[ORAL ARGUMENT SCHEDULED FOR DECEMBER 17, 2014]

No. 14-5018

IN THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT *EN BANC*

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

BRIEF OF *AMICUS CURIAE* FAMILIES USA IN SUPPORT OF APPELLEES

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STATEMENT REGARDING
CONSENT TO FILE AND SEPARATE BRIEFING

Pursuant to D.C. Circuit Rule 29(b), undersigned counsel for *Amicus Curiae* Families USA represents that all parties have consented to the filing of this brief.[1]

Pursuant to D.C. Circuit Rule 29(d), counsel for *Amicus* certifies that a separate brief is necessary, first, because no other *amicus* brief will bring to bear the detailed expertise *Amicus* has to offer regarding the complexities of the Affordable Care Act, including the interrelationships between its numerous sections. *Amicus* conducted studies that informed the Act, and participated actively in the legislative process that led to its enactment. *Amicus* believes that its brief will clarify and simplify important features of this complicated statute, and identify issues that others have overlooked.

In addition, *Amicus* presents the perspective of a nonpartisan group advocating on behalf of patients generally and low-income patients in particular, who have the greatest stake in the outcome of this case. *Amicus* respectfully submits that its expertise and perspective will assist the Court in evaluating this case.

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[1] Pursuant to Federal Rule of Appellate Procedure 29(c), Families USA states that no counsel for a party authored this brief in whole or in part, and no person other than Families USA or its counsel made a monetary contribution to its preparation or submission.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, *Amicus Curiae* Families USA states that no party to this brief is a publicly-held corporation, issues stock, or has a parent corporation.

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

I. PARTIES AND AMICI

Except for any *amici* who have not yet entered an appearance in this Court, all parties and *amici* appearing before the district court are listed in the Brief for Appellants.

II. RULINGS UNDER REVIEW

References to the rulings at issue appear in the Brief for Appellants.

III. RELATED CASES

So far as counsel are aware, this case has not previously been filed with this Court or any other court, and counsel are aware of no other cases that meet this Court's definition of related.

Dated: November 3, 2014

By: /s/ Murad Hussain
Counsel for Amicus Curiae Families USA

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INTEREST OF *AMICUS CURIAE*

Amicus Families USA is a national non-partisan, non-profit organization that has represented the interests of health care consumers and promoted health care reform in the United States for more than 30 years. On behalf of health care consumers, Families USA has addressed the serious medical and financial harms inflicted on the millions of Americans without health insurance. For example, with regard to medical harms, a Families USA study showed that many uninsured forgo needed medical care because of cost, resulting in 26,100 premature deaths in 2010 alone.[3] The financial harms that Families USA has addressed arise because the uninsured, like everyone, face serious accidents and life-threatening illnesses, often resulting in ruinous medical debts. When the uninsured cannot pay, the cost of their care is passed on to other consumers, increasing the prices that health providers charge and the cost of health insurance for everyone.[4]

To remedy these injuries resulting from the widespread lack of health insurance, Families USA has backed reforms to achieve universal health insurance coverage. The organization advocated for the Affordable Care Act ("ACA") and

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[3] Families USA, *Dying for Coverage: The Deadly Consequences of Being Uninsured*, available at http://www.familiesusa.org/resources/publications/reports/dying-for-coverage.html.

[4] In 2010, that increase was $1000 for an average family. Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, § 1501(a)(2)(F) (2010).

sponsored studies that helped shape it.[5] Families USA also convened major, structured dialogues among key health stakeholders – including organizations representing health consumers with diverse demographic backgrounds and leading associations representing hospitals, physicians, insurers, pharmaceutical companies, businesses, and labor – to promote cooperative support for reform. The law that emerged from these efforts marks real progress toward universal, affordable health insurance coverage. A key to this progress was tax relief to low-income families so they can pay for insurance.

Given the role Families USA played in passing the ACA, the organization has a strong interest in its vitality, and, therefore, in the premium assistance central to it. Further, having long represented the interests of health care consumers, Families USA offers a valuable perspective on what this assistance means to real people already at or beyond the cusp of economic hardship, on the personal tragedies that will result if Appellants succeed in taking that assistance away from them, and on how the statute reflects these concerns. In addition, with the comprehensive expertise Families USA has gained regarding the statute – comprising more than 950 interrelated sections – the organization can disentangle some of the complicated arguments presented here. Families USA thus respectfully submits that its analysis will assist the Court.

[5] *See*, *e.g.*, Footnotes 3 and 4 above.

SUMMARY OF ARGUMENT

In an avowed effort to gut the Affordable Care Act, Appellants interpret it in a manner that is as pernicious as it is implausible. Stripped of rhetoric, Appellants' plea is that the Court take money away from millions of poor people, money Congress granted so they could afford health insurance. As of May 1, 2014, more than 6.8 million people who have signed up on an Exchange qualify for this financial assistance.[6] Of these, more than 4.6 million live in States with Federally-facilitated Exchanges. The premise behind the effort to withdraw assistance from these 4.6 million who have already enrolled, and from those who enroll in the future, is that Congress intentionally, but surreptitiously, hurt the people the Act was designed to help and frustrated the purpose announced in the very name of the statute.

