No. 14-1158

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

DAVID KING, 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 EASTERN DISTRICT OF VIRGINIA (No. 3:13-cv-630) (Hon. James R. Spencer)

BRIEF FOR THE APPELLEES

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STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331. The district court entered final judgment on February 18, 2014. Plaintiffs filed a notice of appeal on February 19, 2014. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly rejected plaintiffs' contention that the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") authorizes federal premium tax credits only for individuals who purchase health insurance on a state-run Exchange, and not for individuals who purchase health insurance on a federally-run Exchange.

2. Whether plaintiffs' claims also fail on threshold grounds.

STATEMENT OF THE CASE

I. Statutory Background

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119,[1] "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB v. Sebelius*, 132 S. Ct. 2566, 2580 (2012). This case concerns interrelated provisions

[1] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

of Title I of the Act that, working in tandem, will substantially increase participation in private health insurance markets.[2]

A. The Group and Non-group Health Insurance Markets

Most Americans with private health insurance coverage receive that coverage through an employer-sponsored group health plan. *See* Congressional Budget Office ("CBO"), *Key Issues in Analyzing Major Health Insurance Proposals* xi (2008) ("*Key Issues*"). "One fundamental reason such plans are popular is that they are subsidized through the tax code." *Ibid*. Congress has provided these tax subsidies for many decades and, in 2007 alone, the federal tax subsidy for employment-based health coverage was $246 billion. *Id*. at 31.

Congress has long regulated certain terms of employer-sponsored group health coverage. Federal law generally bars group health plans from excluding individuals based on health status-related factors or charging different premiums for similarly situated employees based on such factors. *See id*. at 79; *see also* 42 U.S.C. § 300gg-1 (2006); 29 U.S.C. § 1182 (2006 & Supp. III 2009).

Before the Affordable Care Act, these federal efforts to make affordable health coverage widely available left a significant gap. Health insurance purchased in the "non-group market" (also known as the "individual market") generally did

[2] Other titles of the Affordable Care Act address public health benefits programs such as Medicaid and Medicare.

not receive favorable federal tax treatment, so the purchasers had to bear the full costs of premium payments. *Key Issues* 9. Moreover, federal law generally did not prevent insurers in the non-group market from increasing premiums, or denying coverage altogether, based on an individual's medical condition or history. Without such rules, insurers denied coverage to or charged higher premiums for individuals with conditions as common as high blood pressure, asthma, ear infections, and pregnancy. *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong., 2d Sess. 52 (2008) (Statement of Prof. Mark Hall); Ed Neuschler, *Policy Brief on Tax Credits for the Uninsured and Maternity Care* 3 (2004). A 2010 survey found that 35% of non-elderly adults who tried to purchase health insurance in the non-group market in the previous three years (about 9 million people) were denied coverage, charged a higher premium, or offered restricted coverage because of their medical condition or history. Sara R. Collins *et al.*, *Help on the Horizon, Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010* xi & Exh. ES-2.

Because of the high cost of policies sold in the non-group insurance market and restrictions on coverage, participation in that market was low even among those who lacked other health coverage options. *Key Issues* at 46. Of the 45 million individuals who lacked access to an employer-sponsored group plan or government health benefits program in 2009, only about 20% were covered by a

policy purchased in the non-group insurance market. *Ibid*. The remaining 80% were uninsured. *Ibid*.

B. The Affordable Care Act's Reforms of the Non-group Market

In Title I of the Affordable Care Act, Congress enacted a set of provisions that work in tandem to reform the non-group health insurance market. As discussed above, before the Act's passage, that market was characterized by high premiums, restrictive insurance industry practices, and low participation.

Premium tax credits. To provide "Affordable Coverage Choices for All Americans," ACA Title I, Subtitle E, Congress provided favorable federal tax treatment for certain health insurance obtained in the non-group market. The Act establishes federal tax credits that assist eligible individuals with household income between 100% and 400% of the federal poverty level to pay premiums for non-group insurance policies on the health insurance Exchanges created pursuant to the Act. *See* ACA § 1401, *codified at* 26 U.S.C. § 36B ("Section 36B").[3] These premium tax credits help to make health insurance affordable by reducing a taxpayer's net cost of insurance. For eligible individuals with income between 100% and 250% of the federal poverty level, the Act also authorizes federal payments to insurers to help cover those individuals' cost-sharing expenses (such

[3] The federal poverty level for an individual is currently $11,670, except in Alaska and Hawaii. *See* 79 Fed. Reg. 3593 (Jan. 22, 2014).

as co-payments or deductibles) for certain insurance obtained through an Exchange. ACA § 1402, *codified at* 42 U.S.C. § 18071(c)(2).

CBO projected in 2009 that 78% of people who would buy non-group insurance policies through Exchanges (18 million of 23 million) would receive premium tax credits, and that those credits, on average, would cover nearly two-thirds of the premium. *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 24 (Nov. 30, 2009) (JA 113). More recent CBO projections indicate that the average tax subsidy will be $5,290 per person in 2014, rising to $7,900 in 2023, and that, by 2018, 80% of people who buy non-group policies through the Exchanges (20 million of 25 million) will receive premium tax credits. CBO, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act: May 2013 Baseline*, tables 1 & 3 (May 14, 2013) (JA 85, 87). CBO projected that federal subsidies for insurance purchased on the Exchanges will total $33 billion in 2014, rising to $153 billion by 2023. *Id*., table 3 (JA 87).

Guaranteed-issue and community-rating requirements. To eliminate restrictive insurance industry practices that prevented people from obtaining affordable coverage in the non-group market, Congress prohibited insurers, starting in 2014, from denying new coverage to any person because of medical condition or history (the guaranteed-issue requirement, *codified at* 42 U.S.C. §§ 300gg-1,

300gg-3, 300gg-4(a)) and from charging higher premiums for such coverage because of a person's medical condition or history (the community-rating requirement, *codified at* 42 U.S.C. §§ 300gg(a)(1), 300gg-4(b)). *See* ACA § 1201. Congress thereby extended to the non-group market norms of non-discrimination parallel to those already applicable to group health plans.

Minimum coverage provision. To ensure that individuals who can afford coverage do not delay the purchase of insurance until they are sick or injured, Congress provided that non-exempted individuals must maintain a minimum level of health coverage for themselves and their dependents or pay a tax penalty. *See* ACA § 1501, *codified at* 26 U.S.C. § 5000A. Congress exempted from this tax penalty individuals who cannot afford coverage, including individuals who cannot afford coverage even with the benefit of the premium tax credits provided under Section 36B. *See* 26 U.S.C. § 5000A(e)(1). In *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012), the Supreme Court upheld the minimum coverage provision as a proper exercise of Congress's taxing power.

Exchanges. Congress provided for the creation of health insurance Exchanges to serve "as an organized and transparent marketplace for the purchase of health insurance where individuals . . . can shop and compare health insurance options." H.R. Rep. No. 111-443, pt. II, at 976 (2010) (quotation marks and citation omitted). Section 1311 of the Act provides that "[e]ach State shall, not

later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')" that "facilitates the purchase of qualified health plans." ACA § 1311(b)(1), *codified at* 42 U.S.C. § 18031(b)(1)). If, however, a State elects not to establish an Exchange, or if the Secretary of Health and Human Services ("HHS") determines that the State will not establish an Exchange that is consistent with federal standards, Section 1321 of the Act provides that the Secretary of HHS "shall . . . establish and operate such Exchange within the State[.]" ACA § 1321(c)(1), *codified at* 42 U.S.C. § 18041(c)(1).

* * *

When Congress enacted the ACA Title I provisions discussed above, Congress understood that the extension of nondiscrimination norms—*i.e.*, the guaranteed-issue and community-rating requirements—to the non-group market would undermine that market unless these new regulations of the insurance industry were coupled with the premium tax credits and the minimum coverage provision. CBO advised Congress that, by themselves, the guaranteed-issue and community-rating requirements would result in "adverse selection" that would "increase premiums in the exchanges relative to nongroup premiums under current law." *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 19 (Nov. 30, 2009) (JA 108).

