ORAL ARGUMENT NOT YET SCHEDULED

In The United States Court Of Appeals
For The District Of Columbia Circuit

NO. 19-5212

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, ET AL.,

Appellants,

v.

UNITED STATES DEPARTMENT OF THE TREASURY, ET AL.,

Appellees.

ON APPEAL FROM THE U.S. DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
CASE NO. 18-2133 (LEON, J.)

BRIEF OF *AMICUS CURIAE* LOUISIANA COMMISSIONER OF INSURANCE JAMES J. DONELON, IN SUPPORT OF APPELLEES AND IN SUPPORT OF AFFIRMANCE

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I. IDENTITY AND INTEREST OF AMICUS[1]

The Louisiana Commissioner of Insurance ("Commissioner"), James J. Donelon, has an interest in this matter due to his constitutional responsibility over the health and welfare of the residents of Louisiana[2] and his role as the primary regulator of health insurance in Louisiana.[3]

The Commissioner is committed to ensuring that affordable, quality health insurance is available to the residents of the State of Louisiana.

II. INTRODUCTION

The district court was correct to refuse to take as fact Appellants' predictions about how States would utilize the flexibility restored to them by the final rule on Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38212 (Aug. 3, 2018) (codified at 26 C.F.R. § 54; 29 C.F.R. § 2590; and 45 C.F.R. §§ 144, 146, 148) ("2018 Rule"), promulgated by the Departments of Labor, Treasury, and Health and Human Services ("Departments"). Appellants base their objections to the 2018 Rule on the assumption that, under the authority clearly delegated to the States in the enactment of both HIPAA and the ACA, States would *only* regulate short-term, limited-duration insurance ("short-term plans") in a way that would necessarily

[1] The Louisiana Commissioner of Insurance files this brief pursuant to Federal Rule of Appellate Procedure 29(a)(2).
[2] La. Const. art. IV, § 11.
[3] LSA-R.S. 22:2.

siphon healthy people out of Qualified Health Plans[4] made available pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("ACA"), to such a degree as to constrain Congress's goals in enacting the ACA.

Appellants failed to wait and see how the States would use the authority restored to them by the 2018 Rule. Instead, Appellants filed their underlying lawsuit, which was essentially a facial challenge to the 2018 Rule, two weeks *before* the 2018 Rule took effect. As discussed below, developments both subsequent to the filing of Appellants' Complaint and subsequent to the district court's July 17, 2019 order demonstrate that the district court's decision to uphold the 2018 Rule was correct.

Furthermore, the reality facing the vast majority of states cannot be ignored. Individuals who do not qualify for premium tax credits (also known as subsidies) continue to be priced out of Qualified Health Plans. These individuals are either forced to go without health insurance or to use lower-priced but often inadequate replacements.[5] The 2018 Rule restores to the States the flexibility and discretion to innovate methods to entice these individuals back into health insurance markets and

[4] For ease of reference, amicus uses the term "Qualified Health Plans" to refer to all ACA-compliant individual health insurance coverage, whether or not certified by an Exchange, with the understanding that the term of art "qualified health plan" includes most, but not all, ACA-compliant individual health insurance coverage. See 42 U.S.C. § 18021(a)(1) (defining a "qualified health plan" for the purposes of the ACA).

[5] John C. Goodman, Opinion, *Alternatives to Obamacare*, FORBES (Jan. 30, 2019, 7:57 AM), https://www.forbes.com/sites/johngoodman/2019/01/30/alternatives-to-obamacare/#644a3e4961ff (accessed Feb. 5, 2020)

ensure that their residents have access to meaningful and affordable coverage. Thus, the district court's order dismissing Appellants' challenge to the 2018 Rule should be affirmed.