To support their counterintuitive premise, Appellants isolate six words from one section in the ACA, quarantining them from the rest of the section, from other provisions of the Act, and from common sense. The provision at issue, Section 36B of the Internal Revenue Code, directs that tax credits and subsidies "shall" be

[6] Department of Health & Human Services, *Health Insurance Marketplace: May Enrollment Report for the Period October 1, 2013 -March 31, 2014 (Including the Special Enrollment Period Activity Reported Through April 19, 2014)* (2014), at 4, 14-15, *available at* http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf ("HHS May 2014 Enrollment Report").

made available to low income families. It is in the explication of how to calculate the amount of these benefits that the language spotlighted by Appellants appears. Subsection 36B(b)(2)(A) bases the computation on the price the taxpayer paid for a policy on "an Exchange established by the State." Appellants leap from this mathematical formula for calculating the subsidy to the conclusion that where a State has failed to establish an Exchange and the Federal Government has stepped in to do so as the law directs, the Exchange is not one "established by the State." Therefore, Appellants say, subsidies are not available, or more precisely, the subsidies the Act mandates add up to zero. Moreover, Appellants assert, this gambit was purposeful: Congress sought to coerce States by threatening loss of tax subsidies for their low-income families unless the States established Exchanges.

The numerous flaws with this theory start with the statutory language. The Act defines "Exchange" *three* times as an Exchange established by a State. To signify that "Exchange" is a defined term, the Act capitalizes the word every time it is used. Contrary to Appellants' implication, at no point does the statute articulate any other definition. This consistency negates the panel opinion's quibble whether one of the three provisions specifying the attributes of Exchanges is definitional or prescriptive. *See Halbig v. Burwell*, 758 F.3d 390, 400-01 (D.C. Cir. 2014). "Exchange established by the State" is the only meaning the statute assigns to the word.

The statute directs that if a State does not establish an "Exchange" (as defined and with a capital "E"), the Secretary of Health and Human Services must step in and establish "such Exchange." But how can the Secretary establish an "Exchange" that, by definition, must be established by the State? As the District Court found, the only way is for the Secretary to act on behalf of the State. In other words, the statute assigns the States a duty, and if the States do not fulfill it, the Federal Government will do it *for* them—*not instead of* them. Such legal proxies are common, and recognizing that relationship here makes sense of the subsidy provision, harmonizes it with many other sections, and furthers the stated purpose of the law – to make affordable insurance broadly available.

The panel opinion acknowledges this substitution, *Halbig*, 758 F.3d at 400-01, but inexplicably extinguishes its legal effect. Appellants deny the intended surrogacy altogether. The destructive effects of both approaches ripple like shockwaves through the statute. If the Secretary does not step into the shoes of the State when establishing an "Exchange," then no such Federal entity could be an "Exchange," as thrice defined in the statute. And Exchanges are indispensable to many provisions. For example, a prerequisite to being a "qualified health plan" is certification by an "Exchange." A Federally-facilitated Exchange could not provide such certification. Further, the *only* definition of "qualified individual" in the Act limits the designation to residents of the State that "established the

Exchange." The theory propagated by Appellants and in the panel opinion would leave no "qualified individuals" in States with Federally-facilitated Exchanges. The panel opinion suggests that nothing limits participation on the Exchanges to qualified individuals. *See Halbig*, 758 F.3d at 405-406. But in common usage, "qualified" means "eligible," and as a matter of syntax and logic, "qualified individuals," are those persons eligible to participate on the Exchanges. Other provisions confirm this common sense, plain English reading. The Court thus cannot avoid the absurd consequences of Appellants' interpretation: that Federally-facilitated Exchanges would have nothing to sell and no one to buy it.

Nor is the Court called upon here to rewrite the statute in service of some unarticulated statutory purpose. Applying the terms as Congress defined them produces a sensible interpretation. But beyond that, the purpose of the statute need not be intuited or inferred. Congress stated it directly, in statutory headings, legislative findings, and substantive text – to make affordable health insurance available to all Americans. The interpretation of the ACA that Appellants propose, and that the panel adopted, is, at once, inimical to this express purpose, divorced from statutory context, and at war with the common sense reading of the statutory text.

ARGUMENT

I. APPELLANTS INAPPROPRIATELY IMPORT A POLITICAL BATTLE INTO A JUDICIAL FORUM AND UNDERMINE THE FUNDAMENTAL PURPOSES OF THE ACA

From the moment the ACA became law, political opponents repeatedly tried and failed to overturn it. Those attempts, which persist, have included more than 50 repeal votes and a 16-day shutdown of much of the Federal government.

Inevitably, the political efforts to rescind the ACA spilled into the courts. The battle on that front failed, too, when the Supreme Court upheld the Act as constitutional in *National Federation of Independent Business v. Sebelius* ("*NFIB*").[7] However, the war did not end. The tactics merely shifted to subverting the law. This case is the forward edge of the new assault. Brought by the same counsel, with one of the same plaintiffs as in *NFIB*, it rests on a reading of the statute so artificial that it did not surface until months after the bill became law, in a talk at the American Enterprise Institute on the quest for a statutory defect. The Institute's resident scholar hailed the presentation and others as a "terrific start" towards a multi-front attack on the ACA, which, he said,

> has to be killed as a matter of political hygiene. I do not care how this is done, whether it's dismembered, whether we drive a stake through its heart, whether we tar and feather it and drive it out of town, whether we strangle it. I don't care who does it, whether it's some court some

[7] 132 S.Ct. 2566 (2012).

