No. 14-5018

[ORAL ARGUMENT SCHEDULED FOR MARCH 25, 2014]

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JACQUELINE HALBIG, *et al.*,

Plaintiffs–Appellants,

v.

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants–Appellees

On Appeal from the United States District Court
for the District of Columbia (No. 13-623 (PLF))

BRIEF OF JONATHAN H. ADLER AND MICHAEL F. CANNON AS *AMICI CURIAE* IN SUPPORT OF THE APPELLANTS

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(1), undersigned counsel certifies that:

(A) Parties and *Amici*: All parties, intervenors, and *amici* appearing before the district court and those that have filed an appearance or notice in this court are listed in the Opening Brief for Plaintiffs-Appellants, except for the following *amici* that have filed notices of intent to participate with this Court: Pacific Research Institute, Cato Institute, State of Oklahoma, State of Alabama, State of Georgia, State of West Virginia, State of Nebraska, State of South Carolina, Consumer's Research, America's Health Insurance Plans, and National Federation of Independent Business Small Business Legal Center.

(B) Rulings Under Review: References to the rulings at issue appear in the Opening Brief for Plaintiffs-Appellants, and *amici* is not aware of any other rulings at issue.

(C): *Amici* are not aware of any related cases within the meaning of Circuit Rule 28(a)(1)(C).

Dated: February 6, 2014

/s/ Andrew M. Grossman
Andrew M. Grossman

CERTIFICATE IN SUPPORT OF SEPARATE BRIEF

Circuit Rule 29(d) provides that "[a]mici curiae on the same side must join in a single brief to the extent practicable." *Amici* are authors of the leading scholarly treatment of the issue presented in this appeal. *Amici's* interest is therefore distinct and narrower from those of other parties filing *amicus curiae* briefs in support of the Appellants. Moreover, this separate brief is necessary to address the complex legislative history of the Patient Protection and Affordable Care Act of 2010, which may be relevant to this appeal and which neither the Appellants nor any other *amici* have addressed in detail.

Dated: February 6, 2014

/s/ Andrew M. Grossman
Andrew M. Grossman

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INTEREST OF THE *AMICI CURIAE*[1]

Amici were among the first to consider the federal government's authority to extend subsidies for coverage purchased through federally established marketplaces. They have since, separately and together, published numerous articles, delivered lectures and testimony, and advised government officials on that issue and, in particular, on the regulation challenged here. They are the authors of the leading scholarly treatment of this issue, Jonathan H. Adler and Michael F. Cannon, Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA, 23 Health Matrix J. L. Med. 119 (2013).

Jonathan H. Adler is the Johan Verheij Memorial Professor of Law and Director of the Center for Business Law and Regulation at the Case Western Reserve University School of Law in Cleveland, Ohio. Professor Adler teaches courses in constitutional and administrative law, among other subjects, and is the author of numerous articles on federal regulatory policy and legal issues relating to health care reform, including Cooperation, Commandeering or Crowding Out? Federal Intervention and State Choices in Health Care Policy, 20 Kan. J. L. & Pub. Pol'y 199 (2011).

[1] Counsel for the *amici curiae* certifies that no counsel for any party authored this brief in whole or in part and that no person or entity other than the *amici curiae* or their counsel made a monetary contribution intended to fund the brief's preparation or submission. All parties have consented to the filing of this brief.

Michael F. Cannon is the director of health policy studies at the Cato Institute, a non-partisan, non-profit educational foundation organized under section 501(c)(3) of the Internal Revenue Code, located in Washington, D.C., and dedicated to the principles of individual liberty, limited government, free markets, and peace. Cannon is a nationally recognized expert on health care reform. He holds masters degrees in economics (M.A.) and law and economics (J.M.).

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act of 2010 ("PPACA" or "Act") declares in Section 1311 (42 U.S.C. § 18031) that "Each State shall . . . establish" an "Exchange" to regulate health insurance within each state; directs the federal government in Section 1321 (42 U.S.C. § 18041) to establish Exchanges in states that do not; and in Section 1401 (26 U.S.C. § 36B) offers health insurance tax credits to certain taxpayers who enroll in a qualified health plan "through an Exchange established by the State under Section 1311 of the Patient Protection and Affordable Care Act." The statutory language limiting tax credits to state-established Exchanges is clear, consistent, and unambiguous. The remainder of the statute and the PPACA's legislative history are fully consistent with the plain text of the tax-credit eligibility rules.

In 2012, the Internal Revenue Service issued a rule that, without any reasoned basis, offers premium-assistance tax credits through Exchanges

established by the federal government under Section 1321. The agency is presently issuing those tax credits in the 34 states that elected not to establish an Exchange. The IRS rule is contrary to the plain language of the PPACA and cannot be justified on other grounds. It exceeds the agency's authority and subverts congressional intent by altering the balance Congress struck between the Act's competing goals.

In order to induce state cooperation, Congress routinely conditions federal benefits to individuals—both via direct spending and the tax code—on their state carrying out congressional priorities. The legislative history shows the authors of the PPACA entertained numerous proposals to condition health-insurance tax credits and subsidies on state cooperation. The Act's supporters endorsed state-run Exchanges out of political necessity, and its authors conditioned premium-assistance tax credits on states establishing Exchanges as one among a number of financial inducements for states to perform this task for the federal government.

