individual mandate as a vital and even necessary part of the ACA to achieve the full ends of the law that its champions desired. But the mandate's inclusion in the ACA goes to the law's efficacy, not its ability to function without it. It may well be (indeed, it no doubt is) that the ACA works less well absent the

individual mandate than with it. But a statute that works less well is not the same thing as a statute that does not work at all. And, as noted below in Part II, ample empirical evidence shows the ACA continues to work by, among other things, providing a health insurance platform on which *millions of Americans rely* to obtain coverage, even if not as originally designed. In any event, the efficacy of a law is not usually the concern of the federal courts. *See*, *e.g.*, *United States v. City & Cty. of San Francisco*, 310 U.S. 16, 26, 60 S. Ct. 749, 755, 84 L. Ed. 1050 (1940) ("It is not the office of the courts to pass upon … the efficacy of the measures chosen for putting [a law's underlying policy] into effect.")

Moreover, as addressed below in Part III, the function of many provisions of the ACA never had any relationship to the individual mandate, so the idea that Congress would not have intended those constitutional provisions—of vital importance to members of *amici* for the reasons described below—to operate in the absence of the mandate makes no sense under any set of circumstances.

The ACA remains an important federal program, independent of the individual mandate. To date, Congress has chosen not to eliminate

the vast majority of the ACA. It is not for the courts to upset that legislative choice.

II. The ACA Remains Operative without the Individual Mandate.

One measure of whether an unconstitutional provision can be severed from a statute without toppling the entire statute—in other words, one jurisprudential proxy for congressional "intent"—is whether the remaining statutory scheme can continue to function with the unconstitutional provision excised, *i.e.*, is the statute operable absent the stricken provision. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) ("Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently"). Here, the answer is clearly yes.

As the district court seems to have construed it, the rest of the ACA would founder without the mandate given the importance of the mandate to the economics of the ACA as a whole, *i.e.*, without the mandate, the ACA would not effectively control for rising costs of insurance as envisioned by its promoters. *See Texas v. United States*, 340 F. Supp. 3d 579, 608–09 (N.D. Tex. 2018). As indicated above, the

district court conflated operability with efficacy. History has shown and continues to show that the individual mandate, while no doubt preferred by the ACA's promoters in Congress, is not (as the district court construed it) necessary to the ACA's ability to function.

Before Congress passed the Tax Cuts and Jobs Act in 2017, the Congressional Budget Office assessed the effects of both repealing the individual mandate and zeroing out the penalties associated with the mandate while keeping the provision in place. *See* CBO, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Nov. 2017). The CBO found that "nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade." *Id.* at 1; *see also* CBO, *Options for Reducing the Deficit: 2017 to 2026* at 237 (Dec. 2016) (finding that adverse selection problems created by repeal of individual mandate would be mitigated by premium subsidies, greatly reducing the effect of premium increases on coverage for subsidized enrollees).

Knowing that, Congress kept the mandate (along with everything else but the penalty) but neutralized its force by eliminating the penalty for non-compliance. Yet even facing no penalty for not doing so, nearly

as many Americans enrolled for coverage on the marketplaces in 2019 as in 2018.[14] And States continue to expand Medicaid.[15] The idea that the ACA cannot operate without the mandate is empirically false.

III. The Loss Of The ACA Would Have Deleterious Consequences To *Amici Curiae* Member Health Plans.

Prior to the enactment of the ACA in 2010, approximately 47 million Americans did not have health insurance.[16] Congress sought to make comprehensive health insurance available and affordable for all

[14] *See* Bob Bryan & Zachary Tracer, *The Newest Obamacare Enrollment Numbers Prove the Health Law Is 'Far From Dead' Despite Repeated Attacks from Trump and the GOP*, Business Insider (Dec. 20, 2018), https://www.businessinsider.com/obamacare-open-enrollment-sign-ups-down-4-after-gop-trump-changes-2018-12. The only source the district court cited for the proposition that eliminating the mandate would undermine other provisions of the Act is a book published before the mandate even went into effect. See ROA.2657 (citing Josh Blackman, *Unprecedented: The Constitutional Challenge to Obamacare* 147 (2013)).

[15] Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision (Feb. 13, 2019) *available at* https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (showing that as-of Feb. 13, 2019, 37 states and the District of Columbia had expanded Medicaid, including States that did so effective in 2019).