> place, or the United States Congress. Any which way. . . Any brief filed toward that end is worth filing.[8]

The subsidy argument, touted by its progenitors as a "threat [to the Act's] survival," fit that bill.[9]

The origins of this interpretation, the unreasonable textual exegesis on which it rests, and the implausible premise underlying it signal that this case continues the unfortunate importation of legislative battles into the judicial arena. That signal is amplified when legislators of one political party, who all voted against or sought to repeal the ACA, file an *amicus* brief expounding on its meaning.[10] Federal courts have long sought to exclude such partisan strife, in part because people affected by

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[8] *See* Linda Greenhouse, "By Any Means Necessary," N.Y. Times (Aug. 20, 2014) (quoting transcript of AEI conference), *available at* http://www.nytimes.com/2014/08/21/opinion/linda-greenhouse-by-any-means-necessary.html.

[9] Michael Cannon, *ObamaCare: The Plot Thickens*, 14 Harvard Health Pol. Rev. 36, 38 (2013); *see also, e.g.*, Sarah Kliff, *Could One Word Take Down Obamacare?*, Wash. Post, Jul. 16, 2012 (quoting Michael Cannon: "the Achilles' heel" of the ACA), *available at* http://www.washingtonpost.com/blogs/wonkblog/wp/2012/07/16/could-a-missing-word-take-down-obamacare/; Dan Diamond, *Could Halbig et al v. Sebelius Sink Obamacare,* The Health Care Blog (June 11, 2013) (quoting Michael Greve: "This is for all the marbles."), *available at* http://thehealthcareblog.com/blog/2013/06/11/could-halbig-et-al-v-sebelius-sink-obamacare/.

[10] *See* Brief For *Amici Curiae* Senator John Cornyn, Senator Ted Cruz, Senator Orrin Hatch, Senator Mike Lee, Senator Rob Portman, Senator Marco Rubio, Congressman Dave Camp, And Congressman Darrell Issa In Support Of the Decision Below. The views of the opponents of the Act would have scant probative value even if they had been expressed during Congressional debate on the Act. *Shell Oil Co. v. Iowa Dep't of Revenue*, 488 U.S. 19, 29 (1988); *Am. Fed. Of Gov't Employees v. Gates*, 486 F.3d 1316, 1326 (D.C. Cir. 2007); *Schwegman Bros. v. Calvert Distillers Corp.,* 341 U.S. 384, 394-95 (1951). Still, the brief of the legislative amici is notable for what it does not say. Nowhere do these amici claim that at the time Congress adopted the ACA, they understood it to deny tax subsidies to low income families in States with Federally-facilitated exchanges.

the legislation, though represented in Congress, may not be (and here, are not) before the Court.[11] While the Executive Branch represents all Americans, it is not, by itself, a suitable representative for every subgroup or individual at risk in a particular lawsuit. Nor is this case a class action, where Appellants at least would have to demonstrate their suitability as class representatives. Appellants here represent only their own interests.

If Appellants' perspective is limited, however, the potential impact of their claims is not. The Complaint describes with anodyne formalism the relief Appellants seek: "a preliminary and permanent injunction prohibiting the application or enforcement of the IRS Rule."[12] But impassive language cannot obscure the practical import of Appellants' request. Appellants would take money away from more than 17.2 million people at the bottom of the economic ladder – individuals making as little as $11,490 a year.[13] Of the 6.8 million people who already have selected insurance on an Exchange, 85 percent qualify for the subsidy.[14] The Federal Government tendered this money to enable the families to buy health insurance. Millions already have taken the Government up on its offer.

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[12] Compl., Pt. 5, ¶ 2.

[13] Families USA, *Help Is at Hand: New Health Insurance Tax Credits for Americans* (Apr. 2013), at 6, *available at* http://familiesusa2.org/assets/pdfs/premium-tax-credits/National-Report.pdf.

[14] HHS May 2014 Enrollment Report, *supra* note 6, at 14-15

They are not combatants in the health care reform wars. Nor are they attempting to make some political point. They are simply trying to protect themselves and their loved ones from catastrophic medical expenses.

For these real people, the effect of losing this money, as Appellants demand, is anything but anodyne and formal. Under the Act, a single parent of two children in Florida, earning $41,000 in 2014 (more than 2.5 times the minimum wage), would pay only $2726 for a silver-level insurance policy, after a tax credit of $3013. Absent the tax credit, she would bear the entire $5739 cost of health insurance, or do without. Similarly, an unmarried 60-year-old Texan earning $25,000 in 2014 would receive a tax credit of $4521 and pay a balance of $1729 for a silver level policy. Absent the tax credit, she would pay full price, $6250, or do without.[15]

Doing without was the status quo that Congress sought to change for millions of people. While the ACA was pending before Congress, legislators heard heart-rending stories in hearings and town meetings. For example, Senator Johnson from South Dakota described a constituent who "was forced to sell his land when a heart attack left him with $60,000 in medical bills." The constituent, a farmer, "couldn't afford to buy private health insurance in the individual market