III. LOUISIANA'S QUALIFIED HEALTH PLANS

Louisiana's experience has been that premiums for Qualified Health Plans have risen dramatically and enrollment in such plans has decreased significantly. For those Louisianans who qualify for subsidies under the ACA, the rise in premiums has been sufficiently offset by the commensurate increase in subsidies to keep those individuals enrolled in Qualified Health Plans.[6] However, as the premiums for Qualified Health Plans have continued to escalate, Louisiana has seen a decrease in the percentage of Louisianans enrolled through its Exchange who do not qualify for subsidies.

This new gap also includes those who fall into the so-called "family glitch." The "family glitch" exists because subsidies are not available to an individual worker and his or her family members to purchase Qualified Health Plans when the

[6] The ACA provides premium tax credits under 26 U.S.C. § 36B to help low and middle income individuals (individuals with household incomes between 100 and 400 percent of the federal poverty line) afford the cost of insurance purchased through the Exchanges. *See King v. Burwell*, 135 S. Ct. 2480, 2487 (2015). "Exchanges" are locations in each state where people can shop for Qualified Health Plans. 42 U.S.C. § 18031(b)(1). The Exchanges provide advance payments of premium tax credits directly to an eligible individual's insurer, lowering the net cost of insurance to the individual. *See* 42 U.S.C. §§ 18081-18082.

individual can enroll in "affordable" job-based health insurance.[7] Nevertheless, the affordability of job-based health insurance is determined by the cost of the worker's coverage as opposed to the often significantly higher cost of coverage for the worker's family members.[8] Thus, for example, health insurance can be unaffordable for the spouses of middle income workers because the cost of enrolling in their spouse's health plan is unaffordable, and the individual does not qualify for subsidies to purchase a Qualified Health Plan.[9]

Finally, eligibility for subsidies is calculated based on the individual's income in the year that coverage is provided.[10] This structure can push individuals and their families with unpredictable annual incomes out of Qualified Health Plans because they are forced to gamble that their income for the upcoming year will qualify them for a subsidy.[11] This unpredictability has real costs. For example, if a family's income in the upcoming year is higher than estimated, the family could be forced to

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[7] Cara M. Passaro, *Using the State Innovation Waiver to Fill Obamacare's Coverage Gaps in Connecticut*, 16 Conn. Pub. Int. L.J. 299, 308-09 n.71, 314 (2017) (citations omitted); 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(2).

[8] *Id.* at 314.

[9] Nancy Metcalf, *When It's Too Expensive to Add Your Family to Your Health Plan: Blame the Unnecessary 'Family Glitch'*, CONSUMER REPORTS (Dec. 3, 2014), https://www.consumerreports.org/cro/news/2014/12/when-it-s-too-expensive-to-add-your-family-to-your-health-plan/index.htm.

[10] 26 U.S.C. § 36B(b)(2)(B)(ii) (basing the premium tax credit calculation in part on "the taxpayer's household income for the taxable year").

[11] Tara Straw, *Threat of Tax Credit Repayment Would Reduce Coverage, Put Many Families at Financial Risk*, CENTER ON BUDGET & POLICY PRIORITIES (Nov. 14, 2017), https://www.cbpp.org/sites/default/files/atoms/files/11-14-17health.pdf (accessed Feb. 5, 2020).

repay some or all of the tax credit the next year, even if they cannot afford to do so.[12] This uncertainty can cause the predicament of individuals choosing to forgo buying Qualified Health Plans, particularly now that the tax penalty for not having health insurance has been reduced to $0.[13]

The vast majority of states are experiencing these same affordability issues. Nationally, marketplace enrollment among subsidized Qualified Health Plan enrollees rose from 8.7 million in 2015 to 9.2 million in 2018 as premiums have risen.[14] However, the number of unsubsidized enrollees in Qualified Health Plans has fallen in this same period from 6.4 million to 3.9 million.[15]

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[12] 26 U.S.C. § 36B(f)(2); *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAMILY FOUNDATION (Jan. 16, 2020), https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/ (accessed Feb. 5, 2020). If the taxpayer has a household income of less than 400 percent of the poverty line for the size of the family, repayment of excess tax credit is capped. 26 U.S.C. § 36B(f)(2)(B)(i). There is no cap if the household income is estimated to be less than 400 percent of the poverty line when the individual ends up with income for the taxable year exceeding 400 percent of the poverty line. *Id.*

[13] *See* 26 U.S.C. § 5000A, as amended by the Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).