The IRS claims its rule reflects congressional intent. Yet the agency has failed to identify *any* statutory language or even a *single* statement prior to or contemporaneous with enactment of the PPACA indicating that the PPACA authorizes tax credits in *federal* Exchanges. Nor has the agency identified any statutory provisions creating any ambiguity about the PPACA's tax-credit

eligibility provisions. The IRS simply rewrote the statute. The IRS's regulation is contrary to law and should be set aside.

ARGUMENT

I. The PPACA Authorizes Premium-Assistance Tax Credits Only in States that Establish Their Own Exchanges

The premium-assistance tax credit provisions of the PPACA clearly, consistently, and unambiguously authorize tax credits only in states that establish a health insurance "exchange" that complies with federal law. Specifically, Section 36B authorizes tax credits for the purchase of qualifying health insurance plans only in exchanges "established by a state under Section 1311." 26 U.S.C. §§ 36B(b)(2)(A), 36B(b)(3)(B)(i), 36B(b)(3)(C), 36B(c)(2), 36B(e); *see also* Adler & Cannon, *supra*, at 144–45. The IRS rule, by contrast, purports to authorize tax credits in Exchanges that are neither "established by the State" nor "established . . . under Section 1311." This it cannot do. Because the language of the PPACA speaks directly to the question at issue, the IRS has no authority to provide tax credits in federal exchanges, nor is the IRS due deference in its interpretation of the Act. To avoid duplicative briefing, *amici* adopt the analysis of the statutory text contained in Section I.A of Appellants' Opening Brief ("Br."), with two exceptions that strengthen the case against the IRS rule.

First, Appellants appear to accept the district court's claim that this condition appears *within* the formula for calculating credits. Br. at 41 n.6. On the contrary, it is a *pre*condition in using the formula: the IRS cannot use the formula unless the taxpayer is enrolled through a state-established Exchange and there exist premiums for plans offered through that Exchange. 26 U.S.C. §§ 36B(b)(2)(A), 36B(b)(3)(B)(i), 36B(b)(3)(C), 36B(c)(2). The fact that this condition lies *outside* the formula renders moot the district court's claim that its placement within the formula somehow indicates a counter-textual intent.

Second, Appellants say the PPACA does not condition credits on "states' adoption of insurance reforms." Br. at 42. On the contrary, Section 1321 directs the Secretary to establish an Exchange—an action that cuts off tax credits to the state—if "the Secretary determines . . . that an electing State will not have any required Exchange operational . . . *or has not taken the actions the Secretary determines necessary to implement the other requirements set forth in the standards under subsection (a); or the requirements set forth in subtitles A and C and the amendments made by such subtitles.*" 42 U.S.C. § 18041(c) (emphasis added). Section 1321 is thus the linchpin of a conscious effort by the PPACA's authors to use tax credits to induce states to implement various elements of the Act.

II. Congress Routinely Conditions Benefits to Individuals on State Action as a Means of Inducing States to Carry Out Federal Priorities

When Congress conditioned premium-assistance tax credits on states establishing health insurance Exchanges, it employed a well-established method of inducing state cooperation with federal programs. The federal government "may not compel the states to implement, by legislation or executive action, federal regulatory programs." *Printz v. United States*, 521 U.S. 898, 925 (1997). *See also New York v. United States*, 505 U.S. 144, 162 (1992) (''[T]he Constitution has never been understood to confer upon Congress the ability to require States to govern according to Congress's instructions.''); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (*NFIB*).

Congress can, and routinely does, provide various incentives to *encourage* states to implement federal programs or enact desired legislation. Such incentives include direct federal spending, as with the PPACA's expansion of the Medicaid program, and often include tax incentives for state residents. The following examples demonstrate that conditioning federal health-insurance subsidies and, in particular, favorable tax treatment for state residents on state compliance with federal requirements is both commonplace and was a part of Congress' deliberations over the PPACA.

A. Congress Conditioned Far Greater Subsidies on States Implementing the PPACA's Medicaid Expansion than Its Exchanges

For 47 years, Congress has conditioned Medicaid grants to states on states enacting and operating Medicaid programs that meet federal specifications. 42 U.S.C. §1396c; *NFIB*, 132 S. Ct. at 2601-02. Both PPACA and its antecedent bill reported by the Senate Finance Committee conditioned all federal Medicaid grants on states expanding their programs to cover all legal residents with incomes below 138 percent of the federal poverty level.[2] PPACA § 2001; America's Healthy Future Act of 2009, S. 1796, § 1601, 111th Cong. (1st Sess. 2009).

The amount Congress originally conditioned on states implementing the expansion totaled roughly *12 times* the aggregate amount of tax credits and cost-sharing subsidies Congress conditioned on states establishing Exchanges. *Compare* Office of Management and Budget, Fiscal Year 2014; Historical Tables - Budget of the U.S. Government 163, *available at* http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/hist.pdf (federal Medicaid grants to states exceeded $250 billion annually, even before the PPACA increased federal Medicaid spending) *with* Cong. Budget Office, The

[2] In *NFIB*, the Supreme Court ruled that conditioning existing Medicaid grants on states implementing the expansion was coercive and thus unconstitutional. But the court allowed Congress to condition the PPACA's new Medicaid grants on states implementing the expansion. 132 S. Ct. at 2607–08. Though the original conditions were invalidated, there is no dispute about what Congress sought to accomplish or the meaning of the relevant statutory text.