[15] *See* Kaiser Family Foundation, Subsidy Calculator, *available at* http://kff.org/interactive/subsidy-calculator/. The hardship exemption from the statute could excuse these taxpayers from the penalty for not obtaining insurance, but they still would not have insurance or qualify for Medicaid.

but didn't qualify for public programs." He suffered a second heart attack and incurred another $100,000 in medical bills. He and his wife exhausted their resources, and "live in fear of a serious illness."[16]

Senator Leahy likewise recounted the anguish of a Vermont constituent whose sister-in-law lost parts of both her feet because her lack of health insurance led her to defer medical assistance: "She waited, hoping things would get better. By the time her family was able to step in, she had to be rushed to the emergency room for amputations."[17]

The individuals whose stories moved Members of Congress exemplify the millions who would suffer if this Court granted Appellants' request to deny low-income families the tax relief that they need, that Congress intended to provide them, and that many already have relied on, in order to purchase insurance. The impact on these families would potentially be devastating. Those unable to buy insurance would be more than twice as likely than the insured to delay or forgo needed care.[18] Studies show that children without insurance are less likely to get

[16] 155 Cong. Rec. S12798 (Dec. 9, 2009).

[17] 156 Cong. Rec. S1841 (Mar. 23, 2010).

[18] *The Uninsured and the Difference Health Insurance Makes,* Kaiser Comm. on Medicaid & the Uninsured (Sept. 2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/1420-14.pdf.

immunized or treated for even a ruptured appendix.[19] Adults without coverage are less likely to get breast or prostate exams. High blood pressure or diabetes is more likely to be out of control. A stroke is more likely to leave permanent damage.[20] Consequently, depriving these individuals of insurance, as Appellants demand, would leave them sicker and more likely to die prematurely than people with insurance.[21]

Some specific examples convey the human face of these statistics. A woman in Tennessee who could not afford health insurance deferred surgery needed for endometriosis, a painful gynecological condition. When the Federally-facilitated Exchange came on line in her State, she qualified for a subsidy, enabling her to purchase a top-tier policy for $125 a month. She then promptly scheduled her pre-surgical appointment to deal with her painful condition. She commented that, "It feels like the light at the end of the long dark tunnel."[22] To take away subsidies now would extinguish that light.

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[19] Lena Sun and Amy Goldstein, *Beneath health law's botched rollout is basic benefit for millions of uninsured Americans*, WASH. POST. (Dec. 28, 2013), available at http://www.washingtonpost.com/national/health-science/beneath-health-laws-botched-rollout-is-basic-benefit-for-millions-of-uninsured-americans/2013/12/28/8ae8d93e-68e5-11e3-8b5b-a77187b716a3_story.html.

[20] *Id.*

[21] *See* Institute of Medicine, *Coverage Matters: Insurance and Health Care* (2001).

[22] Sun and Goldstein, *supra* n. 20.

In addition, many of the 4.6 million low-income people in States with Federally-facilitated Exchanges, like the woman in Tennessee, already signed up for insurance in reliance on the promised tax relief. If Appellants' theory prevailed, these individuals would suffer the hardship of paying or trying to pay for that purchase without this assistance. Many who bought insurance would drop it. Many who have not yet procured insurance would forego it. One thing, though, would not change – the reality that millions of these Americans cannot defer some medical treatments and will incur enormous medical expenses. Even the healthiest individuals can suffer a serious injury or illness that imposes staggering medical costs – more than $13,000 for an appendectomy, $150,000 for drugs to treat a common form of cancer.[23] If low-income families cannot afford to buy insurance because this case takes away the subsidies granted under the ACA, they will be in constant jeopardy of incurring unaffordable medical expenses and ultimately descending into bankruptcy.[24] Congress specifically focused on this risk and sought to abate it.[25]

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[23] Institute of Medicine, *supra*, n. 21 at 14.; Neal J. Meropol *et al*., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007).

[24] Jessica H. May & Peter J. Cunningham, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, Center for Studying Health System Change, Issue Brief 85 (2004), *available at* http://www.hschange.org/CONTENT/689/689.pdf.

[25] ACA, Pub L. No. 111-148, § 1501(a)(2)(E).

This cascade of hardships illustrates how altering the central mechanisms of legislation as complex, extensive, and vital as the ACA can generate far-reaching effects, both systemic and granular, and defeat the explicitly codified objectives of the legislation. That is one reason why the design and implementation of such mechanisms are best left to Congress and Executive agencies, rather than courts. The strong presumption mandated by *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*[26] in favor of the IRS's reading of the statute does just that – it lodges the decision where it belongs. *Chevron* reflects the sensible proposition that the agency charged with implementing a statute is best situated to evaluate assertions about the authority Congress delegated to it. The *Chevron* presumption also guards against the type of policy-based and political claims that properly reside in the elected branches of government and that are advanced here under the guise of textual fidelity, to the detriment of millions of people not before the Court. When the agency designated by Congress determines how to implement a statute, its conclusions thus merit immeasurably more weight than those advocated in litigation by newly minted champions of Congressional intent, who sprang from the ranks of vehement opponents of the ACA, who have declaimed that the statute, among other sins, promotes "baby death panels" and fosters a "parasitic"

[26] 467 U.S. 837 (1984).

bureaucracy, and who now espouse a theory hailed as a stake through the heart of Obamacare.[27]

The *Chevron* presumption ultimately provides an impregnable defense for the District Court's opinion, in large part because the Court did not need to rely on it. Indulging no presumption, the Court held that the language of the statute and the constraints of logic permitted only one conclusion: low-income families in all States are eligible for tax relief. That holding was correct.