CBO also concluded, however, that "several other provisions of the proposal would tend to mitigate that adverse selection." *Ibid*. Most notably, CBO determined that there would be "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed." *Id*. at 6 (JA 95). CBO advised Congress that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people." *Id*. at 19-20 (JA 108-109) (explaining that, for people whose income was below 200% of the federal poverty level, those subsidies would average about 80% of the premium payments). Furthermore, CBO concluded that the structure of the federal tax credits for premium payments would mitigate the impact of adverse selection. Under the Act, "[t]he premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees[.]" *Id*. at 20 (JA 109). Instead, "federal subsidy payments would have to rise to make up the difference." *Ibid*. CBO informed Congress that the premium tax credits "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." *Ibid*. Taking the premium tax credits, minimum coverage provision, and other mitigating influences into account, CBO

concluded that the extent of adverse selection in the non-group market "is likely to be limited[.]" *Ibid.*[4]

State insurance regulators likewise advised Congress that the premium tax credits and minimum coverage provision were necessary to protect insurance markets operating under guaranteed-issue and community-rating rules. The National Association of Insurance Commissioners ("NAIC") offered "the experience and expertise of the states to Congress as it attempt[ed] to improve the health insurance marketplace." *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-503 (2009) (statement of Sandy Praeger, Kansas Commissioner of Insurance, on behalf of the NAIC). "Based on that experience and expertise," the NAIC emphasized the need to avoid adverse selection. *Id*. at 503, 504. The NAIC explained that proposals for "guaranteed issue and elimination of preexisting condition exclusions for individuals" could "result in severe adverse selection," and the NAIC advised Congress that "State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase

[4] The other mitigating influences noted by CBO were an annual open enrollment period that would limit opportunities for people to wait until a health problem arose before enrolling in non-group market coverage, and a temporary reinsurance program that would limit the impact of adverse selection on premiums during the transitional 2014-2016 period.

mandate and appropriate income-sensitive subsidies to make coverage affordable." *Id*. at 504.

Accordingly, Congress coupled the Act's guaranteed-issue and community-rating requirements with the minimum coverage provision and billions of dollars of federal tax credits that will pay the lion's share of the premium for most individuals who buy coverage on an Exchange. Congress found that the premium tax credits "are *key* to ensuring people affordable health coverage." H.R. Rep. No. 111-443, vol. 1, at 250 (March 17, 2010) (JA 41) (emphasis added).

II. Factual Background and District Court Proceedings

This suit presents the same issue that is pending before the D.C. Circuit in *Halbig v. Sebelius*, No. 14-5018 (D.C. Cir.): whether the Affordable Care Act authorizes federal premium tax credits only for individuals who purchase health insurance on a state-run Exchange, and not for individuals who purchase health insurance on a federally-run Exchange. The plaintiffs here and in *Halbig* are represented by the same counsel, and their arguments in both cases are the same. The district court is *Halbig* entered summary judgment for the government, and the district court in this case rejected plaintiffs' position in an opinion that followed the *Halbig* court's reasoning.

Plaintiffs here are four individuals who live in Virginia, where the Exchange is operated by the federal government. They contend that the Affordable Care Act

authorizes federal premium tax credits only for insurance purchased on state-run Exchanges and not for insurance purchased on federally-run Exchanges, which would mean that federal premium tax credits would be unavailable in more than half of the States. "While sixteen states and the District of Columbia have elected to set up their own Exchanges, thirty-four states rely on federally-facilitated Exchanges." *Halbig v. Sebelius*, __ F. Supp. 2d __, 2014 WL 129023 (D.D.C. Jan. 15, 2014). "Seven of these thirty-four states have chosen to assist the federal government with its operation of federally-run Exchanges, while twenty-seven states have declined to undertake any aspect of Exchange implementation." *Ibid*.

Plaintiffs seek to premise their standing on the interaction between the premium tax credits and the minimum coverage provision that the Supreme Court upheld in *NFIB*, 26 U.S.C. § 5000A. Plaintiffs contend that, if they were not eligible for premium tax credits that make health coverage affordable, they would qualify for the "unaffordability" exemption in Section 5000A and thus could purchase "cheaper, high-deductible catastrophic coverage" rather than "costly, comprehensive health insurance." Complaint ¶ 5 (JA 9).

The district court held that plaintiffs have standing and a cause of action under the Administrative Procedure Act ("APA") notwithstanding the availability of a tax refund suit. JA 297-304. Rejecting plaintiffs' argument on the merits, the court explained that plaintiffs rely on one phrase in Section 36B, read in isolation

from the rest of Section 36B and without regard to the statutory provisions that it cross references, the structure of the statute, and the purpose of the Act. JA 305-311. The court concluded that, "when statutory context is taken into account, Plaintiffs' position is revealed as implausible." JA 306. The court thus rejected plaintiffs' challenge to the Treasury Department's interpretative regulation that confirms that premium tax credits are available on federally-run Exchanges, *see* 26 C.F.R. § 1.36B-1(k), finding the intent of Congress to be clear at *Chevron* step one. JA 305-311. The court ruled in the alternative that, "[a]ssuming for the sake of argument that the text of section 36B is ambiguous, Plaintiffs' argument fails at *Chevron* step two" because Treasury's interpretation is reasonable. JA 312-313.

SUMMARY OF ARGUMENT

To provide "Affordable Coverage Choices for All Americans," ACA Title I, Subtitle E, Congress authorized billions of dollars of federal tax credits each year to help middle- and low-income individuals pay the premiums for certain insurance policies sold in the non-group market. Plaintiffs contend that these premium tax credits are available only to individuals who buy health insurance on an Exchange run by a state government, and not to individuals who buy health insurance on an Exchange run by the federal government.

Plaintiffs lack standing or a cause of action for the reasons set out in Point II. Assuming that the Court can reach the merits, the judgment of the district court

should be affirmed. Plaintiffs premise their argument on one phrase in Section 36B, read in isolation from the rest of Section 36B and divorced from the statutory provisions that it cross references, the structure of the statute, and the purpose of the Act. "[W]hen statutory context is taken into account, Plaintiffs' position is revealed as implausible." JA 306. While "there is more than one plausible reading of the challenged phrase in Section 36B when viewed in isolation, the cross-referenced sections, the surrounding provisions, and the ACA's structure and purpose all evince Congress's intent to make premium tax credits available on both state-run and federally-facilitated Exchanges." *Halbig v. Sebelius*, __ F. Supp. 2d __, 2014 WL 129023, *17 (D.D.C. Jan. 15, 2014).

The Supreme Court has repeatedly emphasized that "statutory construction is a holistic endeavor." *Adoptive Couple v. Baby Girl*, 133 S. Ct. 2552, 2563 (2013). "In expounding a statute, [a court] must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Maracich v. Spears*, 133 S. Ct. 2191, 2203 (2013). A statutory phrase cannot be "considered in isolation, and without reference to the structure and purpose of" the statute." *Id*. at 2199, 2200. "It is a 'fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.'" *National Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (quoting *FDA v.*

Brown & Williamson Tobacco Corp., 529 U.S. 120, 132-133 (2000)).[5] Moreover, in the context of federal taxing statutes, the Supreme Court has held that "revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. 224, 238 (1994). "State law may control only when the federal taxing act, by express language or necessary implication, makes its own operation dependent upon state law." *Burnet v. Harmel*, 287 U.S. 103, 110 (1932). These interpretive principles foreclose plaintiffs' claim.

ARGUMENT

I. Federal Premium Tax Credits Are Available for Individuals Who Buy Insurance on Federally-Run Exchanges.

A. The Act's Text and Structure Show That Federal Premium Tax Credits Are Available on Federally-Run Exchanges.

1. *Congress defined the Exchange established by the Secretary on behalf of a State to be the Exchange that a State would have established if it had elected to establish an Exchange*.

Section 36B provides that a tax credit shall be allowed to any "applicable taxpayer," defined as "a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal

[5] *Accord Graham County Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 290 (2010); *Zuni Pub. Sch. Dist. No. 89 v. Dep't of Educ.*, 550 U.S. 81, 98-99 (2007); *Household Credit Servs., Inc. v. Pfennig*, 541 U.S. 232, 239 (2004); *Davis v. Mich. Dep't of Treasury*, 489 U.S. 803, 809 (1989).

to the poverty line for a family of the size involved." 26 U.S.C. § 36B(a), (c)(1)(A). Congress thus identified the taxpayers who are eligible for federal premium tax credits as those with a certain household income, regardless of whether the Exchange on which the insurance is purchased is established by the Secretary on behalf of a State, or by the State itself.