[16] Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer- Key Facts about Health Insurance on the Eve of Coverage Expansions* (Washington, DC: Kaiser Family Foundation), October 23, 2013. *Available at*: http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/

Americans through the ACA. To do so, Congress included provisions in the ACA, *inter alia*, to: (1) ensure coverage of essential health benefits, such as maternity care and mental health and substance use disorder services, in individual and small group insurance policies[17]; (2) enable consumers to purchase and afford health insurance via advance premium tax credits and reduced cost-sharing requirements[18]; (3) encourage States to expand Medicaid eligibility[19]; (4) empower State innovation[20]; and (5) improve Medicare benefits and quality.[21]

Each of those provisions—to say nothing of the scores of other sections in the ACA—exists independently from and is not dependent on the shared responsibility payment or the individual mandate.[22] Moreover, they are critically important to ACHP's and ACAP's member health plans because their insureds include persons covered via the ACA's Medicaid expansion, improved Medicare benefits, or under Marketplace plans. For example, not for profit plans, such as ACAP and

---

[17] ACA Section 1302.
[18] ACA Sections 1401 and 1402.
[19] ACA Title II, Subtitle A.
[20] ACA Section 1332.
[21] ACA Title III.
[22] *See* Intervenor's Opening Brief at 47-48.

ACHP's member plans, serve approximately 50 percent of all Medicaid Managed Care Enrollment.[23] And the coverage provided via ACHP and ACAP members is nationally recognized as high-quality and delivering excellent outcomes for their enrollees, realizing a clear goal of the ACA: access to affordable, high-quality healthcare.[24]

If this Court sustains the trial court's ruling, it will have disastrous effects on millions of people's ability to access and afford health care and may cripple the ability of ACHP and ACAP member plans to serve their communities' needs for high-quality healthcare. For example, Community Health Choice, Inc. ("Community"), an ACAP member in Harris County, Texas, was created by the Harris County Hospital District as a separate not-for-profit organization specifically to serve low-income, underserved residents of the Houston area by becoming licensed as a health maintenance organization and contracting with the State of Texas for its Medicaid Managed Care

---

[23] ACAP, Medicaid Managed Care: An ACAP Analysis (June 19, 2018) *available at* https://www.communityplans.net/wp-content/uploads/2019/03/MMC-Enrollment-Infographic-061918.pdf.
[24] *See, e.g.,* ACHP 2018 Annual Report, at 8 (citing recognitions of member plans as highly rated by CMS and other evaluators), *available at* https://www.achp.org/wp-content/uploads/ACHP-Annual-Report-2018.pdf.

program. It has been serving low-income residents who qualify for Medicaid since 1997, and entered the federally-facilitated health insurance marketplace in 2014. Community offered seven plans in the Texas ACA marketplace in 2018.

Community serves approximately 275,000 Medicaid or CHIP insurance recipients and roughly 110,000 people under its marketplace plans. Community estimates that more than 80,000 of its marketplace enrollees rely on the ACA's advance premium tax credit and/or cost-sharing reductions to afford coverage. Because Community serves a low-income population, many of its members previously were uninsured, have pre-existing conditions, cannot afford large deductibles, and lacked access to health insurance and, by extension, much-needed medical care.

The ACA's optional Medicaid expansion enabled millions of previously uninsured individuals at or below 138% of the federal poverty level in 36 states and the District of Columbia (as-of March 2019) to access Medicaid benefits and obtain health care.[25] Medicaid

---

[25] ACA Title II, Subtitle A; *See* Kaiser Family Foundation State Health Facts, "Status of State Action on the Medicaid Expansion Decision," (Continued…)

expansion eliminates the "coverage gap" between traditional Medicaid eligibility (limited to low-income families, qualified pregnant women and children, and the aged, blind, or disabled) and qualification for federal subsidies to purchase coverage through the Exchanges. Many ACHP and ACAP members who provide Medicaid managed care benefits to beneficiaries also provide coverage through the Exchanges, enabling continuity of care and consistency for beneficiaries who transition from Medicaid to private insurance available via the Exchanges.

Moreover, Medicaid expansion has improved access to health care services because it has had a stabilizing effect on hospitals and other providers—particularly in rural areas. A Health Affairs study determined that Medicaid expansion prevents hospital closures because it reduces hospitals' exposure to uncompensated care for uninsured individuals, "especially in rural markets and counties with large

---

accessed February 2019, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

numbers of uninsured adults before Medicaid expansion."[26] ACHP and ACAP members rely on and partner with rural hospitals and other providers to ensure adequate networks to deliver health care services for Medicaid, Medicare, and Exchange plan members.