II. THE TEXT OF THE ACA PRECLUDES APPELLANTS' INTERPRETATION

Appellants argue that Congress deliberately extended premium assistance tax subsidies only to low-income families who purchase health insurance on a State-run Exchange. This intent, they say, is clear from Congress's directive to calculate the amount of assistance based on premiums for health plans "which

[27] Jacqueline Halbig, *Baby Death Panels* (Apr. 10, 2013), *available at* http://www.jillstanek.com/2013/04/baby-death-panels; Appellant Willey has stated that he has been leading efforts "to get doctors excited about resisting Obamacare." Dan Diamond, *Could This Little-Watched Court Case Sink Obamacare?*, Calif. Healthline (June 12, 2013), *available at* http://www.californiahealthline.org/road-to-reform/2013/could-this-little-watched-court-case-sink-obamacare. And Appellant Klemencic was a plaintiff in the constitutional challenge to the ACA. Robert Pear, *Judge Allows Legal Challenge Of Law To Continue* (November 11, 2013), *available at* http://www.nytimes.com/news/affordable-care-act/2013/10/22/judge-allows-legal-challenge-of-law-to-continue.

were enrolled in through an Exchange established by the State under [section] 1311."[28]

The ACA is long and complicated. But the key text here is straightforward, and the proper interpretation of it is both ineluctable and dispositive. There are only two steps in this interpretation, involving only three provisions:

- ***First*,** Congress defined the term "Exchange," with a capital "*E*," <u>*three times*</u>, as an Exchange "established by the State."
  - — Section 1311(b)(1) directs "Each state [to] establish an American Health Benefit Exchange *(referred to in this title as an 'Exchange')*."
  - — Subsection (d)(1) of the same section reiterates that "[a]n Exchange shall be a governmental agency or nonprofit entity *that is established by a State*."
  - — And Section 1563, the definitions section, says it yet again: "The term 'Exchange' <u>*means*</u> an American Health Benefit Exchange established under section [1311]." The only "Exchange," with a capital "*E*" mentioned in 1311 is the one "established by the State." That is what the term "means" each of the 280 times it appears in the statute.[29]
- ***Second*,** Section 1321(c) directs that if the State does not establish an "Exchange," the Secretary shall "establish and operate such Exchange,"

[28] ACA, Pub L. No. 111-148, § 1401, codified in 26 U.S.C. § 36B(b)(2)(A).

[29] *See Burgess v. United States*, 533 U.S. 124, 130 (2008) ("As a rule, a definition which declares what a term means . . . excludes any meaning that is not stated.") (citing *Colautti v. Franklin*, 439 U.S. 379, 392-93 n.10 (1979))); A. Scalia and B. Garner, *Reading Law: The Interpretation of Legal Texts* (2012), at 154 (when "a definitional section says that a word 'means' something, the clear import is that this is the *only* meaning." (emphasis in original)).

> with a capital "*E*." There is only one conceivable way the Secretary, a federal official, can establish an "Exchange" that has been defined—*three times*—as an entity established by the State: She must act *on behalf of* the State.

To read the statute any other way is illogical and self-contradictory.[30] It would require the Secretary to do something that is, by definition, impossible. In contrast, there is nothing extraordinary about the Secretary acting for, or stepping into the shoes of, or standing in for, the State. This type of legal substitution happens frequently, with the Federal Government and others acting, for example, as proxies, trustees, lawyers, conservators, guardians, representatives, and agents. To take just one example, Rule 12(a)(1)(A) of the Federal Rules of Civil Procedure provides: "A *defendant* must serve an answer within 21 days after being served with a summons or complaint." If Appellants examined only these few words, uninformed by context – as they do here – they would contend that a lawyer cannot file the answer. The text, after all, specifies that the "defendant," not someone acting on the "defendant's" behalf, must file the answer. Under Appellants' acontextual, hyper-myopic approach, no substitution would be permitted. This mode of interpretation thus would lead the Court astray. The drafters of the

[30] *See,* e.g., *Roschen v. Ward*, 279 U.S. 337, 339 (1929) (Holmes, J.) ("there is no canon against using common sense in construing laws as saying what they obviously mean").

Federal Rules did not intend to require the defendant personally to perform this ministerial task.[31]

The two straightforward steps explained above – applying the thrice repeated definition of "Exchange" and the proxy provision of section 1321(c) – dissipate the rhetorical fog Appellants have summoned. Indeed, it appears that the panel opinion accepted this deputation premise, *Halbig*, 758 F.3d at 400-02, but, then, unaccountably, refused to extend it to Section 39B. Courts presume, however, that the same term in the same statute has the same import throughout.[32] To depart from that presumption creates numerous anomalies.

