IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 19-10011

STATE OF TEXAS, et al.
Plaintiffs-Appellees,
v.

UNITED STATES OF AMERICA, et al.
Defendants-Appellants.

STATE OF CALIFORNIA, et al.
Intervenor Defendants-Appellants

On Appeal from the United States District Court
For the Northern District of Texas

AMICUS CURIAE BRIEF OF AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES, AMERICAN CIVIL LIBERTIES UNION, THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, AND ELEVEN OTHER LEADING NATIONAL DISABILITY RIGHTS ORGANIZATIONS IN SUPPORT OF DEFENDANT-APPELLANTS AND INTERVENOR-DEFENDANT APPELLANTS

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SUPPLEMENTAL STATEMENT OF INTERESTED PARTIES

The undersigned counsel of record certifies that the following listed persons and entities have an interest in this amicus brief as required by Fifth Circuit Rule 29.2. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

A. Amici Curiae

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Disability Rights Education And Defense Fund
American Association Of People With Disabilities
American Civil Liberties Union
The Arc Of The United States
Association Of University Centers On Disabilities
Autistic Self Advocacy Network
Autism Society Of America
Center For Public Representation
Disability Rights Legal Center
National Council On Independent Living
National Association Of Councils On Developmental Disabilities
National Association Of The Deaf
National Disability Rights Network
National Down Syndrome Congress

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INTEREST OF AMICI CURIAE

Judge David L. Bazelon Center for Mental Health Law. Founded in 1972 as the Mental Health Law Project, the Judge David L. Bazelon Center for Mental Health Law is a national non-profit advocacy organization that provides legal assistance to individuals with mental disabilities. Through litigation, public policy advocacy, education, and training, the Bazelon Center works to advance the rights and dignity of individuals with mental disabilities in all aspects of life, including community living, employment, education, health care, housing, voting, parental and family rights, and other areas. Expanding the availability of community-based mental health services has been central to the Center's mission and focus.

Disability Rights Education and Defense Fund. The Disability Rights Education and Defense Fund ("DREDF") is a national law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. DREDF is committed to increasing accessible and equally effective health care for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives.

American Association of People with Disabilities. The American Association of People with Disabilities ("AAPD") works to increase the political and economic power of people with disabilities, and to advance their rights. A national cross-disability organization, AAPD advocates for full recognition of the rights of over 60 million Americans with disabilities.

American Civil Liberties Union. The American Civil Liberties Union ("ACLU") is a nationwide, non-partisan organization of over 1.5 million members dedicated to the principles of liberty and equality embodied in the Constitution and our nation's civil rights laws. The ACLU's Disability Rights Program envisions a society in which discrimination against people with disabilities no longer exists, and in which people with disabilities are valued, integrated members of the community, with equal access to education, the community, and our justice system.

The ARC of the United States. The Arc of the United States ("The Arc") is the nation's largest organization of and for people with intellectual and developmental disabilities ("I/DD"). The Arc promotes and protects the human and civil rights of people with I/DD and actively supports their full inclusion and participation in the community. The Arc has a vital interest in ensuring that all individuals with I/DD receive the protections and supports to which they are entitled by law.

Association of University Centers on Disabilities. The Association of University Centers on Disabilities ("AUCD") is a nonprofit membership association of 130 university centers and programs in each of the fifty States and six Territories. AUCD members conduct research, create innovative programs, prepare individuals to serve and support people with disabilities and their families, and disseminate information about best practices in disability programming, including community integration and prevention of needless institutionalization.

Autistic Self Advocacy Network. The Autistic Self Advocacy Network ("ASAN") is a national, private, non-profit organization, run by and for individuals on the autism spectrum. ASAN provides public education and promotes public policies

that benefit autistic individuals and others with developmental or other disabilities. ASAN's advocacy activities include combating stigma, discrimination, and violence against autistic people and others with disabilities, promoting access to health care and long-term supports in integrated community settings, and educating the public about the access needs of autistic people. ASAN takes a strong interest in cases that affect the rights of autistic individuals to participate fully in community life and enjoy the same rights as others without disabilities.

Autism Society of America. The Autism Society of America is the Nation's leading grassroots autism organization. It was founded in 1965 and exists to improve the lives of all affected by autism spectrum disorder. It does this by increasing public awareness and helping with the day-to-day issues faced by people on the spectrum and their families. Through its strong national network of affiliates, it has been a thought leader on numerous pieces of state and federal legislation.

Center for Public Representation. The Center for Public Representation is a national legal advocacy organization that has been enforcing the rights of people with disabilities, both in the community and in institutional settings, for over forty years. Using both litigation and policy advocacy, the Center ensures that people with disabilities have access to the critical health care services they need to live and participate in their own communities, including home and community based services under Medicaid. The Center has brought litigation in dozens of states across the country to expand access to Medicaid-funded home and community based services for people with disabilities, resulting in settlement agreements and court orders for statewide reforms of Medicaid-funded disability service systems. The Center also

helps lead the disability community's advocacy to protect the Affordable Care Act and Medicaid. The Center is a national legal support center, providing training, and technical assistance to federally-designed protection and advocacy programs in each of the fifty states and territories under a contract with National Disability Rights Network.

Disability Rights Legal Center. The Disability Rights Legal Center ("DRLC") is a non-profit legal organization that was founded in 1975 to represent and serve people with disabilities. Individuals with disabilities continue to struggle against ignorance, prejudice, insensitivity, and lack of legal protection in their endeavors to achieve fundamental dignity and respect. The DRLC assists people with disabilities in attaining the benefits, protections, and equal opportunities guaranteed to them under the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Individuals with Disabilities Education Act, and other state and federal laws. Its mission is to champion the rights of people with disabilities through education, advocacy, and litigation. The DRLC is a recognized expert in the field of disability rights.