[14] Rachel Fehr, et al., *How Affordable are 2019 ACA Premiums for Middle-Income People?*, KAISER FAMILY FOUNDATION (Mar. 5, 2019), https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/ (accessed Feb. 7, 2020).

[15] *Id.*

In the Louisiana health insurance market, short-term plans range from plans offering minimal benefits coverage and ACA protections up to coverage commensurate with ACA Bronze level plan actuarial value.

If the 2018 Rule is struck down, Louisiana and other states will be denied the flexibility needed to innovate ways to address the indisputable problem of health insurance affordability and accessibility that afflicts their residents. Therefore, the district court's opinion should be affirmed.

IV. ARGUMENT

A. The 2018 Rule is consistent with Congressional intent to retain significant roles for the States and consistent with the States' constitutional responsibilities for the health and safety of their residents.

The United States Constitution gives the States, not the Federal government, responsibility for "the facets of governing that touch on citizens' daily lives," such as health insurance.[16] The States have historically had "primacy" in "regulation of matters of health and safety."[17] "The Framers thus ensured that powers which 'in the ordinary course of affairs, concern the lives, liberties, and properties of the people' were held by governments more local and more accountable than a distant federal bureaucracy."[18]

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[16] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 536 (2012).
[17] *CTS Corp. v. Waldburger*, 573 U.S. 1, 19 (2014) (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)).
[18] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 536 (quoting THE FEDERALIST NO. 45, at 293 (James Madison)).

With both the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936, in 1996 ("HIPAA") and the ACA, Congress recognized this constitutional imperative, preserving room for the States to continue to exercise their fundamental constitutional roles of protecting the general health and safety of their citizens, more broadly, and of regulating health insurance, more specifically.

When Congress enacted HIPAA in 1996, and excluded short-term plans from the definition of "individual health coverage," it created a scheme that left significant roles for the States in achieving its purpose of, among other things, "improv[ing] portability and continuity of health insurance coverage in the group and individual markets."[19] "[T]he ACA left HIPAA's federal-state relationship largely intact."[20] Instead of creating a federal system such as the Social Security Act to address its concerns about health care, "Congress chose" with the ACA "to preserve a central role for…state governments."[21]

[19] H.R. REP. NO. 104-496, at 1, *reprinted in* 1996 U.S.C.C.A.N. 1865, 1865.
[20] EMPLOYER'S GUIDE TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ¶ 230 (David Slaughter, ed. 2019), 2005 WL 4171609.
[21] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 599 (Ginsburg, J., with Sotomayor, Breyer and Kagan, JJ., concurring in part, concurring in the judgment in part, and dissenting in part).

The ACA is unequivocal about this precept, evidenced by the clause that "disclaim[s] any ACA preemption over the entire field of health insurance."[22] This provision of the ACA mirrors provisions in HIPAA that amended the Public Health Service Act and the Employee Retirement Income Security Act of 1974, allowing states to adopt and enforce laws and regulations that afford greater consumer protections than the federal schemes.[23]

The ACA also authorizes the States to exercise discretion in matters that it directly regulates, including:

- to elect to establish and operate their own Exchanges;[24]
- to create a Basic Health Plan for low income individuals not eligible for Medicaid;[25]

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[22] *Conway v. United States*, 145 Fed. Cl. 514, 522 (2019) (petition for cert. docketed) (citing *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) ("This preemption clause is a narrow one, and only those state laws that 'hinder or impede' the implementation of the ACA run afoul of the Supremacy Clause."); and then citing *UnitedHealthcare of N.Y., Inc. v. Vullo*, 323 F. Supp. 3d 470, 481 (S.D.N.Y. 2018) (holding that the ACA does not preempt the field of health insurance), *appeal argued*, No. 18-2583 (2d Cir. Feb. 8, 2019)); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1321(d), 124 Stat. 119, 187 (2010) (codified at 42 U.S.C. § 18041(d)) ("No Interference with State Regulatory Authority—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.").