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[31] Examples abound where, by operation of law, one person is deemed to act on behalf of another without the statutory flashing lights Appellants claim is required. To determine income, for example, the IRS frequently treats one party as acting on behalf of another *See, e.g.,* Ward L. Thomas and Leonard J. Henzke, Jr, *Agency: A Critical Factor in Exempt Organizations and Ubit Issues,* 2002 EO CPE Text, available at http://www.irs.gov/pub/irs-tege/eotopicc02.pdf ("The question whether an entity or individual is deemed to be an agent of another for tax purposes, is at the heart of many tax controversies. . . Several important exempt organization issues center on agency, such as whether a fundraiser is an agent of the organization so that payments to the fundraiser are deductible; whether a publisher is an agent of an exempt organization so that its advertising activities constitute unrelated 'business' of the exempt organization; and whether a licensee of an exempt organization's intellectual property is an agent for purposes of determining whether payments are royalties."). Under HIPAA, a business associate can be deemed to step into the shoes of a physician and become subject to the confidentiality limitations of the statute, even absent any formal designation. *See* 45 C.F.R. § 160.103. And the FCC applied the federal common law of agency to determine whether a company was vicariously liable for the actions of a telemarketer selling its product in violation of the Telephone Consumer Protection Act. *See Dish Network, L.L.C. v. FCC*, 552 Fed. App'x 1, at *1 (D.C. Cir. 2014).

[32] *See, e.g.*, *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 258 (2008) (explaining that interpretation "accord[s] with our usual preference for construing the 'same terms to have the same meaning in different sections of the same statute") (citing *Barnhill v. Johnson*, 503 U.S. 393, 406 (1992)).

Anomalies also arise when advocates seize on snippets of statutory text, divorced from context and from the objectives of the law voted on and adopted in statutory findings. As Justice Scalia has stated:

> [T]he 'traditional tools of statutory construction' include not merely text and legislative history but also, quite specifically, the consideration of policy consequences. Indeed, that tool is so traditional that it has been enshrined in Latin: *'Ratio est legis anima; mutata legis ratione mutatur et lex.'* ('The reason for the law is its soul; when the reason for the law changes, the law changes as well.') Surely one of the most frequent justifications courts give for choosing a particular construction is that the alternative interpretation would produce 'absurd' results, or results less compatible with the reason or purpose of the statute.[33]

The collateral damage Appellants would cause to the very people the Act sought to help strongly signals that Appellants' interpretation is incompatible with the "reason or purpose" of the statute.

Appellants argue that Congress was willing to harm those the Act sought to help when it threatened to cut off Medicaid funding in States that did not accept the ACA's expansion of Medicaid. Appellants offer this purported parallel to make it seem more plausible that Congress would, in another part of the ACA, impose hardships on low-income families to coerce States to set up Exchanges. The example, however, proves just the opposite. The provision allowing a cutoff of

[33] Antonin Scalia, *Judicial Deference to Administrative Interpretations of Law*, 1989 Duke L.J. 511, 515 (1989).

Federal Medicaid funds in fact was not enacted as part of the ACA. It was in the original Medicaid Act adopted in 1965.[34] The 45 years between adoption of the cutoff provision applicable to Medicaid and enactment of the provisions of the ACA governing Exchanges spoils the parallel Appellants seek to draw.

That fatal flaw aside, Appellants' theory dictates that denial of tax subsidies follows automatically from the State's choice not to establish an Exchange. The Medicaid provision, by contrast, merely *allows* the Secretary to cut off Medicaid funding if a State violates the conditions for receiving Federal funds, and provides discretion to limit the cutoff to certain categories of funding.[35] Moreover, the Secretary's decision is laden with procedural protections, such as notice and an opportunity to be heard, and the statute would permit her to take into account the impact of a cutoff on Medicaid beneficiaries.[36] Perhaps that is why, in the 60 years since the enactment of Medicaid, the Secretary has *never* terminated a State's Medicaid program.[37]

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[34] *See* 42 U.S.C. § 1396c.

[35] The provision states: "The Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. § 1204.

[36] 42 U.S.C. § 1396c.

[37] Kaiser Family Health Foundation, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion* (August 2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf.

Nor does the Medicaid statute bury this sanction in a formula for calculating benefits, as Appellants' reading of the ACA would do. The Medicaid sanction is the subject of its own separate provision explicitly addressing enforcement of the requirements imposed under Medicaid.[38] Thus, when Congress wished to use the stick rather than (or in addition to) the carrot, it knew how to say so, and tempered the process with discretion to ensure that it would further, not hinder, the statutory objectives. In stark contrast, Appellants allege here a stealth sanction, reflexively applied, that is not even remotely analogous to the enforcement mechanism for Medicaid. In short, the Medicaid provision in no sense validates the violence Appellants' interpretation would do to the ACA and its fundamental objectives.

Second, Appellants cannot claim to honor the plain language of particular provisions of the ACA while disregarding other statutory language that specifies the function of those provisions.[39] Here, Appellants' interpretation ignores the stated purpose not only of the Act – which, after all, is named the "Affordable Care Act" – but also of the Title, subtitle, section, and subsection at issue in this case. Title I of the ACA, in which the disputed provisions appear, bears the heading,

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[38] *Id.*

[39] *See, e.g.*, *Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997) ("The plainness or ambiguity of statutory language is determined by reference to the language itself, *the specific context in which that language is used, and the broader context of the statute as a whole*.") (emphasis added); *Ransom v. FIA Card Servs., N.A.*, 131 S.Ct. 716, 723-24 (2011) (interpreting statute based on plain language, statutory context, and broader purpose of statute as a whole).