Plaintiffs attempt to significantly limit the availability of federal premium tax credits, however, by reliance on a phrase in subsection (b) of Section 36B, which sets the formula for calculating the amount of the premium tax credit. That subsection provides that the premium tax credit is calculated by adding up the "premium assistance amounts" for all "coverage months" in a given year; that the "premium assistance amount" is based in part on the cost of the monthly premium for the health plan that the taxpayer purchased "through an Exchange established by the State under [42 U.S.C. § 18031]"; and that a "coverage month" is defined as a month during which the taxpayer (or dependent) is enrolled in and pays the premium for a qualified health plan "that was enrolled in through an Exchange established by the State under [42 U.S.C. § 18031]." 26 U.S.C. § 36B(b)(1)-(2) & 36B(c)(2)(A)(i). Plaintiffs contend the phrase "established by the State under [42 U.S.C. § 18031]" in this provision about how to calculate the amount of the credit means that Congress intended not to make federal premium tax credits available on federally-run Exchanges.

The district courts here and in *Halbig* correctly held that the relevant statutory provisions, read together, preclude this interpretation. Subsection (b) of Section 36B refers to an Exchange "established by the State under [42 U.S.C. § 18031]," and 42 U.S.C. § 18031(a), in turn, provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')." All parties—including plaintiffs—agree that § 18031 "does not mean what it literally says; states are not actually required to 'establish' their own Exchanges." *Halbig*, 2014 WL 129023, *13; *see also* R.40 at 15 ("*All* agree that states are free *not* to establish Exchanges.") (plaintiffs' emphasis). Instead, the Act provides that a State may "elect[]" to establish an Exchange and, if a State does not elect to do so or fails to do so consistent with federal standards, the Act requires the Secretary of Health and Human Services to establish the Exchange on the State's behalf. The relevant provisions are in Section 1321 of the Act, *codified at* 42 U.SC. § 18041, which provides for "State Flexibility" with respect to an Exchange. "Each State that elects" to establish an Exchange meeting federal standards shall have the Exchange operational by January 1, 2014. *Id*. § 18041(b). If, however, "a State is not an electing State," or if "the Secretary determines, on or before January 1, 2013, that an electing State . . . will not have any required Exchange operational by January 1,

2014," the Act provides that "the Secretary shall . . . establish and operate *such Exchange* within the State[.]" *Id*. § 18041(c) (emphasis added).

"In other words, even where a state does not actually establish an Exchange, the federal government can create 'an Exchange established by the State under [42 U.S.C. § 18031]' *on behalf of* that state." *Halbig*, 2014 WL 129023, *14 (court's emphasis). Furthermore, Congress made clear that an Exchange established by the Secretary *is* the Exchange that the State would otherwise have established. The Act provides that, if a State will not have the "*required Exchange*" operational by January 1, 2014, the Secretary shall establish "*such Exchange*" on the State's behalf. 42 U.S.C. § 18041(c) (emphasis added). Congress thus defined the Exchange established by the Secretary to be the Exchange that the State would otherwise have established if it had elected to create an Exchange. *See*, *e.g.*, Black's Law Dictionary 1570 (9th ed. 2009) ("such" means "[t]hat or those; having just been mentioned"). "Read in context," the federally-run Exchange "must be the same ['Exchange'] mentioned at the beginning of [the provision] . . . . Indeed, because there are no other ['Exchanges'] mentioned in the section, there is no other antecedent to which the word 'such' could refer." *Miller v. Clinton*, 687 F.3d 1332, 1344 (D.C. Cir. 2012).

If there were any doubt on this score, it is removed by the ACA's definitional provisions. For each use of the term "Exchange" in Title I of the ACA

(which includes 42 U.S.C. § 18041), that term "means an American Health Benefit Exchange established under [42 U.S.C. § 18031]." 42 U.S.C. § 300gg-91(d)(21) (defining term for purpose of Public Health Service Act); *see* 42 U.S.C. § 18111 (incorporating this definition for Title I of ACA); *see also id.* § 18031(d)(1). Because "Exchange" is a defined term in the ACA, Section 18041(c)(1) effectively reads, "the Secretary shall . . . establish and operate such [American Health Benefit Exchange established under 42 U.S.C. § 18031]." Thus, an Exchange established by the Secretary *is*, "by definition under the statute," the required State Exchange established under Section 18031. JA 307 (district court opinion).

Plaintiffs conceded this key point below: "The term 'such,' and the definition of 'Exchange,' confirm that the federal government should establish *the same Exchange* as the state was supposed to have established." R.40 at 5 (plaintiffs' emphasis). Although plaintiffs now declare this statutory equivalency to be an "oxymoron," Pl. Br. 24, Congress is free to define statutory terms in any way that it chooses. Indeed, plaintiffs recognize that, "if a territory establishes an Exchange, it 'shall be treated as a State' for such purposes." Pl. Br. 24 (quoting ACA § 1323(a)(1), *codified at* 42 U.S.C. § 18043(a)(1)). Plaintiffs assert that this provision "conclusively proves that Congress knew how to create such equivalence when it wanted to, but no provision does so for federal Exchanges." *Ibid.* But that is exactly what Congress did in the statutory provisions quoted above: Congress

created an equivalence between an Exchange established by a State and an Exchange established by the Secretary on the State's behalf. Congress defined an Exchange as "an American Health Benefit Exchange established under [42 U.S.C. § 18031]," and provided that, if a State does not establish "the required Exchange," the Secretary shall establish "such Exchange." That statutory text controls here, rather than the short-hand references in the calculation formula subsection on which plaintiffs rely.[6]

Plaintiffs also recite the canon against superfluity, *see* Pl. Br. 19, but their own argument fails to give meaning to the statutory phrase "such Exchange" and also renders superfluous other provisions of the Act. *See* JA 308, 309 (district court opinion) (providing examples). The "canon against surplusage assists only where a competing interpretation gives effect to every clause and word of a statute," *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013), which is not the case for plaintiffs' position here. In any event, "instances of surplusage are not unknown" in federal statutes, *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 299 n.1 (2006), and the canon cannot override Congress's

[6] Congress addressed the territories separately because territorial residents generally do not pay federal income tax, 26 U.S.C. §§ 931-33, and Congress needed a different mechanism other than federal premium tax credits to effectuate the goals of the Act in the territories.

decision to treat an Exchange established by the Secretary on a State's behalf as the Exchange the State would otherwise have established.

Moreover, "the statutory formula for calculating the tax credit seems an odd place to insert a condition that the states establish their own Exchanges if they wish to secure tax credits for their citizens." *Halbig*, 2014 WL 129023, *17 n.12 (citing *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001) ("[Congress] does not, one might say, hide elephants in mouseholes.")). "One would expect that if Congress had intended to condition availability of the tax credits on state participation in the Exchange regime, this condition would be laid out clearly in subsection (a), the provision authorizing the credit, or some other provision outside of the calculation formula." *Ibid*. "This is particularly so because courts presume that 'Congress when it enacts a statute is not making the application of the federal act dependent on state law.'" *Ibid*. (quoting *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 43 (1989)). That principle has particular force in the area of taxation, where the Supreme Court has emphasized that "'the revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application.'" *Ibid*. (quoting *United States v. Irvine*, 511 U.S. 224, 238 (1994)).[7]

[7] Plaintiffs incorrectly suggest that an earlier statute, the Trade Adjustment Assistance Act, conditioned tax credits for individuals on state action. *See* Pl.

Continued on next page.

2. *The reporting requirements in Section 36B confirm that premium tax credits are available on federally-run Exchanges.*

The reporting requirements in Section 36B confirm that premium tax credits are available on federally-run Exchanges. *See* JA 308-309 (district court opinion). Section 36B(f)—titled "Reconciliation of credit and advance credit"—requires the Internal Revenue Service to reduce the amount of a taxpayer's end-of-year premium tax credit by the amount of any advance payment of such a tax credit. *See* 26 U.S.C. § 36B(f)(1) ("The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit[.]").