National Association of Councils on Development Disabilities. The National Association of Councils on Developmental Disabilities ("NACDD") is the national nonprofit membership association for the Councils on Developmental Disabilities located in every State and Territory. The Councils are authorized under federal law to engage in advocacy, capacity-building, and systems-change activities that ensure that individuals with developmental disabilities and their families have access to needed community services, individualized supports, and other assistance that

promotes self-determination, independence, productivity, and integration and inclusion in community life.

National Association of the Deaf. The National Association of the Deaf ("NAD") was founded in 1880, is the oldest civil rights organization in the United States, and is the nation's premier organization of, by and for deaf and hard of hearing individuals. The NAD is a non-profit membership organization with a mission of preserving, protecting, and promoting the civil, human and linguistic rights of 48 million deaf and hard of hearing individuals in the country. The NAD endeavors to achieve true equality for its constituents through systemic changes in all aspects of society including but not limited to education, employment, and ensuring equal and full access to programs and services. Serving all parts of the USA, the NAD is based in Silver Spring, MD. For decades, the NAD has advocated for equal access for deaf and hard of hearing people within the health care and health insurance systems.

National Council on Independent Living. The National Council on Independent Living ("NCIL") is the oldest cross-disability, national grassroots organization run by and for people with disabilities. NCIL's membership is comprised of centers for independent living, state independent living councils, people with disabilities and other disability rights organizations. NCIL advances independent living and the rights of people with disabilities. NCIL envisions a world in which people with disabilities are valued equally and participate fully.

National Down Syndrome Congress. Founded in 1973, the National Down Syndrome Congress is the leading national resource for advocacy, support, and information for anyone touched by or seeking to learn about Down syndrome, from

the moment of a prenatal diagnosis through adulthood. A member-sustained, 501(c)(3) organization, representing the approximately 350,000 people in the United States with Down syndrome and their families, our programs provide individuals with Down syndrome the opportunities and respect they deserve so they can live the life of their choosing.

National Disability Rights Network: The National Disability Rights Network ("NDRN") is the non-profit membership organization for the federally mandated Protection and Advocacy ("P&A") and Client Assistance Program ("CAP") agencies. The P&As and CAPs were established by Congress to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. There are P&As and CAPs in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the U.S. Virgin Islands) and the Native American Consortium which includes the Hopi, Navajo and San Juan Southern Piute Nations in the Four Corners.

RULE 29 CERTIFICATIONS

This brief is submitted pursuant to Fed. R. App. P. 29(a) and Fifth Cir. R. 29. All parties have consented to the submission of this brief.

Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for Amici represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than Amici or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act[1] has been essential to overcoming the disproportionate impact that America's health care crisis has had on people with disabilities.[2] It is uniquely difficult, for various reasons, for people with disabilities to obtain affordable and adequate health insurance coverage.[3] Yet those same individuals often depend on health care services more than people without disabilities. The result is a cruel irony: the population that needs health care the most has the hardest time obtaining it. For the last nine years, the ACA has helped change that. Stripping away its protections now will reverse the positive gains that people with disabilities have realized and will return the community to the same grim reality as before the ACA, if not place people with disabilities in an even worse position.

The ACA expands access to health insurance for people with disabilities in several important ways, including:

- Creating state-based marketplaces for private health insurance;
- Expanding the scope and affordability of coverage by requiring health plans offer certain "essential benefits";

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[1] The "Affordable Care Act" or "ACA" refers both to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2] For purposes of this brief, amici relies on the definition of disability set forth in the Americans with Disabilities Act ("ADA") at 42 U.S.C. § 12102.

[3] Jae Kennedy et al., *Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Nondisabled Working-Age Adults*, 54 J. OF HEALTH CARE ORG., PROVISION, & FIN. 1, 8 (2017).

- Prohibiting discrimination against individuals based on health status and exclusions on the basis of pre-existing conditions;
- Expanding eligibility for Medicaid; and
- Expanding the types of services permitted to be covered by Medicaid.[4]

In short, the ACA uniquely and extensively benefits people with disabilities.

Thus, declaring the ACA unconstitutional in its entirety will uniquely and extensively harm this community—including millions of people who live in the Appellee states and the states within this Court's jurisdiction. Congress could not have intended to inflict such harm upon people with disabilities when it removed the financial penalty associated with the ACA's individual mandate but left the provisions above intact. And it is even more unlikely that it intended to do so without otherwise protecting disabled people who would shoulder much of the burden of invalidating the entire ACA. This Court should not ascribe such an intent to Congress and should reverse the district court's decision which strips away the significant gains that people with disabilities have made since the ACA's passage.

[4] 42 U.S.C. §§ 18031, 1396a.

ARGUMENT

I. The ACA Uniquely and Extensively Benefits People With Disabilities, And Its Elimination Would Disproportionately Harm That Same Population.

The health care challenges for people with disabilities start—but do not end—with the fact that they still face significant attitudinal and access barriers to finding and maintaining employment.[5] Whether it is explicit or implicit biases in the hiring process, an adverse employment action based on misguided assumptions, or a failure to provide reasonable accommodations to an employee, disability discrimination in employment remains pervasive.[6] Moreover, people with disabilities often lack the supported employment and health care services and supports that they need to secure and maintain work.[7]

Because of the many societal barriers to employment, people with disabilities are much less likely to receive health insurance from an employer than people without

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[5] In 2017, the employment rate of non-institutionalized working-age people with disabilities in the United States was 37.3 percent, compared with 79.4 percent of people without disabilities. *See* W. ERICKSON ET AL., CORNELL UNIV. YANG-TAN INST. ON EMP'T & DISABILITY, 2017 DISABILITY STATUS REPORT: UNITED STATES 31 (2019), http://www.disabilitystatistics.org/StatusReports/2017-PDF/2017-StatusReport_US.pdf ("2017 DSR").