[23] Public Health Service Act, Pub. L. No. 104-191, § 2723(a), 110 Stat. 1936, 1971-72 (1996) (codified at 42 U.S.C. § 300gg–23(a)); *id.*, § 2762(a), 110 Stat. at 1987 (codified at 42 U.S.C. § 300gg–62(a)); Employee Retirement Income Security Act, Pub. L. 104-191, § 704(a), 110 Stat. 1936, 1946-47 (1996) (codified at 29 U.S.C. § 1191(a)).

[24] 42 U.S.C. §§ 18031 and 18041; *King*, 135 S. Ct. at 2489.

[25] 42 U.S.C. § 18051.

- to seek approval for significant changes to their individual marketplaces through Section 1332 State innovation waivers;[26] and

- to exercise primary enforcement authority over health insurance issuers to ensure compliance with the ACA's reforms.[27]

The 2018 Rule is consistent with Congress's demonstrated intent to leave a gap for the States to exercise discretion and authority to meet the needs of their particular populations. Specifically, more flexibility id provided to States to pursue innovative solutions to meet their unique market-specific needs. The 2018 Rule ensures that the States have the necessary gap in exercising their authority to carry out their "robust" roles under the ACA by allowing them to tailor short-term plans to meet the needs of their particular states.[28]

Conversely, Appellants' rigid interpretation of the terms "short-term" and "limited duration" is inconsistent with both Congressional language and intent. Appellants' interpretation demonstrates an intent to remove all discretion and flexibility from the States, an interpretation that is particularly troublesome in an area that Congress expressly carved out from Federal regulation.

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[26] 42 U.S.C. § 18052.

[27] Centers for Medicare & Medicaid Services, The Center for Consumer Information & Insurance Oversight, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance (accessed Feb. 5, 2020).

[28] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 595-96 (Ginsburg, J., with Sotomayor, Breyer and Kagan, JJ., concurring in part, concurring in the judgment in part, and dissenting in part); JA117; *see also* JA119.

HIPAA and the ACA left room for the States to exercise their constitutional responsibilities and thereby implement details to suit the needs of their unique populations. The 2018 Rule ensures that, in the arena of short-term plans, the States can avail themselves of such.

B. States are using the authority restored to them by the 2018 Rule to address health insurance quality and affordability for their populations.

As the Departments anticipated, States are taking a variety of approaches, consistent with their constitutional responsibilities, with the gap in exercising their authority set aside for them by HIPAA, the ACA, and the 2018 Rule to provide for innovative mechanisms in reference to short-term plans. Subsequent to the enactment of the 2018 Rule, multiple States tailored their laws regulating short-term plans to address the challenges facing their populations in accordance with each State's considered judgment.

A few States have enacted or continued bans on the sale of all short-term plans,[29] while several States limit the term and duration of short-term plans to less than what is allowed under the 2018 Rule.[30] Some States have adopted the

[29] *See, e.g.*, Cal. Ins. Code § 10123.61 (West 2019); N.Y. State Dep't of Financial Servs., Ins. Circular Letter No. 7 (Jun. 21, 2018), available at: https://www.dfs.ny.gov/insurance/circltr/2018/cl2018_07.htm (accessed Feb. 5, 2020) (reminding insurers that the sale of short term health insurance plans in New York is prohibited, regardless of federal regulatory changes.)