Budget and Economic Outlook: Fiscal Years 2013 to 2023, 16 (February 5, 2013) (projecting Exchange-related subsidies would total just $21 billion in 2014, and would remain less than one-quarter the amount of total federal Medicaid grants through 2023). Post-*NFIB*, Congress still conditions far more funding on state implementation of Medicaid than on establishment of an Exchange. *See* 132 S. Ct. at 2607 (allowing states to decline the PPACA's Medicaid expansion without losing the "old" Medicaid grants). The "new" Medicaid-expansion grants alone outweigh the conditional Exchange subsidies. *See* Cong. Budget Office, Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act (March 13, 2012), at 11.

B. State Children's Health Insurance Program

In 1997, Congress enacted the State Children's Health Insurance Program ("SCHIP"), which conditions federal grants to states on each state's implementation of a health insurance program for children with low-to-moderate incomes. 42 U.S.C. §§ 1397aa–1397mm. Cong. Res. Serv., State Children's Health Insurance Program (CHIP): A Brief Overview (March 18, 2009), ("All states, the District of Columbia, and the five territories have CHIP programs."). In 2009, Congress reauthorized SCHIP with the Children's Health Insurance Program Reauthorization Act (CHIPRA). *Id.* Over a five-year period, CHIPRA conditioned a total of $100 million in grants on states expanding outreach and enrollment

activities, plus $225 million on states taking steps intended to improve the quality of care for covered children. The Commonwealth Fund, The Children's Health Insurance Program Reauthorization Act: Progress After One Year, States in Action (May 2010).

C. Since 2002, Congress Has Conditioned Health Coverage Tax Credits on States Enacting Certain Laws

In 2002, Congress created "health coverage tax credits" (HCTCs) under the Trade Adjustment Assistance Reform Act. 26 U.S.C. § 35. The HCTC pays, through a credit, 72.5 percent of qualified health insurance premiums for certain taxpayers.

The structure of the HCTC eligibility rules is nearly identical to the PPACA's tax-credit eligibility rules. Congress made HCTCs available only during "coverage months," which would occur only when a taxpayer is enrolled in "qualified health insurance." 26 U.S.C. § 35(b). The rules defining these terms determine eligibility for tax credits. *See* Br. at 6. Those eligibility rules include requirements that states enact specified laws before certain residents may claim the HCTC. 26 U.S.C. § 35(e)(2); s*ee also* Cong. Res. Serv., Health Coverage Tax Credit Offered by the Trade Act of 2002 at ii (January 31, 2008), http://wlstorage.net/file/crs/RL32620.pdf ("The HCTC can be claimed for only 10 types of qualified health insurance specified in the statute, *7 of which require state action to become effective.*") (emphasis added). Senate Finance Committee

chairman Max Baucus introduced a version of the HCTC that would have required states to enact additional measures, such as a minimum-loss ratio requirement on those seven types of qualified coverage. *See* Trade Adjustment Assistance Improvement Act of 2002, S. 2737, 107th Cong. (2d Sess. 2002).

D. States Had to Change Laws Before Residents Could Use Tax-Free Health Savings Accounts

Beginning in 2004, Congress allowed certain individuals to make tax-free contributions to health savings accounts (HSAs), provided their states enact certain laws. 26 USC § 223(c)(2). As one prominent health-law expert explains:

> HSAs received federal tax subsidies only when the HSAs were coupled with high deductible health plans. *These tax subsidies were only available, therefore[,] in states where high deductible plans were permitted. This in turn meant that some states had to repeal or amend laws limiting plan deductibles.* Most states that had provisions limiting high deductible plans quickly fell into line, although a few did not, at least initially.

Timothy Jost, State-Run Programs Are Not A Viable Option For Creating A Public Plan (Jun. 16, 2009) (emphasis added).

E. Conditioning Tax Credits on a "Public Option"

In May 2009, Senator Baucus proposed encouraging states to establish their own "State-run public option" health plans to compete with private insurers. Senator Max Baucus, Description of Policy Options – Expanding Health Care Coverage: Proposals to provide affordable coverage to all Americans, S. Comm.

Fin. White Paper (May 14, 2009), at 14. As a means of encouraging states to create their own "public option," health-law professor Timothy Jost proposed, "Tax credits could be offered to subsidize the purchase of insurance, but *only in states that implemented a public program*." Jost, State-Run Programs, *supra* (emphasis added).

F. Conditioning Small Business Tax Credits on States Establishing Exchanges and Implementing Insurance Reforms

In 2008, a bipartisan group of senators, including members of the Finance Committee and Committee on Health, Education, Labor, & Pensions ("HELP"), introduced a bill to create health-insurance tax credits for certain small businesses that conditioned those credits on states establishing Exchanges. Sponsors included Sens. Richard Durbin (D-IL), Olympia J. Snowe (R-ME), Blanche L. Lincoln (D-AR), Norm Coleman (R-MN), Amy Klobuchar (D-MN), Susan M. Collins (R-ME), Jeff Bingaman (D-NM), Herb Kohl (D-WI), Arlen Specter (R-PA), Robert P. Casey, Jr. (D-PA), Joseph I. Lieberman (I-CT), Mark L. Pryor (D-AR), Ken Salazar (D-CO), and Christopher S. Bond (R-MO). The bill offered tax credits to "qualified small employers" that "purchas[e] health insurance coverage for [their] employees in a small group market *in a State which . . . maintains a State-wide purchasing pool that provides purchasers in the small group market a choice of health benefit plans*, with comparative information provided concerning such plans and the premiums charged for such plans made available through the Internet."