[6] In 2017, the U.S. EEOC reported that 31.9 percent of all charges filed that year related to workplace disability discrimination. *See* EQUAL EMP'T OPPORTUNITY COMM'N, CHARGE STATISTICS: FY 1997 THROUGH FY 2017, https://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm.

[7] *See, e.g.*, Silvia Yee et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, NAT'L ACADS. SCI., ENGINEERING & MED. (2017), http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities (documenting the disparities in access to health care, quality of care, and health outcomes among people with disabilities).

disabilities.[8] While the majority—65.4% in 2017—of Americans without disabilities obtain health insurance from their employers, this statistic almost perfectly inverts as to people with disabilities.[9] In 2017, only 34.7% of people with disabilities received health insurance from employers—meaning that 65.3% did not.[10] Accordingly, unlike most Americans, disabled people must generally look elsewhere for health insurance.

Before the ACA's passage, searching for private insurance was often a futile endeavor with few, if any, other places to look for coverage. Private insurance was not a realistic option for many people with disabilities because of pre-existing condition exclusions, annual or lifetime limits on benefits, and high premium costs.[11] Even if they could obtain private coverage, people with disabilities still might require services that those private health insurance plans would not cover, such as durable medical equipment, mental health and substance use disorder services, or rehabilitation and habitation services.[12]

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[8] Kennedy et al., *supra* note 3, at 1.

[9] 2017 DSR, *supra* note 5, at 55.

[10] *Id.*

[11] Kennedy et al., *supra* note 3, at 1.

[12] Jody S. Hyde & Gina A. Livermore, *Gaps in Timely Access to Care Among Workers by Disability Status: Will the Patient Protection and Affordable Care Act Reforms Change the Landscape?*, 26 J. OF DISABILITY POL'Y STUD. 221, 221 (2016); Kennedy et al., *supra* note 3, at 1.

As one study participant aptly told the National Council on Disability, "[f]or people with significant disabilities, [private] insurance just doesn't work."[13] Instead—unable to obtain adequate private insurance—many people with disabilities turned to Medicaid[14] and/or Medicare[15] as their only options.[16] Indeed, in 2009—before passage of the ACA—58.2% of people with disabilities received insurance from Medicare or Medicaid, compared to just 7.6% of people without disabilities.[17] But many other people with disabilities could not qualify for Medicare or Medicaid. For example, people without a "qualifying permanent disability" (e.g., a blind or Deaf individual) and those who earned income in excess of a defined poverty line were still excluded from coverage. Still others faced long waiting periods—a newly disabled individual had to wait two years from the date of disability before Medicare benefits could begin, or up to a year for Medicaid, depending on the individual's state of

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[13] NAT'L COUNCIL ON DISABILITY, THE IMPACT OF THE AFFORDABLE CARE ACT ON PEOPLE WITH DISABILITIES: A 2015 STATUS REPORT 29 (2016), https://ncd.gov/sites/default/files/NCD_ACA_Report02_508.pdf.

[14] Medicaid is the primary public health insurance program for people with low incomes and is a program administered and financed jointly by states and the federal government. 42 U.S.C. § 1396 et seq.; 42 C.F.R. § 430 et seq.

[15] Medicare provides benefits for individuals aged 65 or older and individuals who are entitled to Social Security Disability Insurance ("SSDI") benefits for at least 25 months. 42 U.S.C. §§ 423, 426(b), 1395c, 1395i-2a; 42 C.F.R. § 406.12.

[16] *See* W. ERICKSON ET AL., CORNELL UNIV. YANG-TAN INST. ON EMP'T & DISABILITY, 2009 DISABILITY STATUS REPORT: UNITED STATES 55, 56 (2011), http://www.disabilitystatistics.org/StatusReports/2009-PDF/2009-StatusReport_US.pdf ("2009 DSR").

[17] 2017 DSR, *supra* note 5, at 55-56.

residence.[18] These individuals were left stranded, without the coverage they needed to live full, independent lives.

The ACA made significant and measurable progress toward improving access to health insurance and improving the quality of health insurance plans and, thus, increasing the affordability and scope of coverage for people with disabilities. Since the ACA's passage, the uninsured rate for people with disabilities has fallen significantly. In 2009, 17.4% of disabled individuals did not have insurance coverage. By 2017, that rate fell to 9.8%.[19] The rate of those who received health insurance from their employer stayed roughly constant during that time frame with 36.5% in 2009 and 34.7% in 2017.[20] The largest gains for people with disabilities came from the ACA's Medicaid expansion with 42.9% receiving Medicaid coverage in 2017, an increase from 34.9% in 2009.[21] Altogether, 3 million more Americans with disabilities gained access to health care.

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[18] Individuals with disabilities who receive SSDI are eligible for Medicare, but benefits do not begin until 25 months from the individual's date of disability. In addition, states are generally required to provide Medicaid coverage to people with disabilities who receive Supplemental Security Income ("SSI") benefits, but establishing eligibility for SSI based on a qualifying disability through the Social Security Administration ("SSA") can take up to a year. 42 U.S.C. § 1396a(a)(10)(A)(i)(II)(aa); 42 C.F.R. § 435.120 (2019); *see* SOC. SEC. ADMIN., SOCIAL SECURITY ADMINISTRATION (SSA) ANNUAL DATA FOR INITIAL DISABILITY CASES INVOLVING THE PROCESSING CENTERS AVERAGE PROCESSING TIME (2018), https://www.ssa.gov/open/data/program-service-centers.html.

[19] *Compare* 2009 DSR, *supra* note 16, at 55, *with* 2017 DSR, *supra* note 5, at 56.