To enable the IRS to perform this reconciliation of end-of-year and advance premium tax credits, Section 36B(f) requires "each Exchange" to report specified information to the Department of the Treasury. There is no dispute that these reporting requirements apply regardless of whether an Exchange was established by the State under 42 U.S.C. § 18031 (ACA § 1311) or by the Secretary of HHS under 42 U.S.C. § 18041 (ACA § 1321). Section 36B(f) provides in relevant part:

Br. 44 (citing 26 U.S.C. § 35(a), (e)(2)). That statute provided a tax credit for certain workers displaced by foreign competition, which could be used to offset the costs of several different kinds of qualifying health insurance. The statute made some forms of qualifying insurance available nationwide, and permitted States to designate additional kinds of insurance that would meet certain minimum standards. *See* 26 U.S.C. § 35(e).

> (3) Information requirement.—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) *or 1321(c)* of the Patient Protection and Affordable Care Act [42 U.S.C. § 18031(f)(3) or 42 U.S.C. § 18041(c)]) shall provide the following information to the Secretary [of the Treasury] and to the taxpayer with respect to any health plan provided through the Exchange:
>
> (A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.
>
> (B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.
>
> (C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.
>
> (D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.
>
> (E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.
>
> (F) Information necessary to determine whether a taxpayer has received excess advance payments.

The italicized text above makes clear that these reporting requirements apply to an Exchange established by the Secretary of HHS under ACA § 1321(c), 42 U.S.C. § 18041(c). The district court correctly reasoned that these reporting requirements would be nonsensical if premium tax credits were not available on federally-run Exchanges. JA 308-309; *accord Halbig*, 2014 WL 129023, *15.

The purpose of requiring these reports to Treasury is to enable the IRS to reconcile end-of-year premium tax credits with advance premium tax credits. *See* 26 U.S.C. § 36B(f) ("Reconciliation of credit and advance credit"). To that end, the Act directs federally-run Exchanges (as well as state-run Exchanges) to report a taxpayer's "advance payment of such credit"; information needed to determine the taxpayer's "eligibility for, and the amount of, such credit"; and "[i]nformation necessary to determine whether a taxpayer has received excess advance payments." 26 U.S.C. § 36B(f)(3)(C), (E), (F). These reporting requirements leave no doubt that Congress intended taxpayers to receive tax credits for payments of premiums for insurance purchased on federally-run Exchanges.

On plaintiffs' theory, the information that Congress required federally-run Exchanges to report to Treasury and the taxpayer would never exist. If, as they propose, there were no premium tax credits on federally-run Exchanges, there would be no "advance payment of such credit"; there would be no information needed to determine the taxpayer's "eligibility for, and the amount of, such credit"; and there would be no "[i]nformation necessary to determine whether a taxpayer has received excess advance payments." 26 U.S.C. § 36B(f)(3)(C), (E), (F).

Plaintiffs admit that their position would make these categories of information "irrelevant" for federally-run Exchanges. *See* Pl. Br. 35. "That plaintiffs interpret [these reporting requirements] to be an empty gesture is yet

another indication that their submission is erroneous." *Fund for Animals, Inc. v. Kempthorne*, 472 F.3d 872, 878 (D.C. Cir. 2006).

Moreover, plaintiffs incorrectly assert that Treasury needs other categories of information set out in Section 36B(f)(3) for purposes that are unrelated to premium tax credits, rather than for Congress's stated purpose of allowing the reconciliation of premium tax credits and advance credits. For example, plaintiffs declare that "Treasury needs enrollment information to enforce the Act's individual mandate to buy insurance." Pl. Br. 36 (referring to ACA § 1501, *codified at* 26 U.S.C. § 5000A). However, in Section 1502 of the Act, Congress separately required "[e]very person who provides minimum essential coverage to an individual during a calendar year" to report specified information that enables Treasury to determine whether the individual is in compliance with Section 1501, the minimum coverage provision. *See* ACA § 1502, *codified at* 26 U.S.C. § 6055.

Similarly, plaintiffs declare that the government needs "enrollment and premium data, even with respect to individuals who do not obtain subsidies," so that the Comptroller General can conduct a "study on affordable coverage" that is required under ACA § 1401(c). Pl. Br. 36. But Section 36B(f) requires reports to Treasury to reconcile premium tax credits; it does not require reports to the Comptroller to conduct a study. In any event, the provision that requires a study on affordable coverage directs the Comptroller to consider "the impact of the tax

credit for qualified health insurance coverage of individuals under section 36B[.]" ACA § 1401(c)(1)(A)(i), 124 Stat. at 220. Congress understood that premium tax credits are essential to make coverage affordable on the Exchanges.

3. *Other Affordable Care Act provisions confirm that references to State-established Exchanges include Exchanges established by the Secretary on a State's behalf.*

Various other Affordable Care Act provisions confirm that, when Congress referred to a state-established exchange, it included an Exchange established by the Secretary on a State's behalf. The provisions discussed below are illustrative.

The definition of a "qualified individual." Section 1312 of the Act provides that a "qualified individual" may buy insurance on an Exchange. *See* ACA § 1312(a)(1), *codified at* 42 U.S.C. § 18032(a)(1) ("A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible."). Congress provided that "[t]he term 'qualified individual' means, with respect to an Exchange, an individual who—(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) *resides in the State that established the Exchange*." 42 U.S.C. § 18032(f)(1)(A) (emphasis added). Individuals who are incarcerated, and individuals who are not U.S. citizens, nationals, or lawfully present aliens, are not qualified individuals. *See id.* § 18032(f)(1)(B), (f)(3).

"There is no separate provision defining 'qualified individual' for purposes of the federally-facilitated Exchanges." *Halbig*, 2014 WL 129023, *15. "If [the italicized] provision were read literally, no 'qualified individuals' would exist in the thirty-four states with federally-facilitated Exchanges, as none of these states is a 'State that established [an] Exchange.'" *Ibid*. "The federal Exchanges would have no customers, and no purpose." *Ibid*.

Even plaintiffs do not endorse "this absurd construction." *Ibid*. "Plaintiffs concede that the federally-run Exchanges *must* be able to offer insurance, and suggest that the Court should not interpret the residency requirement literally." *Id*. at *16 (court's emphasis). According to plaintiffs, "[t]hat definition *assumes* a state-created Exchange; it thus can readily be construed as not prohibiting eligibility where that assumption proves false." Pl. Br. 34 (plaintiffs' emphasis). "But plaintiffs' concession only proves the [government's] point." *Halbig*, 2014 WL 129023, *16. The definition of "qualified individual" makes sense "when construed consistently with [the government's] interpretation of the Act—*i.e.*, viewing 42 U.S.C. § 18041 as authorizing the federal government to create 'an Exchange established by the State under [42 U.S.C. § 18031] on behalf of a state that declines to establish its own Exchange." *Ibid*.

In several variants on the same argument, plaintiffs urge the Court to ignore the residency requirement. *See* Pl. Br. 32 (arguing that "the solution is to excise

the words" from the statute). "Plaintiffs' insistence that the Court should read the Residency Requirement out of the ACA or not apply Section 1312 to federally-facilitated Exchanges is a telltale sign" that their position is wrong. JA 307-308 (district court opinion).

For example, plaintiffs propose that, in the 34 States with federally-run Exchanges, the residency requirement should be ignored and "an applicant should still be understood to satisfy [the 'qualified individual' definition] based solely on its *other* prong." Pl. Br. 34 (plaintiffs' emphasis). Congress, however, specified that both clause (i) *and* clause (ii) of the definition must be met for a person to be a "qualified individual." If an applicant resides in a State where the Secretary established an Exchange on the State's behalf, the residency requirement in clause (ii) is satisfied because the reference to "the State that established the Exchange" includes a State in which the Secretary established the Exchange on the State's behalf.

Alternatively, plaintiffs propose that *none* of the provisions of Section 1312 should apply to federally-run Exchanges, Pl. Br. 33, or that Section 1312 should be interpreted as a "non-exclusion provision" that does not restrict who may shop on any Exchange (state-run or federally-run). Pl. Br. 33-34. On this reasoning, incarcerated individuals and undocumented aliens could shop on Exchanges, which is clearly not what Congress provided. Section 1312 indicates who is "qualified"

to shop on an Exchange, and its qualifications apply to state-run and federally-run Exchanges alike. "There is no separate provision defining 'qualified individual' for purposes of the federally-facilitated Exchanges." *Halbig*, 2014 WL 129023, *15. Section 1312 is not a "non-exclusion" or "non-discrimination" provision; other Affordable Care Act provisions ensure that qualified individuals are allowed to enroll in qualified health plans without discrimination. *See, e.g.*, ACA § 1201 (prohibiting "Discrimination Based on Health Status" and "Discriminatory Premium Rates" in certain plans); ACA § 1557 (requiring "Nondiscrimination" on specified bases in certain programs).