Small Business Health Options Program Act, S. 2795, 110th Cong. (2nd Sess. 2008) (emphasis added). Sen. Durbin reintroduced the bill in 2009, adding as sponsors Sens. Roland Burris (D-IL), Jeanne Shaheen (D-NH), Kirsten Gillibrand (D-NY), and Mark Begich (D-AK). Small Business Health Options Program Act of 2009, S. 979, 111th Cong. (1st Sess. 2009) (identical language to S. 2795).

In a November 2008 "white paper" and through most of 2009, Finance Committee chairman Baucus proposed small-businesses tax credits modeled on S. 2795 and S. 979, and that likewise conditioned credits on state action. *See* Senator Max Baucus, Call to Action: Health Reform 2009, Senate Finance Committee White Paper (Nov. 12, 2008), at 20 ("Initially, the credit would be available to qualifying small businesses that operate in states with patient-friendly insurance rating rules."); *id*. at 32 n.10; Baucus, Description of Policy Options, *supra* (certain "small employers can purchase through the Health Insurance Exchange [where tax credits are available] once the federal rating rules are fully phased in by their state."); S. Comm. Fin., Framework for Comprehensive Health Reform 3 (Sept. 8, 2009) (proposing small-business tax credits available through "a SHOP exchange modeled after S. 979, the 'Small Business Health Options Program Act'"); S. Comm. Fin., America's Healthy Future Act, Chairman's Mark (Sept. 22, 2009) ("If a State has not yet adopted the reformed rating rules, qualifying small employers in the state would not be eligible to receive the credit").

When the Finance Committee reported its version of health care reform in 2009, the bill conditioned small-business tax credits on state action. America's Healthy Future Act of 2009, S. 1796, 111th Cong. 182-83 (1st Sess. 2009) ("STATE FAILURE TO ADOPT INSURANCE RATING REFORMS.—*No credit shall be determined* under this section . . . *for any month of coverage before the first month the State establishing the exchange has in effect the insurance rating reforms*") (emphasis added); S. Rep. No. 111-89 (2009) ("If a State has not yet adopted the reformed rating rules, qualifying small business employers in the State are not eligible to receive the credit")

G. Conditioning Federal Grants on States Enacting Medical Malpractice Liability Reforms

The PPACA adopted language from the Finance Committee bill expressing the "sense of the Senate" that Congress should condition grants to states on states' enacting laws to reform medical malpractice liability. S. Rep. No. 111-89. During the Finance Committee's mark-up of its health care bill (S. 1796), Republican senators offered amendments that would have conditioned new Medicaid grants on states enacting medical malpractice reforms. *Id*. The PPACA created such a conditional-grant program, as did the House-passed Affordable Health Choices for America Act. PPACA §10607; Affordable Health Choices for America Act, H.R. 3962, § 2531, 111th Cong. (1st Sess. 2009).

H. Conditioning Premium Credits on States Implementing an Employer Mandate

The bill reported by the Senate HELP Committee shared the same basic structure as the bill reported by the Finance Committee and the final PPACA. *See* Affordable Health Choices Act, S. 1679, 111th Cong. (2009). The HELP bill conditioned its version of premium credits on states enacting laws to implement that bill's employer mandate. *Id.* at § 3104(d). *See also* Adler & Cannon, *supra*, at 155-56. As Prof. Jost explained, "A state's residents will only become eligible for federal premium subsidies . . . if the state provides health insurance for its state and local government employees." Timothy Jost, Health Insurance Exchanges in Health Care Reform Legal and Policy Issues, Washington and Lee Public Legal Studies Research Paper Series (2009).

I. Conditioning Tax Credits to Individuals on States Establishing a Compliant Exchange

The legislative history shows that conditioning subsidies on states establishing Exchanges, as a means of encouraging states to establish them, was quite common in the run-up to the PPACA. The Finance bill, the HELP bill, and the PPACA each created incentives for states to establish Exchanges, including offering states *unlimited* start-up funds. *See* America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 2237(c) (1st Sess. 2009); Affordable Health Choices Act, *supra*, at § 3101(a); 42 U.S.C. § 18031(a)(2).

The Finance bill offered tax credits to certain individuals only if they purchased a qualified health plan through a state-established Exchange. America's Healthy Future Act of 2009, supra § 1205 (specifying that the "premium assistance amount" can only be calculated using premiums from qualified health plans offered in "an Exchange established by the State" and that taxpayers are eligible for credits only during "coverage months," defined by cross-reference as months during which the taxpayer is enrolled in a qualified health plan purchased through "an exchange established by the State").