[20] *Id.*

[21] *Id.*

II. The ACA's Expansion of Health Care Access and Coverage for People With Disabilities Benefits Society as a Whole.

Before addressing how the specific provisions of the ACA directly affect the lives of people with disabilities, *infra* Sections III and IV, it is important to explain how the ACA's specific, positive impacts on disabled people extend beyond that population alone. Research has consistently demonstrated that the ACA's improved access to health care for people with disabilities has benefited the broader population in many ways.

First, the ACA's expansion of Medicaid eligibility has enabled more people with disabilities to access the workforce. Many people with disabilities depend on health care services and supports—items and services as simple as a wheelchair, pain management treatment, mental health supports, or an accurate glucose monitor—to function, go to work, or even get out of bed. Several studies examined the impact that increased access to health care—and specifically the expansion of Medicaid—has had on employment rates. Most studies show a significant positive link between Medicaid expansion and employment rates; none show a negative correlation.[22] Because of the ACA, disabled people are less likely to face the dilemma of keeping their health insurance or working to their fullest potential and losing good health coverage because of income thresholds or other barriers to coverage.[23] In states that

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[22] Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUND. 7-8 (Mar. 2018), http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review.

[23] Jean P. Hall et al., *Medicaid Expansion as an Employment Incentive Program for People With Disabilities*, 108 AM. J. PUB. HEALTH 1235, 1235 (2018).

have expanded Medicaid coverage, people with disabilities are more likely to be employed and fewer people are likely to report not working because of a disability, in comparison to states that have not expanded Medicaid.[24]

Second, emerging research shows that the expanded access to health care may reduce hospital emergency room usage. A recent study examining California emergency room usage found that "[emergency] patients actually had a lower likelihood of being frequent users after [the ACA's] implementation" once other variables in the population are controlled for.[25] The study's authors explained:

> While our findings do not provide evidence that the ACA caused these changes, they suggest that expanded Medicaid coverage might have allowed patients to access needed medical services outside of the [emergency room]. This might have been especially true among people with chronic conditions who used the [emergency room] frequently pre ACA but who became connected to a primary care provider as a result of the ACA Medicaid expansion via Medicaid managed care plans.[26]

Because emergency room visits are costly and subsidized by the entire health care system, reducing these frequent visits could lead to overall cost-reductions for the larger population.[27]

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[24] *Id.*

[25] Shannon McConville et al., *Frequent Emergency Department Users: A Statewide Comparison Before And After Affordable Care Act Implementation*, 37 HEALTH AFFAIRS 881, 886 (2018).

[26] *Id.* at 887.

[27] *See id.* at 881.

The ACA's increase in options for Medicaid coverage of disabled individuals and the provision of long-term services and supports ("LTSS") under Medicaid also has important ramifications for the broader population. Specifically, it has reduced reliance on informal, unpaid caregivers, such as people who provide care to a disabled family member. In 2013, informal caregivers provided up to three-quarters of uncompensated LTSS care, amounting to an estimated $470 billion in unpaid care.[28] Additionally, informal caregivers are frequently called on to provide more complex and demanding medical or nursing care to family members, such as medication management, wound care, and incontinence care, but such caregivers often lack adequate support or training.[29] The provision of LTSS through Medicaid to individuals with disabilities allows informal caregivers to return to work and full economic participation while ensuring that their disabled family members receive proper and necessary care.

Finally, Medicaid expansion has the potential to reduce the needless incarceration of people with disabilities. As a result of the expansion, many people with disabilities now have access to community-based services that reduce the likelihood that they will have police encounters and find themselves incarcerated.[30]

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[28] Susan C. Reinhard et al., AARP PUB. POLICY INST., VALUING THE INVALUABLE: 2015 UPDATE 1 (2015), https://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.

[29] Kali S. Thomas & Robert Applebaum, *Long-term Services and Supports (LTSS): A Growing Challenge for an Aging America*, 25 PUB. POL'Y & AGING REP. 56, 59 (2015).

[30] Sarah Liebowitz et al., AM. CIVIL LIBERTIES UNION OF S. CAL. & BAZELON CTR. FOR MENTAL HEALTH LAW, *A Way Forward: Diverting People with Mental Illness from Inhumane and Expensive Jails into Community-Based Treatment that Works* (2014),

The expansion has also made it possible for many people with disabilities to receive needed services when they re-enter society following incarceration. "Upon release from prison and jail, individuals are often uninsured, making it difficult to access stable sources of care in the community to address these needs. Expanding health insurance to these individuals [through the ACA] will likely facilitate their ability to access needed care and manage their ongoing conditions."[31] Although research is not yet available to measure this impact, the ACA's expansion of access to medical care for people with disabilities should lead to similar benefits for people involved with the criminal justice system.

III. Several Generally Applicable Provisions in the ACA Are Critical to Providing People With Disabilities Access to Health Care.

The ACA contains a number of provisions that apply equally to all Americans, regardless of disability status or income. These provisions are critical to ensure that people with disabilities, who would be disproportionately harmed by removing them, have access to adequate and affordable health care. We describe some of these provisions below.

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http://www.bazelon.org/wp-content/uploads/2017/11/A-Way-Forward_July-2014.pdf.

[31] Alexandra Gates, *Health Coverage and Care for the Adult Criminal Justice-Involved Population*, KAISER COMM'N ON MEDICAID & THE UNINSURED 5-6 (Sept. 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf.

A. Protections for Pre-Existing Conditions

One of the ACA's central benefits is the protections it provides to people with pre-existing conditions.[32] Coupled with other provisions discussed below, an issuer cannot deny or alter coverage, or charge more for insurance simply because a person has a medical condition that existed prior to enrollment. This protects individuals with pre-existing conditions from being denied coverage altogether or from obtaining a health plan in the individual or group markets that does not cover the individual's pre-existing condition or would only do so at exorbitant premium costs.[33]

In 2016, the non-partisan Kaiser Family Foundation ("KFF") estimated that nationwide, roughly 27% of adults under the age of 65 have a pre-existing condition that without the ACA could result in the loss of coverage.[34] KFF estimates that within this Court's jurisdiction nearly 6 million people have pre-existing conditions.[35] Research conducted before the ACA's passage by the non-partisan Commonwealth Fund found that 53% of individuals with health problems who tried to buy coverage in the individual market found it very difficult or impossible to find a health plan with

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[32] *See* 42 U.S.C. § 300gg-3.