Likewise, Medicaid expansion, the ACA's nondiscrimination provision, Section 1557, prohibition on preexisting condition limitations, and guaranteed issue requirements have enabled persons with HIV to access health care benefits *before* their disease progressed to AIDS. Historically, many HIV patients were unable to access health insurance coverage until qualifying for Medicaid benefits via disability resulting from AIDS.[27] Medicaid expansion alone has reduced the percentage of

---

[26] Richard C. Lindrooth, Marcelo C. Perraillon, Rose Y. Hardy, and Gregory J. Tung, Understanding the Relationship Between Medicaid Expansions and Hospital Closures, Health Affairs Vol 37, No. 1 (January 2018), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976.

[27] Madison Adler, trump HIV Goal Not Possible Without Obamacare, Advocates Say, Bloomberg (Mar. 27, 2019) *available at* https://news.bloomberglaw.com/health-law-and-life-sciences/trump-hiv-goal-not-possible-without-obamacare-advocates-say?usertype=External&bwid=00000169-bb26-db5f-ad6f-ff7796010002&qid=6318947&cti=LFVL&uc=1320010475&et=FIRST_MOVE&emc=hsnw_bf%3A2&access-ticket=eyJjdHh0IjoiSFNOVyIsImlkIjoiMDAwMDAxNjktYmIyNi1kYjVmLWFkNmYtZmY3Nzk2MDEwMDAyIiwic2lnIjoiWDR6NWZTVzM0V2
(Continued…)

HIV-positive persons without health insurance coverage by half, dropping from 14 percent to 7 percent.[28] Medicaid expansion is vitally important to the mission of ACHP and ACAP members. It allows them to provide much-needed care to critical populations before health status deteriorates and, in so doing, saves Medicaid money and, more importantly, lives.

Additionally, the ACA reduced costs for the more than 57 million Medicare beneficiaries by requiring free coverage of certain preventive screenings and eliminating the Part D prescription drug coverage gap.[29] These changes empowered Medicare beneficiaries to access services and potentially catch dangerous and costly medical conditions earlier, permitting ACHP and ACAP members to more effectively manage care,

---

tUSGVTUmxlTHNtL3RZWW1vPSIsInRpbWUiOiIxNTUzNjg0ODI1Iiwi dXVpZCI6Ik1GVkZheGtqVFVBM0JMUWxaUFhtU3c9PWt1MzcvWUN McVJhVFI2RFdwL294akE9PSIsInYiOiIxIn0%3D

[28] Kaiser Family Foundation, Medicaid's Role for Individuals with HIV (April 18, 2017) *available at* https://www.kff.org/infographic/medicaids-role-for-individuals-with-hiv/.

[29] Juliette Cubanski, Tricia Neuman, Gretchen Jacobson, Cristina Boccuti, What are the Implications of Repealing the Affordable Care Act for Medicare Spending and Beneficiaries, Kaiser Family Foundation (Dec. 13, 2016) *available at* https://www.kff.org/health-reform/issue-brief/what-are-the-implications-of-repealing-the-affordable-care-act-for-medicare-spending-and-beneficiaries/.

mitigate risks, and improve the lives of their Medicare beneficiary members.

The ACA has had a transformative effect on millions of people covered by ACHP and ACAP members, enabling them to access health care, manage pre-existing and chronic conditions, and lead better, more engaged lives. The ACA's expanded access to affordable healthcare with meaningful benefits furthered the core mission of not-for-profit community health plans to transform healthcare in their communities by reducing costs, improving health outcomes, and delivering high-quality care. Absent the ACA, millions will lose health insurance coverage and access to health care, crippling ACHP and ACAP member plans' abilities to fulfill their commitments to their communities.[30]

---

[30] *See* CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018) *available at* https://www.cbo.gov/publication/53826#section0.

IV. CONCLUSION

For the reasons stated, this Court should reverse.

s/ A. Xavier Baker
A. Xavier Baker
Daniel W. Wolff
CROWELL & MORING LLP
1001 Pennsylvania Ave., N.W.
Washington, D.C. 20004
(202) 624-2500
xbaker@crowell.com

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2019, I electronically filed the foregoing brief with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ A. Xavier Baker
A. Xavier Baker

CERTIFICATE OF COMPLIANCE

The undersigned counsel certifies that this brief:

(i) complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,361 words, including footnotes and excluding the parts of the brief exempted by Rule 32(f);

(ii) complies with the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14 point Century Schoolbook;

(iii) all required privacy redactions have been made;

(iv) the hardcopies submitted to the Clerk are exact copies of the ECF submission; and

(v) the digital submission has been scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses.

Dated: April, 1, 2019

s/ A. Xavier Baker
A. Xavier Baker