The HELP bill allowed states to choose either a state-run Exchange ("Gateway") or a federal Exchange, and offered "premium credits" through both—subject to certain conditions. If a state established an Exchange, residents could receive credits almost immediately. Affordable Health Choices Act, *supra*, § 3104(b)(1) (residents become eligible for credits 60 days after Exchange certification). If a state's Exchange fell out of compliance with federal standards, the Secretary would revoke credits from residents who had already been receiving them. Residents would remain ineligible until the state Exchange came back into compliance, or the federal government established an Exchange in the state. *Id*. at § 3104(b)–(c). If a state requested a federal Exchange, the Secretary would establish one, and residents would become eligible for credits, only if "the State has enacted and has in effect the insurance reforms provided for in subtitle A of

title I of the Affordable Health Choices Act." *Id*. at § 3104(c). If a state neither established an Exchange nor requested a federal Exchange, "the residents of such State *shall not be eligible for credits*" until *four years* after the date of enactment, at which point the bill allowed the Secretary to establish Exchanges for non-establishing, non-requesting states. *Id*. at § 3104(d) (emphasis added). Even then, as noted above, the HELP bill permanently withheld credits in states that failed to enact legislation implementing the bill's employer mandate. *Id*. at § 3104(d); *see also* Adler & Cannon, *supra*, at 154-155. HELP Committee Republicans offered an alternative bill that likewise would have conditioned new Medicaid payments to states on states establishing Exchanges. Patients' Choice Act, S. 1099, 111th Cong. (1st Sess. 2009).

When Senate leaders merged the Finance and HELP bills to create the PPACA, they dropped the Finance bill's language conditioning small-business tax credits on states enacting certain health-insurance laws, but *strengthened* the language conditioning premium-assistance tax credits on states establishing an Exchange. *Compare* America's Healthy Future Act of 2009, S. 1796, § 1205, 111th Cong. *with* PPACA § 1401 (26 U.S.C. § 36B) (cross-reference in "coverage months" definition augmented with explicit requirement that tax credit recipients be enrolled in a qualified health plan "through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act").

III. The Legislative History of the PPACA Supports the Plain Meaning of the Statutory Text

That legislative history further shows the PPACA's authors had ample motivation to condition tax credits on states establishing Exchanges. As some PPACA supporters acknowledged, due to the constitutional prohibition on commandeering, such inducements would be necessary to ensure state cooperation. *See* Timothy Jost, O'Neill Institute Legal Solutions in Health Reform, Health Insurance Exchanges: Legal Issues 7 (2009). And while not all reform advocates wanted to rely upon state exchanges, Congress adopted this approach because it was the only way a bill could garner enough votes to pass the Senate.

A. Supporters of State-Run Exchanges Prevailed over Supporters of Federal Exchanges in the Senate

Senate Finance Committee Chairman Max Baucus was the primary author of the Finance Committee bill containing the Exchange and premium-assistance tax-credit provisions that would become law under the PPACA. *See, e.g.,* Kate Pickert, Max Baucus, Obamacare Architect, Slams Healthcare.gov Rollout, TIME.com (November 6, 2013) (identifying Baucus as "a key architect of the law"). As noted above, Baucus routinely proposed conditioning health-insurance tax credits on state cooperation.

In November 2008, Baucus proposed a "nationwide insurance pool called the Health Insurance Exchange." *See* Senator Max Baucus, Call to Action: Health

Reform 2009, Senate Finance Committee White Paper (Nov. 12, 2008). However, many observers, including state officials, instead favored a system of 50 state-run Exchanges rather than a single, nationwide Exchange operated by federal officials. Adler & Cannon, *supra*, 148-49 n.107; NAIC Ltr. to Speaker Pelosi and Majority Leader Reid (Jan. 6, 2010) ("We urge . . . that health insurance Exchanges be established and administered at the state level with the flexibility to meet the needs of our local markets and consumers."). Key U.S. senators also favored state-run Exchanges. Patrick O'Connor & Carrie Brown, Nancy Pelosi's Uphill Health Bill Battle, Politico (Jan. 9, 2010) ("Two key moderates—Sen. Ben Nelson (D-Neb.) and Sen. Joe Lieberman (I-Conn.)—have favored the state-based exchanges over national exchanges."); *see also* Reed Abelson, Proposals Clash on States' Roles in Health Plans, N.Y. Times (Jan. 13, 2010) ("The state-federal divide between the House and Senate could be a difficult gap to bridge. One possible compromise would be to have a federal exchange set up alongside the state exchanges. Senator Ben Nelson, Democrat of Nebraska, is a former governor, state insurance commissioner and insurance executive who strongly favors the state approach. His support is considered critical to the passage of any health care bill."); Carrie Brown, Nelson: National Exchange a Dealbreaker, Politico (Jan. 25, 2010).

By late 2009, the authors of both the Finance and the HELP Committee bills had abandoned the idea of a single, nationwide Exchange in favor of 50 state-run

Exchanges, with the federal government operating Exchanges only in those states that declined to do so. *See* S. Comm. Fin., Framework for Comprehensive Health Reform (Sept. 8, 2009); S. Comm. Fin., America's Healthy Future Act, Chairman's Mark (Sept. 22, 2009).