[33] Louise Norris, *Health Insurance and High-Risk Pools: ACA's coverage of pre-existing conditions made high-risk pools obsolete. Will they be resurrected as an Obamacare replacement?*, HEALTHINSURANCE.ORG (Dec. 10, 2018), https://www.healthinsurance.org/obamacare/risk-pools.

[34] Gary Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, KAISER FAMILY FOUND. (Dec. 12, 2016), https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca.

[35] *Id.*

the coverage they needed, compared to 31% of those without a health problem.[36] In addition, 46% of individuals were denied coverage, charged more, or had benefit excluded from their plan because of a pre-existing condition.[37]

Because many people have disabilities for their entire lives, they are particularly at risk for losing insurance coverage due to a pre-existing condition at one point or another. They also have a disproportionate need for health insurance, given the high health care costs that can be associated with certain types of disabilities. Prior to the ACA, insurers routinely denied coverage to people with disabilities such as vision loss, autism, and mental health-related conditions. In fact, according to a 2012 Government Accountability Office study, mental health disorders were the second most commonly reported condition that could result in a denial of coverage, impacting 19 million people nationwide.[38]

B. Guaranteed Issue

Prior to the ACA, insurers could refuse to cover someone because of their disability. The ACA's guaranteed-issue provision prohibited that. In general, this

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[36] Sara R. Collins et al., *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief*, THE COMMONWEALTH FUND 4 (Mar. 2011), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2011_mar_1486_collins_help_on_the_horizon_2010_biennial_survey_report_final_v2.pdf.

[37] *Id.*

[38] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-439, PRIVATE HEALTH INSURANCE: ESTIMATES OF INDIVIDUALS WITH PRE-EXISTING CONDITIONS RANGE FROM 36 MILLION TO 122 MILLION 10 (2012), https://www.gao.gov/assets/590/589618.pdf.

provision requires insurers to issue a health plan to any applicant, regardless of their health status or disability. Previously, only six states required insurers to do so.[39]

The ACA expanded that protection to the entire country and requires each issuer that offers coverage in the individual or group market to offer coverage and accept *every* employer and individual in the state that applies for it during the operative enrollment periods.[40]

Though many people with disabilities use public health insurance programs, access to the private markets is another important avenue for obtaining the coverage that people need.[41] Restricting an issuer's ability to refuse to offer or issue a policy to people with disabilities helps expand private insurance as viable sources of coverage for them and may serve to reduce reliance on (and thus save costs for) public programs.

C. Dependent Coverage for Adult Children

The ACA also requires many health plans to make dependent child coverage available under a parent's plan for children up to the age of 26.[42] This provision has improved access to health care for all young adults, including young adults with disabilities.

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[39] KAISER FAMILY FOUND., *Health Insurance Market Reforms: Guaranteed Issue* 3 (2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8327.pdf.

[40] 42 U.S.C. § 300gg-1; 45 C.F.R. § 147.104.

[41] Nancy A. Miller et al., *The Relation Between Health Insurance and Health Care Disparities Among Adults with Disabilities*, 104 AM. J. OF PUB. HEALTH e85 (2014).

[42] 42 U.S.C. § 300gg-14.

The ACA's expanded dependent coverage has decreased the overall uninsured rate by approximately 20%.[43] Though more research is needed, studies *have* shown that "young adults with health problems and foreseeable health care needs" have seen greater increases in health coverage thanks to the ACA's expanded dependent coverage.[44] Similarly, "the uninsurance rate among young adults who may have mental health care needs and seek treatment declined by [12.4%] because of the provision."[45]

The disproportionate benefits for youths with disabilities are consistent with research showing that, across the board, young adults with disabilities generally have lower rates of coverage, lack regular health care providers, have more unmet health care needs, and receive fewer routine checkups and have decreased access to health care compared to older ones.[46] Without the ACA, these disparities would surely grow even wider, resulting in a reversal of these positive developments for younger people with disabilities.

D. Essential Health Benefits

The ACA also mandated a minimum level of benefits that health plans in the individual and small-group markets must cover. The ACA requires all individual and

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[43] *See* NAT'L COUNCIL ON DISABILITY, *supra* note 13, at 18 (citing studies).

[44] *Id.* at 20-21.

[45] *Id.* at 21.

[46] Catherine A. Okoro et al., *Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults—United States, 2016*, 67 MORBIDITY & MORTALITY WKLY. REP. 882, 886, Table 2 (2018) (examining age cohorts of 18-44, 45-64, and over 65).

small-group plans, and all plans sold in the state exchanges, to cover "essential health benefits."[47] The ACA defines "essential health benefits" as a series of ten enumerated categories of benefits and the corresponding items and services that must be included within each of the categories.[48] In particular, mandated benefits includes hospitalization, outpatient medical care, mental health and substance abuse treatment, rehabilitative and habilitative services and devices, and prescription drugs.[49] The ACA grants the Secretary of the Department of Health and Human Services ("HHS") authority to further define the benefits included in each benefit category, but is directed to ensure that the scope of "essential health benefits" is equal to the scope of benefits provided by a "typical employer plan."[50] Notably, HHS must define the essential health benefits in a manner that, *inter alia*, does not discriminate on the basis of disability or health status or otherwise discourage people with significant health needs from enrolling in their plans.[51]

Of particular importance here is the inclusion of rehabilitative and habilitative services and devices as essential health benefits. Habilitative services and devices are provided to help an individual attain new skills not developed because of a disabling condition and then maintain or prevent deterioration of such skills. In contrast, rehabilitative services and devices are intended to help a person regain, maintain, or

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[47] 42 U.S.C. §§ 18022(b)(1), 300gg-6.