The Medicaid maintenance-of-effort requirement. The Affordable Care Act provides, as a condition of receiving Medicaid funds, that a State may not tighten its Medicaid eligibility standards for adults until "the date on which the Secretary determines that an Exchange established by the State under [42 U.S.C. § 18031] is fully operational." ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg)(1). This transitional measure was intended to protect Medicaid recipients from a loss of coverage until January 1, 2014, when those Medicaid recipients who would lose Medicaid eligibility would be able to obtain subsidized health insurance on an Exchange. Accordingly, HHS advised Maine, which has a federally-run

Exchange, that its maintenance-of-effort obligation would nonetheless expire on January 1, 2014.[8]

By contrast, under plaintiffs' theory, a State with a federally-run Exchange "would *never* be relieved of this maintenance of effort requirement." JA 309 (district court's emphasis). Although plaintiffs declare that such a perpetual obligation "makes perfect sense," Pl. Br. 37, the point of the maintenance-of-effort requirement was to serve as an interim measure until affected Medicaid recipients could transition to health insurance obtained on the Exchanges.

By plaintiffs' account, their proposed interpretation of the maintenance-of-effort requirement would present constitutional problems. *See* JA 310 (district court opinion). Plaintiffs argued below that this requirement would be unconstitutional if—as they proposed—the requirement were interpreted as a "stick" used to coerce States to act. *See* R.40 at 14 n.4 (urging that "[p]rospectively, this 'stick' may have been invalidated by the Supreme Court's decision on Medicaid" in *NFIB*). But, as plaintiffs recognize, *see* Pl. Br. 50, courts "have a duty to construe a statute to save it, if fairly possible." *NFIB*, 132 S. Ct. at

[8] Letter of January 7, 2013 from the Acting Administrator of HHS's Centers for Medicare & Medicaid Services to the Maine Commissioner of Health & Human Services; *see also* CMS, FAQs on Exchanges, Market Reforms, and Medicaid (Dec. 10, 2012), *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf (deadline for States to submit a blueprint for operating their own Exchange was December 14, 2012).

2600; *see also id*. at 2594 ("every reasonable construction must be resorted to, in order to save a statute from unconstitutionality"). Here, the maintenance-of-effort requirement is readily construed to expire when the Secretary establishes the required State Exchange on behalf of the State. Congress provided that, if a State will not have the "required Exchange" operational by January 1, 2014, the Secretary shall establish "such Exchange" for the State. 42 U.S.C. § 18041(c). The maintenance-of-effort requirement confirms that statutory references to "an Exchange established by the State" include an Exchange established by the Secretary on the State's behalf.

* * *

These and other Affordable Care Act provisions "reflect an assumption that a state-established Exchange exists in each state." *Halbig*, 2014 WL 129023, *16; *see* JA 310 n.8 (district court opinion) (citing additional examples). "If construed literally, these provisions would be nullified when applied to states without state-run Exchanges, leading to strange or absurd results." *Halbig*, 2014 WL 129023, *16. "These provisions make far more sense when construed consistently with [the government's] interpretation of the Act—*i.e.*, viewing 42 U.S.C. § 18041 as authorizing the federal government to create 'an Exchange established by the State under [42 U.S.C. § 18031]'" on behalf of the State that elects not to establish the required Exchange. *Ibid.*

B. Plaintiffs' Position Would Undermine Congress's Objective To Make Affordable Insurance Available in the Non-Group Health Insurance Market.

1. *Congress understood that federal premium tax credits are essential to protect insurance markets operating under guaranteed-issue and community-rating rules.*

The purpose of the Affordable Care Act is "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 132 S. Ct. at 2580. In combination, the Act's provisions are designed to achieve "near-universal coverage" for all Americans. ACA § 1501(a)(2)(D), *codified at* 42 U.S.C. § 18091(2)(D). To that end, Congress included a set of interrelated provisions in ACA Title I that, working in tandem, have reformed what was the dysfunctional non-group health insurance market.

As discussed above (pp. 2-4, *supra*), before the Affordable Care Act was enacted, the non-group health insurance market was characterized by high premiums, restrictive insurance industry practices, and low participation. Health insurance obtained in the non-group market did not receive federal tax subsidies, so purchasers had to bear the full cost of premiums. Federal law did not prevent insurers from denying coverage or charging higher premiums based on an individual's health status, and, without such rules, millions of individuals were denied coverage or offered premiums that they could not afford. As a result, participation in the non-group market was low even among those who lacked other

health coverage options. Of the 45 million individuals who did not have access to an employment-based group health plan or government health benefits program in 2009, only 20% were covered by a policy purchased in the non-group insurance market. The remaining 80% were uninsured.

To reform the non-group health insurance market, Congress: (1) extended federal tax subsidies to the non-group market (the premium tax credits and cost-sharing subsidies); (2) barred insurers from denying coverage to or charging higher premiums because of an individual's health status (the guaranteed-issue and community-rating requirements); and (3) required that non-exempted individuals maintain minimum essential health coverage or else pay a tax penalty (the minimum coverage provision, which plaintiffs refer to as the "individual mandate"). *See* pp. 4-6, *supra*.

Congress understood that the guaranteed-issue and community-rating requirements would undermine—rather than reform—the non-group health insurance market unless those requirements were paired with the minimum coverage provision and premium tax credits that make minimum coverage affordable. As discussed above (pp. 7-9, *supra*), the Congressional Budget Office ("CBO") and state insurance regulators warned Congress that, by themselves, the guaranteed-issue and community-rating requirements would create adverse selection that would lead to a cycle of rising premiums and declining enrollment in

the non-group market. CBO explained that the premium tax credits and minimum coverage provision were needed to mitigate such adverse selection. CBO informed Congress that there would be "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed," JA 95; that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people," JA 108; and that the structure of the premium tax credits (under which federal subsidies increase if premiums rise) "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." JA 109.

The National Association of Insurance Commissioners ("NAIC"), which offered Congress "the experience and expertise of the states to Congress as it attempt[ed] to improve the health insurance marketplace," likewise warned Congress that proposals for "guaranteed issue and elimination of preexisting condition exclusions for individuals" could "result in severe adverse selection." The NAIC advised Congress that "State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-503, 504 (2009).

Accordingly, Congress coupled the Act's guaranteed-issue and community-rating requirements with the minimum coverage provision and premium tax credits designed to provide "Affordable Coverage Choices for All Americans." ACA Title I, Subtitle E. Congress understood when it enacted the legislation that the vast majority of people who bought non-group health insurance on the Exchanges would receive premium tax credits, and that, on average, the tax credits would cover the lion's share of the premiums. In response to Congress's request that CBO analyze how health care reform proposals would affect premiums in various markets, CBO advised Congress that, under the proposed legislation, 78% of the people (18 million of 23 million) who bought insurance through the Exchanges in 2016 would receive premium tax credits, and that those credits, on average, would cover nearly two-thirds of the premium. *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* i, 24 (Nov. 30, 2009) (JA 89, 113). Congress found that the premium tax credits "are *key* to ensuring people affordable health coverage." H.R. Rep. No. 111-443, vol. 1, at 250 (March 17, 2010) (JA 41) (emphasis added).

Given this background, it is untenable to suggest that Congress withheld premium tax credits from individuals who live in States with federally-run Exchanges. Congress sought to *reform* the non-group market, not to *destroy* it. "Plaintiffs' proposed construction in this case—that tax credits are available only

for those purchasing insurance from state-run Exchanges—runs counter to this central purpose of the ACA: to provide affordable health care to virtually all Americans." *Halbig*, 2014 WL 129023, *16; *see also* JA 311. Insurers in States with federally-run Exchanges would still be required to comply with guaranteed-issue and community-rating rules, but, without premium tax subsidies to encourage broad participation, insurers would be deprived of the broad policy-holder base required to make those reforms viable. Adverse selection would cause premiums to rise, further discouraging market participation, and the ultimate result would be an adverse-selection "death spiral" in the individual insurance markets in States with federally-run Exchanges. *See, e.g.*, Amicus Br. of America's Health Insurance Plans 3-6, *Halbig v. Sebelius*, No. 14-5018 (D.C. Cir.); Amicus Br. for Economic Scholars 3-6, *Halbig v. Sebelius*, No. 14-5018 (D.C. Cir.); Jonathan Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act* (Aug. 2010) (JA 164-169).