B. A Solution to the "Commandeering" Problem

In early 2009, however, the influential health-law expert Timothy Jost noted that relying on states to run Exchanges presented a problem. *See generally* Press Release, W&L Law's Jost Invited to Health Care Bill Signing Ceremony (March 23, 2010) (quoting Jost as having attended with "secretaries and Congress people and various other leaders who had worked on the bill"). Prof. Jost explained that Congress cannot compel states to operate Exchanges or enact other insurance reforms, but suggested Congress could encourage state cooperation by (among other things) "offering tax subsidies for insurance *only in states that complied with federal requirements* (as it has done with respect to tax subsidies for health savings accounts)." Timothy Jost, O'Neill Institute Legal Solutions in Health Reform, Health Insurance Exchanges: Legal Issues 7 (2009) (emphasis added).

Both the Finance and HELP bills adopted this suggestion. Each conditioned its health insurance subsidies to individual taxpayers on states establishing compliant Exchanges and implementing other elements of the bills' regulatory schemes. Those requirements were consistent with, and in addition to, other

incentives the bills created to encourage state cooperation, including unlimited start-up funds for states establishing Exchanges and the Finance Committee bill's imposition of a costly "maintenance of effort" requirement on state Medicaid programs that lifted only if states established a functional Exchange. *See* Br. at 35.

C. House Democrats Recognized States Could Block the PPACA's Benefits

While acknowledging these incentives, many House members nevertheless disapproved of the PPACA's approach to Exchanges and feared that reliance upon state exchanges would enable individual states to undermine the goal of expanded health insurance coverage. Eleven House members from Texas signed a letter to the President and the House leadership protesting that the PPACA "relies on laggard state leadership that, in Texas, would be unwilling or unable to administer the exchange, *leaving millions of Texans no better off* . . . . Not one Texas child has yet received any benefit from the Children's Health Insurance Program Reauthorization Act (CHIPRA) . . . since Texas declined to expand eligibility or adopt best practices for enrollment . . . . *The Senate approach would produce the same result—millions of people will be left no better off than before Congress acted*." U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans, My Harlingen News (Jan. 11, 2010) (emphasis added); *see also* Julie Rovner, House, Senate View Health Exchanges Differently, Nat'l Public Radio (Jan. 12, 2010) (the letter's authors "worry that because leaders in their state

oppose the health bill, *they won't bother to create an exchange, leaving uninsured state residents with no way to benefit from the new law*") (emphasis added).

D. Scott Brown's Election Rendered the PPACA the Only Bill that Could Pass Congress

House and Senate leaders had hoped to iron out differences between the two chambers' bills in a traditional conference committee or informal negotiations, but it was not to be. On January 19, 2010, Massachusetts voters elected Republican Scott Brown to the U.S. Senate. Brown had vowed to filibuster any compromise between the House bill and the PPACA, meaning that no longer could a compromise bill clear the 60-vote hurdle necessary to pass the Senate. Any hope of enacting anything but the PPACA disappeared. *See* Michael Cooper, G.O.P. Senate Victory Stuns Democrats, New York Times (January 19, 2010), http://www.nytimes.com/2010/01/20/us/politics/20election.html (noting once Brown takes office "the Democrats will no longer control the 60 votes in the Senate needed to overcome filibusters"). At this point, the *only* way Congress could enact a comprehensive health care bill was if the House accepted the Senate's PPACA. The choice was either the PPACA, which many members found quite unsatisfactory, or no health care bill at all.

House Democrats grudgingly agreed to enact the PPACA as-is, after receiving assurances that Senate Democrats would approve the limited changes the House planned to make to the PPACA bill through the reconciliation process,

which Senate rules allowed Senate Democrats to do with just 51 votes, rather than the 60 required to overcome a filibuster. But the Senate's budget-reconciliation rules also limited the range and types of amendments that may be made. *See generally* Cong. Res. Serv., The Budget Reconciliation Process: The Senate's "Byrd Rule" (July 2, 2010). The PPACA and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029, 1035 (2010) ("HCERA") became law on, respectively, March 23 and March 30, 2010.

The HCERA amended Section 36B seven times, but did not alter the language restricting credits to state-established Exchanges. Adler & Cannon, *supra*, at 162-163. Congress included a provision directing the IRS to treat Exchanges established by U.S. territories as if they had been established by states. HCERA § 1204; PPACA § 1323 (42 U.S.C. § 18043), 124 Stat. at 1055–56 ("A territory that elects . . . to establish an Exchange in accordance with part II of this subtitle and establishes such an Exchange in accordance with such part *shall be treated as a State* for purposes of such part.") (emphasis added). Yet it included no language to create equivalence between state-established Exchanges and federal Exchanges.[3]

[3] The HCERA also imposed certain reporting requirements on both state-established and federal Exchanges. HCERA § 1004, 124 Stat. at 1035; PPACA § 1401 (adding § 36B(f) to Title 26). This provision identified Section 1311 Exchanges and Section 1321 Exchanges separately, reflecting the understanding that the two types of Exchange are legally distinct. Were they equivalent, as the government now claims, there would have been no need to identify them separately. *See* Br. at 21, 30-31.

Even if Congress had wanted to use the HCERA to change Section 36B to authorize tax credits in federally established health insurance exchanges, Senate rules governing the consideration of reconciliation measures would likely have made it either procedurally or politically impossible. *See* Declaration of Douglas Holtz-Eakin, Brief of Jonathan Adler and Michael Cannon in *Halbig v. Sebelius*, No. 13-cv-623 (D.D.C. filed Nov. 18, 2013), Att. A, ¶¶14–16. Therefore, if the language of the PPACA prior to enactment of the HCERA does not authorize tax credits in federal exchanges, such credits are not authorized.