[30] *See, e.g.*, D.C. Code Ann. § 31-3303.13d(d), (e) (West 2019) (limiting the term to 3 months and prohibiting extension or renewal); Haw. Rev. Stat. Ann. § 431:10A-605(a) (West 2018) (limiting the initial duration of any short-term, limited duration

outermost limits allowed by the 2018 Rule as the permissible term and duration for short-term plans.[31] Other States impose requirements on the benefits that must be covered by short-term plans.[32] Some States require health insurers offering short-term plans to cover preexisting conditions.[33] Some States limit the marketing and sale of short-term plans during the open enrollment window for Qualified Health Plans.[34] One State prohibits a health insurer from enrolling or renewing an individual in a short-term plan if the individual was eligible to purchase a Qualified Health Plan during open or special enrollment during the previous calendar year.[35] And finally, some States impose strict limits on the ability of health insurers to

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insurance to 91 days); IDAPA 18.04.16.010.03 (making traditional short-term, limited duration insurance nonrenewable and limiting it to a duration of six months or less); 215 Ill. Comp. Stat. Ann. 190/10(c) (West 2018) (limiting the initial duration to 181 days and prohibiting renewal, reissuance or extension for 365 after the coverage ends); Me. Rev. Stat. Ann. tit. 24-A, § 2849-B(8) (West 2019) (allowing renewal or extension of a short-term, limited duration policy up to 24 months).

[31] *See* Idaho Code Ann. § 41-5203(11) (West 2019) (for ESTPs only); Okla. Stat. Ann. tit. 36, § 4419 (West 2019); Tex. Ins. Code Ann. § 1509.001 (West 2019).

[32] *See, e.g.*, 3 Colo. Code Regs. § 702-4:4-2-41 (West 2019); 18 Del. Admin. Code 1320-5.0 (West 2019); Ind. Code Ann. § 27-8-5.9-3 (West 2019); Iowa Admin. Code r. 191-36.6(514D) (West 2019); Wash. Admin. Code § 284-43-8000(1)(a) (West 2020).

[33] *See, e.g.*, Conn. Gen. Stat. Ann. § 38a-476(b)(3) (West 2020); D.C. Code Ann. § 31-3303.13d(c) (West 2019); 4-3 Vt. Code R. § 61:8(D)(3) (West 2019).

[34] *See, e.g.*, Me. Rev. Stat. Ann. tit. 24-A, § 2849-B(8)(D) (West 2019); Wash. Admin. Code § 284-43-8000(4) (West 2020).

[35] Haw. Rev. Stat. Ann. § 431:10A-605(a) (West 2018).

rescind short-term plans, a practice in which health insurers retroactively cancel coverage.[36]

C. Short-term insurance plans are consistent with the Congressional goal of increasing the number of Americans covered by health insurance and decreasing the cost of health care.

In 2010, Congress enacted the ACA with the aim of "increas[ing] the number of Americans covered by health insurance and decreas[ing] the cost of health care."[37] One of the assumptions underlying the ACA was that premiums paid by young, healthy individuals would help keep premiums for the old and the sick manageable and would help retain health insurers in a given market. A consequence of that assumption in practical application is that young, healthy individuals who are not eligible for subsidies are effectively priced out of Qualified Health Plans. Regarding the Louisiana market, Louisiana believes short-term plans will provide the portion of its population that is currently being priced out of unsubsidized Qualified Health Plans access to quality, affordable health insurance.

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[36] *See, e.g.*, 215 Ill. Comp. Stat. Ann. 190/10(d) (West 2018) (prohibiting rescission except in cases of nonpayment of premiums, fraud or at the insured's option); Nev. Rev. Stat. Ann. § SB 481, § 8 (West 2020) (prohibiting rescission except in six defined circumstances).

[37] *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 538; *id*. at 596 (Ginsburg, J., with Sotomayor, Breyer and Kagan, JJ., concurring in part, concurring in the judgment in part, and dissenting in part) ("A central aim of the ACA is to reduce the number of uninsured U.S. residents.").

Short-term plans encourage participation and competition in the market, as short-term plans not only decrease costs and increase the number of individuals covered by health insurance, but also increase choice and coverage options. As Appellees contend and the district court correctly concluded, Congress did not intend for every American be enrolled in a Qualified Health Plan. Short-term plans are likely to increase the number of individuals with affordable health insurance, which aligns with Congressional intent.