The lead *Halbig* plaintiff, David Klemencic, was also a plaintiff in *NFIB*, where he urged the Supreme Court that the Exchanges could not operate without the premium tax credits. There, he argued (through the same counsel) that, "[w]ithout the subsidies driving demand within the exchanges, insurance companies would have absolutely no reason to offer their products through exchanges, where they are subject to far greater restrictions." Brief for Private

Petitioners on Severability, *NFIB v. Sebelius*, Nos. 11-393 & 11-400 (S. Ct.), 2012 WL 72440, *51-*52. The four Justices who considered the issue of severability agreed: "Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges, and some insurers may be unwilling to offer insurance inside of exchanges. With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all." *NFIB*, 132 S. Ct. at 2674 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).

By contrast, plaintiffs here and in *Halbig* would now ascribe to Congress the intent to render the non-group insurance markets in States with federally-run Exchanges dysfunctional. Their argument is, at bottom, a *post hoc* account designed to dismantle the health care reform legislation that they have steadfastly opposed. In the words of the Oklahoma Attorney General, who appears as plaintiffs' *amicus* here, if plaintiffs' position is adopted, "the structure of the ACA will crumble." Scott Pruitt, *ObamaCare's Next Legal Challenge*, The Wall Street Journal (Dec. 1, 2013). "While much time has been devoted in Washington to the issue of 'defunding' the Affordable Care Act, the success of these lawsuits would have much the same effect." *Ibid*.[9]

[9] Although Georgia also appears here as plaintiffs' *amicus*, the Georgia Health Insurance Exchange Advisory Committee advised the Governor that the Affordable Care Act "provides HHS subsidies and IRS refundable tax credits to individuals meeting federal eligibility requirements and an income between 100-

Continued on next page.

2. *Exchanges are not an end in and of themselves, but a means to provide affordable health insurance, and Congress did not "coerce" States into establishing Exchanges.*

"Plaintiffs try to explain away the inconsistency between their proposed construction and the statute's underlying purpose by proposing that Congress had another, equally pressing goal when it passed the ACA: convincing each state to set up its own health insurance Exchange." *Halbig*, 2014 WL 129023, *16. On plaintiffs' theory, Congress threatened to withhold premium tax credits from people who need them in order to coerce States into establishing Exchanges, by making a threat to state residents so dire that a State "could not refuse" to set up an Exchange. Pl. Br. 13. Summarizing this "coercion" theory for the D.C. Circuit, the *Halbig* plaintiffs declared that Congress threatened to "hurt not only low-income" individuals "but people of *all* income levels—plus insurers, hospitals, pre-Medicare adults" and all of the other groups that filed *amicus* briefs in support of the government—so that "states would have felt compelled to establish Exchanges." Pl. Reply 16, *Halbig v. Sebelius*, No. 14-5018 (D.C. Cir.) (plaintiffs' emphasis).

400% of Federal Poverty Level" and that "*Georgians will be eligible for these subsidies whether the [American Health Benefits Exchange] in Georgia is established by the state or federal government*." Georgia Health Insurance Exchange Advisory Committee, *Report to the Governor* 13 (Dec 15, 2011) (emphasis added).

That is absurd. "A state-run Exchange is not an end in and of itself, but rather a mechanism intended to facilitate the purchase of affordable health insurance." *Halbig*, 2014 WL 129023, *17. Congress obviously did not threaten to destroy health insurance markets and thereby hurt millions of people as a means to coerce States to establish Exchanges.

Plaintiffs' "coercion" theory disregards the plain language of the Act, which provides that the Secretary of HHS will establish an Exchange if a State elects not to do so. 42 U.S.C. § 18041(c)(1). Congress did not "coerce" States to establish Exchanges. Instead, Congress authorized federal grants to assist States in establishing Exchanges. *See id*. § 18031(a); *see also id*. § 18031(d)(5)(A) (continuing Exchange operations may be financed through user fees). Congress also vested the Exchanges with certain regulatory power with respect to health insurers seeking to offer plans on the Exchanges. *See id*. § 18031(e) (power to certify qualified health plans and to review insurers' proposed premium rates); *id*. § 18021(a)(1)(C)(iv) (power to impose additional requirements for qualified health plans). Congress thus gave States the option of accepting that regulatory power by operating the Exchange or forgoing it and having its Exchange run by the federal government instead.

Contrary to plaintiffs' premise (Pl. Br. 13), "there can be no suggestion that the Act commandeers the legislative processes of the States by directly compelling

them to enact and enforce a federal regulatory program." *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981). "The most that can be said is that the [Act] establishes a program of cooperative federalism that allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." *Id*. at 289.

Although plaintiffs seek to analogize the Exchange provisions with the Medicaid eligibility expansion that was at issue in *NFIB*, *see* Pl. Br. 13, 29-30, 44, the twenty-six plaintiff States in *NFIB* repeatedly contrasted the Medicaid eligibility expansion with "the real choice that the ACA offers States to create exchanges or have the federal government do so." Brief of State Petitioners on Medicaid, *Florida v. HHS*, No. 11-400, 2012 WL 105551, *51. Medicaid is jointly funded by the federal and state governments and administered by the States. If a State does not participate, the Secretary of HHS has no authority to administer the program in its place. By contrast, if a State declines to establish the required State Exchange, the Affordable Care Act directs the Secretary to do so on the State's behalf.

Thus, the plaintiff States in *NFIB* explained: "Because States were given a meaningful choice whether to operate the health benefit exchanges created by the Act, there is a plan B. The federal government will step in if States decline." *Id*. at

*22. The "lack of any contingency plan" in the Medicaid eligibility expansion "stands in stark contrast to other provisions of the Act in which Congress gave States a meaningful option and expressly accounted for the possibility that States might decline the federal blandishments." *Id*. at *35. "Most prominently, in providing for the creation of 'health benefit exchanges' in each State, Congress authorized the federal government to establish and operate those exchanges in any State that chooses to forgo federal funding to do so itself." *Id*. at *35.

In short, plaintiffs' "coercion" theory is baseless. Premium tax credits are not grants to States. They are federal subsidies that Congress provided directly to federal taxpayers so that they can afford health insurance. Like other federal tax benefits, the premium tax credits that Congress authorized for middle- and low-income Americans in Section 36B are available nationwide. *United States v. Irvine*, 511 U.S. 224, 238 (1994) ("revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application"). Indeed, if Congress had intended to depart from this principle and to use the availability of federal tax credits for individuals as a tool to coerce action by a State, Congress would have said so directly, thereby giving individuals and States themselves clear notice of the consequences of a State's decision.

3. *The legislative history confirms that Congress gave States the option to establish Exchanges and did not coerce States to do so*.

Because plaintiffs' "coercion" theory is foreclosed by the Affordable Care Act's text, there is no need to consult the legislative history. In any event, the legislative history is entirely consistent with the statutory text: Congress gave States "the option of establishing their own Exchanges" and did not "coerce" States to do so. *Halbig*, 2014 WL 129023, *17.

The legislative history on which plaintiffs rely confirms that their "coercion" theory is baseless. For example, based on a clip from the floor statement of Representative Waxman, plaintiffs declare that the Act "had to include strong incentives 'to encourage State participation.'" Pl. Br. 46 (quoting 156 Cong. Rec. H2423-24 (Mar. 25, 2010) (Rep. Waxman)). What Representative Waxman actually said was this:

> Mr. Speaker, the bill is to be commended as a model of cooperative federalism. Under the new law, a State is free to establish a health insurance exchange if it so chooses. But if it declines, the Secretary will establish an exchange. This is a strong example of what the Supreme Court has recognized as an appropriate exercise of federal power to encourage State participation in important federal programs. . . . . This arrangement, which has been termed "a program of cooperative federalism," *Hodel*, *supra*, 452 U.S., at 289, is replicated in numerous federal statutory schemes. *New York v. United States*, 505 U.S. 144, 165 (1992).