"Quality Affordable Care For *All* Americans," not "Quality Affordable Care for *Some* Americans," or "Quality Affordable Care for Americans *in States that Have Set Up Their Own Exchanges*." The applicable subtitle bears a similarly inclusive caption, "Affordable Coverage Choices for *All* Americans." And the section that grants the tax credit Appellants attack is entitled "Refundable tax credit providing *premium assistance* for coverage under a qualified health plan." The word "assistance" communicates that the goal is to *help* people pay for insurance.

Third, Appellants cannot plausibly read the same section to both giveth and taketh away benefits at the same time. Subsection 36B(a) directs that for applicable taxpayers – defined as those earning less than 400 percent of the federal poverty level[40] – "there *shall* be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year."[41] Subsection (b), bearing the caption "PREMIUM ASSISTANCE CREDIT AMOUNT," then lays out how to calculate the credit required by preceding subsection. It is here, in subsection (b)(2)(A), that the language trumpeted by Appellants appears, in describing the formula for that calculation based on the monthly premiums for qualified health plans "which were enrolled in through an Exchange established by the State under 1311 of the Patient

[40] 26 U.S.C. § 36B(C)(1)(A).
[41] 26 U.S.C. § 36B(a) (emphasis added).

Protection and Affordable Care Act."[42] Appellants focus on the quoted words in isolation, cabined from the definitions in the Act, from the provision designating the Secretary as the proxy for the State, and even from the immediately preceding subsection mandating a tax credit. Thus, on Appellants' blinkered interpretation, subsection (a) of the refundable tax credit provision awards applicable taxpayers a credit to buy insurance, but then subsection (b) calculates the amount of that credit as *zero* for taxpayers who live in States with Federally-facilitated Exchanges. Had Congress intended to deny such taxpayers a credit, it would not likely have chosen the perverse route of first instructing the IRS to bestow it and then setting the amount of at zero – the legal equivalent of stone soup.

Fourth, Appellants cannot use "Exchange," a term defined the same way three times, to mean one thing in some provisions and something else in others. Section 1563 of the Act in particular bars such inconsistency, as it explicitly stipulates that "Exchange" "*means*" an Exchange established by the State, conveying "the clear import that this is its *only* meaning."[43] The instruction is fortified by the longstanding canon of construction presuming that Congress uses

[42] 26 U.S.C. § 36B(b)(2). The language is repeated in the explanation of how to determine each "coverage month" for applicable taxpayers. *Id.* § 36B(c)(2)(A).

[43] *Burgess*, 553 U.S. at 130; A. Scalia and B. Garner, *Reading the Law: The Interpretation of Legal Texts,* at 176, citing *Helvering v. Morgan's Inc.*, 293 U.S. 121, 125 n.1 (1934) ("where 'means' is employed, the term and its definition are to be interchangeable equivalents").

words and phrases consistently throughout a particular statute.[44] Therefore, if Appellants were right that Section 1321 does not authorize the Secretary to act on behalf of the State in establishing an Exchange, then the definitions in Sections 1311 and 1563 would confine every use of the word "Exchange," with a capital "E," only to an entity established by the State itself, not by anyone acting for the State, or on its behalf, or as its proxy. A Federally-facilitated Exchange, on Appellants' approach, does not and never can qualify as an "Exchange," as defined in the statute. That, too, produces a torrent of anomalies. For example, in the States with Federally-facilitated Exchanges, there would be no "qualified health plans," because to fall within that definition, the plan must be certified through an "Exchange."[45] With no "qualified health plans," the insurance provisions of the statute would unravel in those States. The Act would become a health insurance law without health insurance.

Moreover, the only people who can purchase insurance on an "Exchange" are "qualified individuals." Section 1312(f) of the Act defines a qualified individual as one who "resides in the State *that established the Exchange*." There

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[44] *See, e.g.*, *Powerex Corp. v. Reliant Energy Services, Inc.*, 551 U.S. 224, 232 (2007) (explaining it is a "standard principle of statutory construction" that "identical words and phrases within the same statute should normally be given the same meaning"); *Brown v. Gardner*, 513 U.S. 115, 118 (1994) ("there is a presumption that a given term is used to mean the same thing throughout a statute").

[45] *See* ACA, §1301(a)(1) (42 U.S.C. §18021).

could be no "qualified individuals" in States with Federally-facilitated Exchanges because those States did not themselves establish the Exchange. Appellants brush off this lethal defect by implying that Congress simply assumed States would establish the Exchanges. But Appellants' sleight of hand violates the very canon of construction they tout – requiring that a statute be interpreted to give meaning to every word it contains. Appellants ignore the language referring to the State's establishing the Exchange when it suits them, but exalt that language as the seminal text in the Act when that result is more congenial.

The panel opinion is no less fallacious. The panel suggests that its cramped interpretation of Sections 1311 and 1321 does not leave Exchanges without customers because the statute nowhere states that only "qualified individuals" can purchase insurance on an Exchange. *Halbig*, 758 F.3d at 405. If that were so, Congress would have had no reason to define "qualified individual." According to the Merriam-Webster Dictionary, "qualified" means "having complied with the specific requirements or precedent conditions (as for an office or employment): Eligible."[46] The use of the term in the ACA begs the question, "Qualified for what?" The only possible answer is participation in the Exchange. And those who are not qualified are not eligible to participate. If there were any doubt, other provisions of the ACA would conclusively resolve it. For example,

[46] *Available at* http://www.merriam-webster.com/dictionary/qualified.

under Section 1311(e)(1)(B) of the ACA, an Exchange may certify a qualified health plan only if it finds that making the plan available through the Exchange "is in the interests of qualified individuals and qualified employers in the State." An Exchange with only "unqualified individuals" could not certify any plans for sale.