Some PPACA supporters may have *preferred* to authorize tax credits through both state-run and federal Exchanges, but like many proposals that could not command enough votes to pass the Senate, that was not an option. The choice faced by supporters was between a bill many found inadequate and no bill at all. *See* Letter from Henry J. Aaron, Senior Fellow, The Brookings Institution, et al. to Nancy Pelosi, Speaker of the House, et al. (Jan. 22, 2010), *republished in* Harold Pollack, "47 (Now 51) Health Policy Experts (Including Me) Say 'Sign the Senate bill,' *The New Republic* (Jan. 22, 2010), http://www.newrepublic.com/blog/the-treatment/47-health-policy-experts-including-me-say-sign-the-senate-bill (51 signatories, including "long-standing advocates of progressive causes," acknowledged that the PPACA is "imperfect" but urged the House must "adopt the Senate bill, and the President must sign it").

E. If Congress Erred, It Was in Miscalculating States' Willingness To Implement the PPACA

The IRS asks this Court to believe the language limiting tax credits to state-run Exchanges is a mistake, perhaps even a drafting error. The mistake, if there was one, is not that the text of the PPACA somehow failed to capture congressional intent, but that the law's supporters inside and outside Congress failed to anticipate the widespread rejection by states of the role the law had assigned them. Much as most PPACA supporters assumed that all states would accept the Medicaid expansion (and thus that those below 100 percent of the poverty line would have available coverage even though ineligible for subsidies on exchanges), most PPACA supporters assumed that states would acquiesce to creating their own exchanges.

As was widely reported at the time of the PPACA's enactment, PPACA proponents were confident that all states would establish Exchanges and never even contemplated the possibility that numerous states would refuse. *See* Remarks on Health Insurance Reform in Portland, Maine, 2010 Daily Comp. Pres. Doc. 220 (Apr. 1, 2010) (quoting President Barack Obama, ‘‘by 2014, each state will set up what we're calling a health insurance exchange"). *See also* Dep'ts of Labor, Health & Human Servs, Educ., & Related Agencies Appropriations for 2011, Hearing Before a Subcommittee on Appropriations, House of Representatives, 111th Cong. 171 (Apr. 21, 2010) (statement of Kathleen Sebelius, Secretary, Department of

Health & Human Services), http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg58233/pdf/CHRG-111hhrg58233.pdf (‘‘We have already had lots of positive discussions, and States are very eager to do this. And I think it will very much be a State-based program.’’); Br. at 7.

The assumption that states would create their own Exchanges as called for by the PPACA—much like the assumption that all states would accept the Medicaid expansion—was nearly universal among the PPACA’s supporters in Congress and the Executive Branch. It accounts for why the Congressional Budget Office scored the bill without considering whether tax credits would be limited to state-run Exchanges, why the agency scored the bill as if federal government would not have to spend any money paying to implement federal Exchanges, and why the PPACA did not authorize funding for the creation of federal Exchanges. Adler & Cannon, *supra*, at 186-188; J. Lester Feder, HHS May Have to Get ‘Creative’ on Exchange, Politico (Aug. 16, 2011), http://www.politico.com/news/stories/0811/61513.html. This situation is not anomalous. Recent events have shown many PPACA supporters made many misjudgments about how the law would be implemented.

IV. The PPACA’s Medicaid Expansion Shows the Government’s Inferences Fundamentally Misunderstand Congressional Intent

The IRS and the district court infer that Congress could not have intended to condition tax credits on states establishing Exchanges because: such a condition

would conflict with the goal of expanding coverage; official estimates of the law's cost assumed tax credits would be available in all states; the condition is not displayed prominently enough in the statute; the legislative history presents no discussion about what would happen if states were not to establish Exchanges; and such a condition would create supposed operational anomalies.

The foregoing discussion of legislative history shows that many of these assumptions are invalid, and none support the agency's inferences. Expanding coverage may have been Congress' primary goal in enacting the PPACA, but it was not the only goal. As with other efforts to expand coverage, Congress struck a balance between that goal and others, such as state cooperation. Congress drafted this condition on tax-credit eligibility in the exact same manner it crafted the condition on eligibility for HCTCs. And the legislative history *does* offer insight on what would happen if states do not establish Exchanges: House Democrats recognized that recalcitrant states could block the PPACA's benefits and frustrate its goal of expanding coverage.

Each of these inferences could also be made about Medicaid, and yet no one disputes that Congress conditions Medicaid funding on state action. Medicaid's purpose is also to expand health insurance coverage, but that purpose does not swallow the condition. When scoring the Medicaid expansion, the Congressional Budget Office likewise assumed all states would take the deal, but that does not

mean states do not face that choice. *See, e.g.*, Cong. Budget Office, Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act (March 13, 2012), at 11. Congress often imposes conditions on Medicaid or Health Coverage Tax Credits or tax-free health savings account contributions that are no more prominently displayed than those imposed on Exchange subsidies. Congress spent little or no time discussing what would happen if states refused to cooperate with the Medicaid expansion, but that does not suggest the absence of the condition.