156 Cong. Rec. H2423-24 (March 25, 2010) (Rep. Waxman) (quotation marks omitted).

Similarly, based on a news article, plaintiffs assert that Senator Nelson opposed a bill that would "allow states the *option* to establish Exchanges." Pl. Br. 3 (plaintiffs' emphasis); *see also* Pl. Br. 46. In reality, that news article stated that Senator Nelson "would oppose any health care reform bill *with a national insurance exchange*, which he described as a dealbreaker." Carrie Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO (Jan. 25, 2010) (emphasis added). The Affordable Care Act did not establish a "national insurance exchange." *Ibid*. Instead, the Act gave each State the option to establish an Exchange and provided that, if a State chose not to do so, the federal government would establish the Exchange on the State's behalf. As the *Halbig* court explained, early proposals such as a House bill to create "a national exchange within a newly created Health Choices Administration located in the Executive Branch" proved "politically untenable and doomed to failure in the Senate, so the Senate passed a bill that provided 'flexibility' to each state as to whether it would operate the Exchange." *Halbig*, 2014 WL 129023, *17 (citing 42 U.S.C. § 18041 (titled "State flexibility in operation and enforcement of Exchanges ...")). "As the Chairman of the Senate Finance Committee—the committee that considered and reported the bill—described it, the ACA 'fundamentally gives States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges.'" *Ibid*. (quoting 155 Cong. Rec. S13, 832

(Dec. 23, 2009) (Sen. Baucus)). Thus, the legislative history "reveals an intent to grant states the option of establishing their own Exchanges, rather than an intent to coerce or entice states into participating." *Ibid.*

C. Treasury's Reasonable Interpretation Is Entitled to Deference.

For the reasons discussed above, plaintiffs' position is not a permissible interpretation of Section 36B. Even assuming that "the statute could be characterized as ambiguous—which it cannot—[Treasury's interpretative regulation] must be upheld at *Chevron* step two as a permissible construction of the statute." *Halbig*, 2014 WL 129023, *18 n.14; *see also* JA 312-313.

Congress expressly delegated authority to Treasury to resolve ambiguities in Section 36B, which is a provision of the Internal Revenue Code. *See* 26 U.S.C. § 36B(g) ("The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section."). Moreover, Congress expressly granted Treasury authority to "prescribe all needful rules and regulations for the enforcement of this title, including all rules and regulations as may be necessary by reason of any alteration of law in relation to internal revenue," 26 U.S.C. § 7805(a), and the Supreme Court found this "express congressional authorization[] to engage in the process of rulemaking" to be "a very good indicator of delegation meriting *Chevron* treatment." *Mayo Found. for Med. Educ.*

& Research v. United States, 131 S. Ct. 704, 714 (2011) (quotation marks and citation omitted).

After notice and comment rulemaking, the Treasury Department issued a regulation that (*inter alia*) confirms that premium tax credits are available on any Exchange, regardless of whether the Exchange is run by a State or by the Secretary of HHS. *See* 26 C.F.R. § 1.36B-1(k) (adopting the same definition of Exchange that the Secretary of HHS adopted in 45 C.F.R. § 155.20). Treasury explained that "[t]he statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange." 77 Fed. Reg. 30,377, 30,378 (May 23, 2012). "Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges." *Ibid*. "Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole." *Ibid*.

Plaintiffs' contention that their position is compelled by the statutory text, *see* Pl. Br. 48, 56, fails for the reasons already discussed. "[T]he plain text of the statute, when considered in light of the statutory structure, the statute's purpose, and the limited legislative history, establish that the Secretary's interpretation is, at

minimum, a reasonable one." *Halbig*, 2014 WL 129023, *18 n.14; *see also* JA 313 (district court opinion). Plaintiffs insist that the Court must consider one phrase of one provision in isolation, divorced from the rest of that provision, the provisions that it cross references, and the structure and purpose of the Act. But it is well settled that, "[i]n determining whether a statute is ambiguous and in ultimately determining whether the agency's interpretation is permissible or instead is foreclosed by the statute, [a court] must employ all the tools of statutory interpretation, including text, structure, purpose, and legislative history." *Loving v. IRS*, _ F.3d _, 2014 WL 519224, *2 (D.C. Cir. Feb. 11, 2014) (quotation marks omitted) (cited at Pl. Br. 49).

Plaintiffs three other arguments for why the Treasury's interpretation of Section 36B should not receive *Chevron* deference, none of which has merit. First, they contend that important issues should be resolved by courts rather than by agencies. Pl. Br. 49. The Supreme Court reached the opposite conclusion. Writing for the Court, Justice Scalia explained that *Chevron* deference applies to "big, important" matters as well as to "humdrum, run-of-the-mill stuff." *City of Arlington v. FCC*, 133 S. Ct. 1863, 1868 (2013). Justice Scalia emphasized that "the question in every case is, simply, whether the statutory text forecloses the agency's assertion of authority, or not." *Id*. at 1871. And he explained that *Chevron* "provides a stable background rule against which Congress can legislate:

Statutory ambiguities will be resolved, within the bounds of reasonable interpretation, not by the courts but by the administering agency." *Id*. at 1868.

Second, plaintiffs declare that Treasury's interpretation of Section 36B is not owed deference because Treasury and HHS coordinate responsibility for other parts of the Act. Pl. Br. 53-55. But there is no dispute that Treasury has authority to interpret Section 36B, and the reporting requirements of Section 36B itself show that premium tax credits are available on federally-run Exchanges. *See* pp. 21-25, *supra*.

In any event, the fact that Treasury and HHS coordinate responsibility for administering parts of the Act is not a reason to withhold *Chevron* deference. When, as here, agencies issue coordinated regulations, *see* JA 312-313, *Chevron* deference applies. For example, in *National Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 664-666 (2007), the Supreme Court accorded *Chevron* deference to a regulation jointly issued by the two agencies charged with implementing the Endangered Species Act—the Departments of Commerce and the Interior—and upheld that regulation as a reasonable interpretation of the statute. *See also Coeur Alaska, Inc. v. Southeast Alaska Conservation Council*, 557 U.S. 261, 277-278 (2009) (deferring under *Chevron* to "agencies' regulations construing" the Clean Water Act); *Kentuckians for Commonwealth Inc. v. Rivenburgh*, 317 F.3d 425, 446 (4th Cir. 2003) (deferring to the "contemporaneous

explanation by the two agencies charged with the responsibility of administering the Clean Water Act").[10]

Finally, plaintiffs assert that "*Chevron* Deference Would Be Displaced Here by the Venerable 'Clear Statement' Rule for Tax Exemptions and Credits." Pl. Br. 50. There is no such principle. Although "exemptions from taxation are to be construed narrowly," *Mayo Found.*, 131 S. Ct. at 715, the Supreme Court has never suggested that this principle displaces *Chevron* deference. *Id*. at 711 (analyzing Treasury's interpretation of a tax exemption under the *Chevron* framework). A tax benefit, "even if not supported by express statutory language," can "nonetheless be recognized if it is in harmony with the statute as an organic whole." *Centex Corp. v. United States*, 395 F.3d 1283, 1295 (Fed. Cir. 2005).

The relevant canon here is not a presumption against federal tax credits—which Congress clearly authorized in Section 36B—but the principle that "revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. 224, 238 (1994). "State law may control only when the federal taxing act, by express language or necessary implication, makes its own operation

[10] Plaintiffs rely on the D.C. Circuit's decision in *American Federation of Government Employees v. Shinseki*, 709 F.3d 29 (D.C. Cir. 2013), but that case was decided at *Chevron* step 1. *See id*. at 33 ("Because we conclude that 'Congress has directly spoken to the precise question at issue' and that the text is unambiguous, our analysis also ends with the text.").

dependent upon state law." *Burnet v. Harmel*, 287 U.S. 103, 110 (1932). For the reasons already discussed, Congress did not allow States to block federal taxpayers from receiving the federal premium tax credits they need to purchase health insurance.[11]

II. Plaintiffs' Claims Also Fail on Threshold Grounds.

A. Plaintiffs Lack Standing.

Plaintiffs seek to premise their standing on the interaction between premium tax credits and the minimum coverage provision that the Supreme Court upheld in *NFIB*, 26 U.S.C. § 5000A. Under Section 5000A, non-exempted individuals who fail to maintain minimum essential coverage incur a tax penalty. Congress exempted from this tax penalty individuals who cannot afford coverage, including individuals who cannot afford coverage even with the benefit of the premium tax credits. *See* 26 U.S.C. § 5000A(e)(1).