D. The district court was correct to reject the conclusions argued by Appellants that short-term plans would destabilize the Exchanges.

The district court correctly determined that the 2018 Rule should be given *Chevron* deference, thereby upholding it against Appellants' challenge. The district court also correctly concluded that allowing states to offer short-term plans consistent with the 2018 Rule would not cause a mass exodus from the individual market Exchanges that would threaten the ACA's structural foundation.

Short-term plans do not threaten the ACA's structural core, as the availability of such plans poses even less of a threat of drawing subsidized Qualified Health Plan enrollees out of that market. The costs of subsidized Qualified Health Plans generally remain much more attractive than other options. For example, the Kaiser Family Foundation has calculated that 4.2 million people

nationwide in 2019 and 4.7 million people nationwide in 2020 were or are eligible to pay a $0 premium for a Bronze level ACA plan due to the effect of subsidies.[38]

The U.S. Constitution intended to reserve broad powers to the States. This latitude granted to the States, necessary to deal with difficult legal problems and rapidly developing issues, has been likened to a laboratory of democracy.[39] As with any laboratory, approaches that are ultimately successful in one State can be adopted by another as befits the needs of that State's population.

V. CONCLUSION

At this time, the facts simply do not show that the availability of short-term plans for terms up to less than twelve months and renewable up to thirty-six months undermines the ACA, let alone threatens its structural foundation. The district court was correct to reject Appellants' predictions. Moreover, the district court properly followed Congressional intent, expressed in HIPAA and the ACA and restored by

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[38] Rachel Fehr, *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?*, KAISER FAMILY FOUNDATION (Dec. 10, 2019), https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020 (accessed Feb. 6, 2020) ("We estimate that 28% of uninsured individuals who can shop on the Marketplace, or 4.7 million people nationwide, are eligible to purchase a bronze plan with $0 premiums after subsidies in 2020. This figure is similar to 2019, when 27% of uninsured individuals, or 4.2 million people, could purchase a no-premium bronze plan.")

[39] *See Ariz. State Legis. v. Ariz. Indep. Redistricting Comm'n*, 135 S. Ct. 2652, 2673 (2015) (citations omitted); *Oregon v. Ice*, 555 U.S. 160, 171 (2009) (citation omitted); *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., with Stone, J., dissenting).

the 2018 Rule, wherein the States are authorized to structure individual solutions to the problem of health insurance affordability.

In conclusion, the judgment of the district court should be affirmed.

Respectfully submitted,

Dated: February 17, 2020

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CERTIFICATE OF COMPLIANCE

1. This document complies with the word limit of Fed. R. App. P. 29(a)(5) and 32(a)(7) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f) and Circuit Rule 32.1, this document contains 3,655 words, according to the word-processing program used to prepare it.

2. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it uses proportionately spaced 14-point Times New Roman typeface.

Dated: February 17, 2020 /s/Monica Derbes Gibson

F.R.A.P. RULE 29(a)(4)(E) STATEMENT

1. Counsel for the Louisiana Commissioner of Insurance authored the foregoing Brief of *Amicus Curiae* in Support of Appellees and in Support of Affirmance in its entirety.

2. Neither the Louisiana Commissioner of Insurance nor the Commissioner's counsel contributed money that was intended to fund preparing or submitting the foregoing Brief.

3. No person contributed money that was intended to fund preparing or submitting the foregoing Brief.

CERTIFICATE OF COUNSEL

A separate amicus curiae brief is needed for the Louisiana Commissioner of Insurance James J. Donelon because Louisiana's insurance industry faces issues that differ from those of other states.

Dated: February 17, 2020

/s/Monica Derbes Gibson
Name

CERTIFICATE OF SERVICE

I hereby certify that on February 17, 2020, I caused a true and correct copy of the foregoing to be served on all counsel of record through the Court's CM/ECF system.

Dated: February 17, 2020

/s/Monica Derbes Gibson
Name