[48] *Id.*; *also* 45 C.F.R. § 156.110.

[49] *Id.* § 18022(b)(1).

[50] *Id.* § 18022(b)(2); *see* 45 C.F.R. § 156.110.

[51] 42 U.S.C. § 18022(b)(4).

prevent deterioration of a skill or function that may have been lost due to a disabling condition.[52] Prior to the ACA, health plans would typically cover rehabilitative services, such as occupational, physical, or speech therapy to help individuals with an accident or illness *recover* their ability to walk, speak and function. However, habilitative services were generally excluded, as insurers would argue such services were not medically necessary if they would not result in "improvement" or if an individual did not have some level of functional ability in the first place. Likewise, habilitative devices include durable medical equipment ("DME"), such as walkers, ventilators, wheelchairs and glucose monitors that help individuals maintain their health and live independently. [53]

Another key category of "essential health benefits" is mental health and substance use disorder services (collectively, "behavioral health services").[54] Prior to the ACA, 38% of health plans did not provide coverage for mental or behavioral health care services, and 45% of health plans did not provide coverage for substance abuse disorder services.[55] Though Congress had required group insurers to provide

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[52] *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10811 (Feb. 27, 2015) (as codified at 45 C.F.R. § 156.115).

[53] DME encompasses a variety of devices that help with such basic functions as breathing, mobility, using the restroom, and monitoring one's health. The ACA's legislative history demonstrates that members of Congress understood that rehabilitative and habilitative services and devices include DME. 156 CONG. REC. H8812 (daily ed. Mar. 21, 2010) (statement of Rep. Miller).

[54] 42 U.S.C. § 18022(b)(1)(E).

[55] Claxton et al., *supra* note 34, at 2.

coverage for certain behavioral health benefits that was no more restrictive than other medical benefits covered by the health plan, these requirements did not translate into comparable coverage for behavioral health services. [56]

The ACA, however, amended and extended the federal parity provisions to require behavioral health parity in the individual markets, and the inclusion of behavioral health services as "essential health benefits" provided additional strength to the parity requirements.[57]

E. Ban on Annual and Lifetime Limits

Among its lesser-known provisions, the ACA also prohibits lifetime or annual limits on the amount of essential health benefits payable on behalf of a covered individual.[58]

In the decade before the ACA, studies showed that the majority (59%) of workers with employer-provided health plans faced a cap on lifetime benefits.[59] As a result, even if a person had access to health insurance, the coverage could discontinue

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[56] *See* 29 U.S.C. § 1185a; 26 U.S.C. § 9812; Kirsten Beronio et al., U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans* (2013), https://aspe.hhs.gov/system/files/pdf/76591/rb_mental.pdf.

[57] 42 U.S.C. § 300gg-26.

[58] 45 C.F.R. § 147.126; *see also* Sarah Kliff, *The Obamacare Provision that Saved Thousands from Bankruptcy*, VOX (Mar. 2, 2017), https://www.vox.com/policy-and-politics/2017/2/15/14563182/obamacare-lifetime-limits-ban.

[59] Gary Claxton et al., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY 184 (2009), https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7936.pdf.

forever once the limit had been reached. The ACA now prohibits both lifetime and annual limits on coverage for essential health benefits.

The implications of this prohibition profoundly impact disabled people, particularly those who require lifelong health services to support their health and independence. Disabled people, on average, utilize more health care and incur more medical expenses than people without disabilities.[60] The ACA has likewise allowed those with chronic conditions to find stable insurance coverage that will not suddenly be exhausted.[61] For these people or others with disabilities requiring regular medical attention, the ACA's ban on lifetime and annual limits has dramatically reduced the likelihood of having to endure medical bankruptcy to obtain needed medical treatment.

F. Non-Discrimination Requirements

Finally, the ACA expanded protections for disabled individuals through the expansion of non-discrimination requirements. Section 1557 of the ACA adopts and applies existing federal laws that prohibit discrimination on the grounds of, *inter alia*, disability. It applies non-discrimination provisions broadly to: (1) any health program or activity, any part of which is receiving federal financial assistance; (2) any publicly-

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[60] Kennedy et al., *supra* note 3, at 8, Table 5; Chaiporn Pumkam et al., *Health Care Expenditures Among Working-age Adults with Physical Disabilities: Variations by Disability Spans*, 6 DISABILITY & HEALTH J. 287, 294, Table 4 (2013).

[61] *See* Joanne Volk, *Affordable Care Act's Ban on Lifetime Limits Has Ended Martin Addie's Coverage Circus*, GEORGETOWN UNIV. HEALTH POLICY INST. (Nov. 14, 2012), https://ccf.georgetown.edu/2012/11/14/affordable-care-acts-ban-on-lifetime-limits-has-ended-martin-addies-coverage-circus/.

administered health program or activity; and (3) the state health care exchanges created by the ACA.[62]

Pursuant to its implementing regulations, Section 1557 specifically prohibits discriminatory health plan benefit designs, which is a more subtle and insidious form of discrimination against disabled people.[63] An issuer does so by, *inter alia*, designing a plan that effectively discourages disabled people from enrolling or limits the scope of coverage in such a way as to void or reduce the benefit that a person may receive from the insurance.

These provisions provide a powerful protection for people with disabilities, allowing them to seek redress from those who may want to exclude them from receiving the health care they need or to make it unfairly cost prohibitive.[64]

IV. The ACA's Changes to Medicaid Also Provide People With Disabilities Better, and Sometimes Unprecedented, Access to Health Care.