Plaintiffs claim that, if they were not eligible for premium tax credits, they would qualify for the "unaffordability exemption" in Section 5000A and would not be subject to a tax penalty if they did not maintain minimum essential coverage.

[11] On February 5, 2014, the House Committee on Oversight and Government Reform, which is chaired by Representative Darrell Issa, issued a report critical of Treasury's interpretation of Section 36B (the "Issa Report"). The following day, Chairman Issa and plaintiffs' other congressional *amici* submitted a brief in the *Halbig* appeal that relied on the Issa Report. The Issa Report, which advanced plaintiffs' "coercion" theory, *see* Issa Report at 14-15, did not acknowledge the contrary district court decision in *Halbig*.

None of the plaintiffs in this case claims to be uninsured, however. In this respect at least, these plaintiffs differ from the lead *Halbig* plaintiff, Mr. Klemencic, who claims to be uninsured. Here, plaintiffs allege that they wish to purchase what they describe as "cheaper, high-deductible catastrophic coverage" rather than "costly, comprehensive health insurance." Complaint ¶ 5 (JA 9).

However, the record shows that two of the plaintiffs (Mr. King and Ms. Luck) will qualify for the "unaffordability" exemption in Section 5000A regardless of whether they are eligible for premium tax credits. *See* JA 32-34 (Moulds Decl. ¶¶ 7, 10). Thus, the availability of premium tax credits has no bearing on their ability to purchase catastrophic coverage.

Moreover, for all four of the plaintiffs, the record shows that, after the tax credit is applied, comprehensive coverage will be *less expensive* than a catastrophic plan. JA 32-34 (Moulds Decl. ¶¶ 7-10). Mr. Hurst, for example, would pay only $62.49 per month for a bronze-level plan, but would pay $415.61 per month for a catastrophic plan. JA 33 (Moulds Decl. ¶ 8). Similarly, Ms. Levy would pay only $148.72 per month for a bronze-level plan, but would pay $245.56 for a catastrophic plan. JA 33 (Moulds Decl. ¶ 9).

Thus, the entire premise of this lawsuit—which is that plaintiffs are injured by premium tax credits because, without those credits, they allegedly could obtain

"cheaper, high-deductible catastrophic coverage" (JA 9 ¶ 5)—is incorrect, and the injury that plaintiffs allege is nonexistent.

B. The Availability of a Tax-Refund Action Bars This Suit.

Even if plaintiffs could demonstrate standing, the availability of a tax-refund action is an independent bar to this suit under the APA. Assuming that one or more of the individual plaintiffs will incur tax liability under Section 5000A, their remedy is to pay the tax penalty, sue for a refund, and present whatever legal arguments they might have in a tax-refund action. That is the avenue Congress prescribed for challenging federal tax liability. *See* 28 U.S.C. § 1346 (district courts have jurisdiction to hear "[a]ny civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal-revenue laws").

Even apart from the jurisdictional bar established by the Anti-Injunction Act (which does not apply to a tax penalty incurred under Section 5000A, *see NFIB*, 132 S. Ct. at 2582-84), "general equitable principles disfavor[] the issuance of federal injunctions against taxes, absent clear proof that available remedies at law [are] inadequate." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 742 n.16 (1974).

Moreover, the APA itself provides that its cause of action does not displace adequate legal remedies. *See* 5 U.S.C. §§ 703, 704.

A tax-refund action plainly would afford adequate relief—payment in full, with interest, of any overpayment of their federal tax obligations—if plaintiffs were to prevail. And, based on plaintiffs' declarations, their potential tax liability would be quite limited even if they were to forgo health insurance: the most that any of the four plaintiffs would incur in tax liability is $330 for the entire 2014 year. *See* R.18 at 17 & n.4 (estimating Ms. Levy's potential tax liability under Section 5000A).

The district court noted that there is also an administrative process by which individuals can apply for "certificates of exemption" from Section 5000A, *see* JA 300, but plaintiffs do not need a certificate of exemption to challenge a Section 5000A assessment. Assuming that they incur tax liability, they can present the same theory that they now advance in the forum that Congress designated, a tax-refund action. "[T]he alternative remedy need not provide relief identical to relief under the APA, so long as it offers relief of the same genre." *Garcia v. Vilsack*, 563 F.3d 519, 522 (D.C. Cir. 2009); *see also Cohen v. United States*, 650 F.3d 717, 733 (D.C. Cir. 2011) (en banc) ("challenges to the validity of an individual tax" must be brought in a refund suit).

The district court mistakenly believed that the Tenth Circuit's decision in *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1127 (10th Cir. 2013), *cert. granted*, No. 13-354 (S. Ct.), suggests that this suit can proceed under the APA despite the availability of a tax-refund action. JA 301. The preventive-services coverage provision at issue in *Hobby Lobby* is a freestanding obligation that is enforceable under ERISA and the Public Health Service Act (in addition to the Internal Revenue Code). For these and other reasons, the government conceded that a Religious Freedom Restoration Act claim could proceed notwithstanding the Anti-Injunction Act. That concession has no bearing here, where plaintiffs' only asserted injury is potential tax liability under Section 5000A.

C. This Suit Is Not a Class Action, and Plaintiffs Cannot Seek to Extinguish the Tax-Credit Claims of Non-Parties.

Plaintiffs also argued below that an order setting aside the Treasury regulation would prevent millions of other people from obtaining premium tax credits on federally-run Exchanges around the country or, alternatively, within this Circuit. R.40 at 38-39. Even assuming that the four individuals before the Court could prevail on their own claims, they have no standing to prevent *other people* from seeking premium tax credits.

This suit is not a class action, and an adjudication of plaintiffs' claims could not extinguish the tax-credit claims of non-parties. Regardless of the outcome of this case, other people will remain free to seek premium tax credits on an

Exchange and, if such tax credits are denied, to sue in the Court of Federal Claims ("CFC") or their local district courts for such tax credits. It makes no difference that plaintiffs here and in *Halbig* seek to "set aside" Treasury's regulation interpreting Section 36B. Such a ruling would not bind the Federal Circuit (which hears appeals from the CFC) or any other court of appeals. *See Virginia Soc'y for Human Life v. FEC*, 263 F.3d 379, 394 (4th Cir. 2001). Moreover, even if Treasury's interpretive regulation did not exist, individuals who are not parties to this suit could seek premium tax credits under the authority of Section 36B itself.

The *Halbig* plaintiffs urged the D.C. Circuit that "[i]t does not matter that this 'is not a class action'" and that the court could extinguish the tax-credit claims of individuals who live in "states like Texas." Pl. Reply 26, *Halbig v. Sebelius*, No. 14-5018 (D.C. Cir.). That assertion ignores the teachings of the Supreme Court, which has held that protections for non-parties are grounded in the requirements of due process. "[B]efore an absent class member's right of action was extinguishable due process require[s] that the member 'receive notice plus an opportunity to be heard and participate in the litigation,'" and, "'at a minimum . . . an absent plaintiff [must] be provided with an opportunity to remove himself from the class.'" *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 848 (1999) (quoting *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 812 (1985)).

Plaintiffs here and in *Halbig* did not even seek to represent a class, and they manifestly could not satisfy the "constitutional requirement" that a "'named plaintiff at all times adequately represent the interests of the absent class members.'" *Id*. at 848 n.24 (quoting *Shutts*, 472 U.S. at 812). For millions of people across the country, premium tax credits are not a burden to be avoided but a desperately needed federal benefit that makes their health insurance affordable. Plaintiffs' pronouncement that "artificially limiting relief to the particular plaintiff in the case . . . would only generate a flood of duplicative litigation by identically situated parties," R.40 at 38 (quotation marks omitted), ignores the fact that no one else wants to extinguish the tax credits they need to pay for health insurance.

CONCLUSION

The case should be remanded with instructions to dismiss the complaint or, alternatively, the judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(A)

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I further certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 12,513 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

/s/ Alisa B. Klein
Alisa B. Klein

CERTIFICATE OF SERVICE

I hereby certify that on March 18, 2014, I electronically filed the foregoing brief with the Clerk of this Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/ Alisa B. Klein
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