Finally, if states were to refuse to implement the Medicaid expansion, it would also create "anomalies." Under the PPACA, both as enacted and as "amended" by the Supreme Court in *NFIB*, if a state establishes an Exchange but does not implement the Medicaid expansion, then moderate-income residents receive subsidies while lower-income residents receive nothing, because those earning below 100 percent of the poverty line are generally ineligible for tax credits even in state-run exchanges. 26 U.S.C. § 36B(c)(1). *See* Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, Oct. 23, 2013, http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ ("In states that do not expand Medicaid, nearly five million poor uninsured adults have incomes above Medicaid eligibility levels but below poverty and may fall into a

'coverage gap' of earning too much to qualify for Medicaid but not enough to qualify for [Exchange] tax credits."); Healthcare.gov, Is my state expanding Medicaid coverage?, https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicaid/ ("Many adults in those states with incomes below 100% of the federal poverty level fall into a gap. Their incomes are too high to get Medicaid under their state's current rules. But their incomes are too low to qualify for help buying coverage in the [Exchange].").

Another "anomaly" exists around the fact that the PPACA reduces federal subsidies for uncompensated care on the premise that broader health insurance coverage will mean providers will suffer fewer such losses. Yet those subsidies "will be reduced by the same across the nation whether or not states implement the [Medicaid] expansion." Cong. Res. Serv., Medicaid: An Overview, CRS Report (January 10, 2014). This leads to a potentially anomalous result in states that do not expand Medicaid: uncompensated care *subsidies* could fall even if uncompensated care *losses* do not. Cong. Res. Serv., Medicaid: An Overview, CRS Report (January 10, 2014) ("If a state chooses not to implement the expansion, the demand for uncompensated hospital care is expected to persist but the amount of [such] payments hospitals receive to subsidize such care may be reduced.").

The presence of these and other "anomalies" does not negate, or give the executive authority to negate, the deal Congress offered to states. The statutory language is clear, and the statute means what it says.

CONCLUSION

Many provisions of the PPACA have not worked out the way its supporters had hoped. *See, e.g.,* PPACA Implementation Failures: Answers from HHS Before the Energy and Commerce Comm., 113th Cong. (2013) (testimony of Sec. Kathleen Sebelius on the failures of Healthcare.gov). Some provisions of the Act have been struck down in Court, *NFIB*, 132 U.S. at 2600 (striking down mandatory Medicaid expansion). Other provisions have been repealed. *See, e.g.*, American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642 (2012) (repealing the CLASS Act); *see generally* Cong. Res. Serv., Enacted Laws that Repeal or Amend Provisions of the Patient Protection and Affordable Care Act (ACA); Administrative Delays to ACA's Implementation, Memorandum to Hon. Tom Coburn (September 5, 2013), www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=b8e7a876-ee12-477f-8c62-a9dd9294f537 (finding Congress has repeatedly amended or repealed discrete provisions of the PPACA). As President Obama recently acknowledged, "Obviously, we didn't do a good enough job in terms of how we crafted the law." NBC News, Interview with President Obama (November 7, 2013), http://www.nbcnews.com/video/nbc-news/53492840.

If supporters believe the PPACA's premium-assistance tax credit eligibility rules are flawed, the way to repair the statute is through the legislative process. With this rule, the IRS has arrogated for itself the power to rewrite a federal statute, triggering federal appropriations and financial penalties beyond those authorized by the legislature. Such "administrative hubris" cannot stand. *See Brungart v. BellSouth Telecommunications, Inc.*, 231 F.3d 791, 797 (11th Cir. 2000).

If the IRS can offer tax credits to those who purchase health insurance in federally created Exchanges, there is nothing to stop it from offering them to other ineligible categories of individuals, such as households with income below 100 percent or above 400 percent of the poverty level, Medicare and VA enrollees, workers with employer-sponsored health insurance, undocumented residents, those who purchase health insurance plans that do not constitute qualified health plans, or those who do not purchase health insurance "through an Exchange." As the IRS can identify no textual or other basis for its rule, it can provide no limit to the power it asserts here.

The decision to limit the availability of premium-assistance tax credits to the purchase of qualified health insurance plans in Exchanges established by states under Section 1311 may or may not have been a sound policy decision. That is not the question before this Court. The text of the PPACA clearly, consistently, and unambiguously provides premium-assistance tax credits for the purchase of

qualified health insurance in Exchanges established by states under Section 1311, and only in such Exchanges. The remainder of the PPACA's text and legislative history fully support the plain meaning of the text. As a result, the IRS lacks the authority to provide for tax credits in federally facilitated Exchanges.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) because it was written in Times New Roman, 14-point font. It complies with the type-volume limitations contained in Fed. R. App. P. 28.1(e)(2)(C), because it contains 6,814 words, excluding those parts of the brief excluded from the word count under Fed. R. App. P. 32(a)(7)(B)(iii). The text of the hard copy of this brief and the text of the PDF version of the brief filed electronically are identical. A virus check was performed on the PDF version and no virus was detected.

Dated: February 6, 2014

/s/ Andrew M. Grossman
Andrew M. Grossman

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of February, 2014, I caused the foregoing Brief of Jonathan H. Adler and Michael F. Cannon as *Amicus Curiae* in Support of the Appellants to be filed with the Court in hard copy and through the Court's CM/ECF system. Counsel of record are registered CM/ECF users and will be served by the appellate CM/ECF system.

Dated: February 6, 2014

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