Medicaid is a joint federal-state program that provides health care and long-term services and supports to individuals that meet certain income, eligibility, and assets requirements.[65] While federal law and regulations guide Medicaid, states have some authority to vary the coverage of services, eligibility requirements and provider reimbursement under the program. Each state specifies the nature and scope of its

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[62] ACA § 1557 *codified at* 42 U.S.C. § 18116.

[63] *See* 45 C.F.R § 155.120(c). Section 1311 of the ACA also prohibits discriminatory plan design. ACA § 1311 *codified at* 42 U.S.C. § 18031.

[64] *See, e.g.*, http://www.chlpi.org/wp-content/uploads/2013/12/LA-Humana.pdf (complaint against Humana in Louisiana).

[65] *See* 42 U.S.C. §§ 1396, 1396a.

Medicaid program through a state plan.[66] The state plan is a comprehensive document that must be approved by the Centers for Medicare and Medicaid Services ("CMS") in order for the state to access federal Medicaid funds and may be amended to reflect changes in state policy and federal law and regulation.[67]

Medicaid is an important source of health insurance coverage for people with disabilities, and the ACA's improvements to the Medicaid program have had a substantial impact on their ability to access much-needed health care services.

A. Medicaid Eligibility Expansion

Prior to the ACA, to qualify for Medicaid, an individual generally had to have low income and, in addition, meet one of several eligibility categories. Low-income children, parents or caretakers of children, disabled children or adults or elderly adults were all eligible for Medicaid, but not *all* "poor" persons qualified.[68]

Effective in 2014, the ACA expanded Medicaid eligibility to include all adults with income up to 138% of the federal poverty line.[69] Though made optional by the

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[66] *Id.* § 1396a.

[67] 42 C.F.R. § 431.10.

[68] 42 U.S.C. § 1396a(a)(10)(A)(i); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID: TITLE XVIII AND TITLE XIX OF THE SOCIAL SECURITY ACT 24 (2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2016.pdf.

[69] 42 U.S.C. § 1396a(e)(14)(I); 42 C.F.R. § 435.603(d)(4).

Supreme Court,[70] to date, 36 states and D.C. have expanded Medicaid eligibility.[71] Within the Fifth Circuit, only Louisiana has expanded Medicaid.[72] However, among the 37 states appearing before this Court, 25 of those states have expanded Medicaid—including 9 of the 20 original plaintiffs and 16 of the 17 intervener-defendants.[73]

Medicaid eligibility based solely on income is especially important for individuals with disabilities because it generally provides faster access to health insurance coverage, without the delay of a formal disability determination.[74] Moreover, Medicaid's narrow definition of "disability" is notoriously underinclusive of the many people with chronic conditions and functional limitations—sometimes episodic or compounding—that need sufficient health care services and support to access employment and to participate in their communities.

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[70] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 587 (2012).

[71] KAISER FAMILY FOUND., STATUS OF STATE ACTION ON THE MEDICAID EXPANSION DECISION (2019), https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

[72] *Id.*

[73] *Id.*

[74] *See* Molly O'Malley Watts et al., *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015*, KAISER COMM'N ON MEDICAID & THE UNINSURED, 10 (2016), http://files.kff.org/attachment/report-medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015; MaryBeth Musumeci, *The Affordable Care Act's Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities,* KAISER COMM'N ON MEDICAID & THE UNINSURED (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8390-02-the-affordable-care-acts-impact-on-medicaid-eligibility.pdf.

Medicaid expansion represents the primary new coverage option for people with disabilities under the ACA.[75] Research has already shown that the expansion of Medicaid has especially benefitted various marginalized populations, resulting in larger gains in insurance coverage in expansion states as compared to the general population.[76] The ACA's Medicaid expansion is responsible for the largest portion of the decrease in the uninsurance rate for people with disabilities, with 42.9% receiving insurance from Medicaid in 2017, an increase from 34.9% in 2009.[77]

B. Long-Term Care Services and Supports

The ACA also provided additional flexibility for Medicaid to cover long-term services and supports ("LTSS"). Medicaid is the primary payer for LTSS, including nursing facility and home and community-based services ("HCBS").[78] All states are required to provide coverage under Medicaid for nursing facility services, but HCBS coverage is optional.[79] Medicaid LTSS expenditures include services and supports for

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[75] Stephan Lindner et al., "*Canaries in the mine…": The Impact of Affordable Care Act Implementation on People with Disabilities: Evidence from Interviews with Disability Advocates*, 11 DISABILITY & HEALTH J. 86, 89 (2016).

[76] Antonisse et al., *supra* note 22, at 3.

[77] 2017 DSR, *supra* note 7, at 56.

[78] Musumeci, *supra* note 74.

[79] U.S. Dep't of Health & Human Servs., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, AN OVERVIEW OF LONG-TERM SERVICES AND SUPPORTS AND MEDICAID: FINAL REPORT 5 (2018), https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf ("LTSS and Medicaid Report").

seniors and people with a wide range of physical, intellectual, developmental, and mental disabilities.[80]

LTSS refers to a variety of health and social services that assist individuals with functional limitations due to chronic conditions or disabilities with self-care tasks and can allow individuals with disabilities to live independently in their homes and communities. LTSS includes assistance with activities of daily living (e.g., eating, bathing, and dressing) and instrumental activities of daily living (e.g., housekeeping, preparing meals, and managing medication). Most LTSS is provided informally by unpaid caregivers such as family or friends, but may also be provided formally by paid caregivers. Traditionally, LTSS was provided in an institutional setting (e.g., a nursing home), but there has been a shift to providing it in the individual's home or in community-based settings (e.g., personal care assistant may come to one's private home or a group home), so as to afford individuals the choice to live in their communities. In fact, under the ADA, individuals with disabilities have the civil right to choose to receive LTSS in the community, rather than in an institutional setting, where appropriate.[81]

People with disabilities are the primary population served by LTSS.[82] Medicaid is the primary payer for LTSS as other public and private health insurers do not offer

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[80] *Id.* at 1.