Applied with the constraint of consistency, then, Appellants' interpretation, and the panel's replication of it, robs entire statutory provisions of both meaning and function. Under their approach, in States with Federally-facilitated Exchanges, there would be no "qualified health plans" to sell, and no "qualified individuals" to buy them. Further, the instruction in Section 1321(c) that the Secretary set up an Exchange if the State does not, would be a nullity because any entity the Secretary set up could perform virtually none of the functions it was intended to handle.

Appellants suggest that interpreting "Exchange" to mean the same thing as "Exchange established by the State," renders the words "established by the State" superfluous in Section 36B, in violation of the surplusage canon. The claim is ironic, given that Appellants' approach nullifies many central provisions of the statute. It is also pedantic. When a statute defines a single word like "Exchange," drafters can on occasion revert to the longer description from the definition instead of using the short form, defined term. The two are interchangeable, and the choice between them is stylistic, not substantive, as when a statute uses both the term

"President" and "President of the United States,"[47] or "House" and "House of Representatives."[48] In any event, the ACA defines "Exchange" three times. Once would have sufficed. Avoiding redundancy did not appear to be a high legislative priority in these particular provisions.[49]

Appellants' approach makes even less sense given that other ACA provisions discuss the availability of subsidies on "Exchanges," without the follow-on phrase "established by the State" that Appellants aggrandize. For example, Section 1413(a) requires the Secretary to establish a system allowing residents of "each State" to apply and, receive a determination of eligibility, for an "applicable State health subsidy program[]." Under Section 1413(e)(1), the term "applicable State health subsidy program" includes the program for enrollment in "qualified health plans offered through *an Exchange,* including *the premium tax credits under Section 36B*."

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[47] *See, e.g.*, 18 U.S.C. § 871.

[48] *See, e.g.*, ACA, § 3403(d)(1)(A).

[49] Appellants misread Section 36B(f)(3) as distinguishing between two types of Exchanges -- those established by the State under Section 1311 and those established by the Secretary under Section 1321. In adverting in that subsection to "*any person carrying out 1 or more responsibilities* of an Exchange under section 1311(f)(3) or 1321(c)," Congress was not differentiating between types of Exchanges. It was addressing the ways in which a third-party contractor might be authorized to carry out the responsibilities of running an Exchange. Section 1311(f)(3) authorizes States to contract with third parties to operate the Exchange. Section 1321(c) authorizes the Secretary, when she steps into the shoes of the State, to contract with a not-for-profit entity. Section 36B(f)(3) simply cross-references the two identified sources of contractual authority for such a private party to operate the Exchanges. Appellants' reading is implausible, and even the panel opinion ignores it.

Finally, a subset of the Appellants, the employer-plaintiffs, predicate standing on the argument that the tax penalty enforcing the employer mandate does not apply unless employees receive subsidies. Because, on this view, there are no subsidies in States with Federally-facilitated Exchanges, there is also no employer mandate. If so, then Appellants' theory further dismantles the ACA in States that do not run their own Exchanges. Not only would Exchanges have no qualified policies to sell and no qualified individuals to buy them, but employers in the State need not offer coverage – all in a statute designed to advance the goal of universal affordable insurance coverage. That is not credible. There is not the slightest indication in the statute that Congress intended to impose disparate obligations on employers in different States. Such disparities would enable States with Federally-facilitated Exchanges to tout a tax advantage in luring businesses away from States running their own Exchanges. The ACA was intended to eliminate such interstate disparities, not create them.

In sum, Section 1321 provides that if the State does not establish an "Exchange" under Section 1311, the Federal Government must establish "such Exchange." The only way the Federal government can comply with the instruction in Section 1321 to establish an "Exchange" that the Act defines exclusively as one established by the State, is to step into the shoes of the State. That interpretation allows the Act to function. By contrast, Appellants' reading posits that Congress

created Exchanges with neither a product to sell nor customers to buy it. As there is only one sensible reading of the statute that is faithful to the text, Congress's intent necessarily is clear, and the District Court correctly found that IRS has implemented it.

It was at the very least reasonable for the IRS to interpret the instruction in Section 1321(c) to the Secretary to "establish and operate such Exchange within the State" as directing the Secretary to act *for* the State. With a choice between, on the one hand, an interpretation that makes Section 36B consistent with all the other provisions in the Act and furthers the statutory purpose, and, on the other hand, an interpretation that presupposes a statutory death wish, the IRS could properly choose viability over dissolution. Even without the benefit of *Chevron* deference, the IRS's determination would prevail through the force of its logic. With *Chevron* deference, the conclusion is unassailable.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment below.

Dated: November 3, 2014

Respectfully submitted,

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Dated: November 3, 2014

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I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the D.C. Circuit by using the appellate CM/ECF system on November 3, 2014.

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