[81] *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 607 (1999); 42 U.S.C. § 12101 et seq.

[82] LTSS and Medicaid Report, *supra* note 79.

such coverage.[83] Individuals who need LTSS may qualify for Medicaid based solely on their low income or may qualify at slightly higher incomes by meeting disability-related functional criteria.[84]

The ACA provided new and expanded options for states to offer LTSS in home and community-based settings to Medicaid beneficiaries.[85] People with disabilities generally prefer to receive services in their homes and communities, which is also more cost-efficient than institutional services.[86] A number of new programs created by the ACA expand eligibility for and provide increased access to HCBS.

1. State Plan HCBS Option

States have had the option to include HCBS in their state Medicaid plans without a waiver since 2005. However, the ACA expanded financial eligibility for HCBS and allowed states to target specific populations for coverage.[87] States could provide full Medicaid benefits, as well as HCBS, to individuals who are not otherwise eligible for Medicaid and who meet certain financial and functional eligibility criteria.[88]

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[83] Erica L. Reaves & MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer*, KAISER FAMILY FOUND. 3 (Dec. 2015), http://files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer.

[84] *Id.*

[85] *See* 42 U.S.C. § 1396n.

[86] *See*, *e.g.*, Arpita Chattopadhyay et al., *Cost-efficiency in Medicaid Long-term Support Services: The Role of Home and Community Based Services*, 2 SPRINGERPLUS 1 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3710567.

[87] 42 U.S.C. § 1396n.

[88] 42 U.S.C. § 1915(i).

Under the ACA, states can cover: (1) people up to 150% of the federal poverty line with no asset limit who meet functional eligibility criteria and who will receive HCBS; and/or (2) people up to 300% SSI who would be eligible for Medicaid under an existing HCBS waiver and will receive state plan HCBS.[89] These provisions primarily benefit children and adults with significant mental health needs and people with intellectual and developmental disabilities.

2. Community First Choice Option

The ACA also created the Community First Choice Option, which allows states to provide HCBS to Medicaid enrollees and increased the federal share of funding available to participating states by 6%.[90] States can provide these services to individuals who are eligible for the state's Medicaid program and whose income does not exceed 150% of the federal poverty line. Alternatively, if the individual's income is higher than this threshold but the individual has been determined to require an institutional level of care and is eligible for nursing facility services, then the individual is also eligible for HCBS.[91]

Five states implemented the Community First Choice Option, including Texas. CMS approved Texas's plan amendment to add Community First Choice services on April 2, 2015, with an effective date of June 1, 2015. Texas provides a variety of services under its Community First Choice amendment:

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[89] Watts, *supra* note 74, at 9.

[90] 42 U.S.C. § 1396n(k).

[91] 42 U.S.C. § 1396n(k)(1).

- **Personal assistance services**. These services include non-skilled assistance with activities of daily living, household assistance, assistance with health-related tasks and escort services to assist individuals with accessing services and activities in the individual's community.

- **Habilitation services**. These services are provided to allow an individual to acquire, maintain and enhance the skills necessary for the individual to accomplish activities of daily living and health-related tasks independently or with less support.

- **Emergency response services**. Texas provides reimbursement for electronic devices for individuals who live alone or who are alone for extended periods of time, intended to ensure continuity of services and supports for such individuals.

- **Support system**. Depending on an individuals' disability, various entities provide service coordination, case management and other supports for individuals receiving services.

For states such as Texas and Louisiana with long waiting lists of children in need of services, the ACA created opportunities for them to expand their HCBS programs.[92] In fact, nearly two-thirds of the children who are on waiting lists for HCBS are in Texas.[93] Research has already demonstrated that the Medicaid waiver programs provide coverage for services, such as independent living skills, that are important for individuals with disabilities.[94] Invalidating the ACA would not eliminate

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[92] Elizabeth Edwards, *Helping Those on HCBS Waiting Lists: Positive Impacts of the ACA*, NAT'L HEALTH LAW PROGRAM 4-5 (Feb. 14, 2017), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2017/02/HCBS-ACA-WaitingListsFinal.pdf.

[93] *Id.*

[94] Lindner et al., *supra* note 75, at 89.

the legal obligation for states to meet the needs of disabled people, but would decrease the options available for states to meet these obligations.[95] It would also eliminate CMS' statutory authority to implement these innovative programs that have provided much-needed LTSS to individuals with disabilities who are covered by Medicaid.

C. Behavioral Health Parity

As set forth in Section III.D, behavioral health services were generally not covered by private health insurance.[96] The ACA expanded their availability by mandating behavioral health services be included in Medicaid to the same extent as other medical benefits and be provided to Medicaid-expansion adults and other adult populations.[97]

* * *

Taken together, the ACA's provisions have transformed the lives of people with disabilities. The ACA has increased the availability of health care, allowing those who previously did not have coverage to gain access to essential health services and supports. It has increased the affordability of coverage, and significantly expanded access to and quality of services. Invalidating the ACA now would reverse all these positive gains and disproportionately harm an already marginalized group of Americans.

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[95] Edwards, *supra* note 92, at 4.

[96] Claxton et al., *supra* note 34.

[97] 42 U.S.C. § 1396u-7.

CONCLUSION

Amici respectfully request that the Court reverse the district court's ruling declaring the ACA unconstitutional in its entirety and remand for further proceedings.

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because it contains 6,409 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) and the Rules of this Court.

2. This brief 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 has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Garamond.

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CERTIFICATE OF SERVICE

I hereby certify that this brief has been served through the Court's ECF system on counsel for all parties required to be served on April 1, 2019.

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