[ORAL ARGUMENT SCHEDULED FOR MARCH 25, 2014]

No. 14-5018

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

JACQUELINE HALBIG, ET AL.,
Plaintiffs-Appellants,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Defendants-Appellees.

On Appeal from the United States District Court
for the District of Columbia

NOTICE OF INTENT TO FILE *AMICUS CURIAE* BRIEF OF FAMILIES USA IN SUPPORT OF DEFENDANTS-APPELLEES

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Pursuant to D.C. Circuit Rule 29(b), Families USA hereby notifies this Court of its intent to file an *amicus curiae* brief in support of Defendants-Appellees in the above-captioned appeal. All parties have consented to the filing of this amicus brief.

DATED: February 17, 2014

/s/ Murad Hussain
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CERTIFICATE OF SERVICE

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 February 17, 2014.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: February 17, 2014

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

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BRIEF OF *AMICUS CURIAE* FAMILIES USA

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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.

[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: February 17, 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 nearly 50 million Americans who have no health insurance. For example, a study by Families USA has shown that many uninsured forgo needed medical care because of cost, resulting in 26,100 premature deaths in 2010 alone.[2] The financial harms that Families USA has addressed arise because the uninsured, like everyone else, 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 raising the cost of health insurance for everyone.[3]

Because the widespread lack of health insurance has inflicted these harms on individual families and the U.S. economy, Families USA has backed reforms to achieve universal health insurance coverage. The organization actively supported

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

[3] In 2010, that increase was $1000 for an average family. Families USA, *Hidden Health Tax: Americans Pay a Premium* (May 2009), available at http://www.familiesusa.org/resources/publications/reports/hidden-health-tax.html; Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, § 1501(a)(2)(F) (2010).

the Affordable Care Act ("ACA"), sponsoring studies that helped shape the statutory design and advocating for the legislation.[4] The law that emerged from these efforts is a significant advance toward the goal of universal, affordable health insurance coverage. A key way it made this progress was by granting low-income families tax relief so they can pay for insurance.

Given the role Families USA played in the enactment of the ACA, the organization has a strong interest in its vitality, and, therefore, in the premium assistance that is 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 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 these concerns are reflected in the statute. In addition, with the comprehensive expertise Families USA has gained regarding the structure of the statute—comprising more than 950 interrelated sections—the organization can disentangle some of the complicated arguments presented here and identify features of the statute that others have overlooked. Families USA thus respectfully submits that its perspective and analysis will assist the Court.

[4] *See, e.g.*, Footnotes 2 and 3 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. To state the point directly, Appellants ask the Court to take money away from millions of poor people, money Congress granted so they could afford health insurance. As of February 1, 2014, more than 2.6 million people who have signed up on an Exchange qualify for this financial assistance.[5] Of these, more than 1.6 million live in States with Federally-facilitated Exchanges. The premise behind the effort to deny assistance to these 1.6 million who have already enrolled, plus those who enroll in the future, is that Congress intentionally hurt the people the Act was designed to help and knowingly frustrated the purpose embodied in the very name of the statute.

To support their counterintuitive premise, Appellants isolate six words from one of the 950 sections in the ACA, quarantining those words 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 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

[5] Department of Health & Human Services, *Health Insurance Marketplace: February Enrollment Report for the Period October 1, 2013 - February 1, 2014* (2014), at 4, 13, available at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf ("HHS February 2014 Enrollment Report").

Appellants appears. Sub-sub-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 amount of 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 grants add up to zero. Moreover, Appellants assert, this gambit was purposeful: Congress sought to coerce States by threatening a loss of tax subsidies for their low-income families if the States did not establish 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 either articulate any other definition or suspend the one it sets forth in triplicate. "Exchange established by the State" is the one and only meaning assigned to the word in the statute.

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 in place of them, *for* them. Such legal proxies are common, and to recognize that type of relationship here makes sense of the subsidy provision, harmonizes it with scores of other sections, and furthers the stated purpose of the law—to make affordable insurance broadly available.

By contrast, Appellants' reading renders much of the law inoperative. 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. The destructive effects of Appellants' approach thus ripple like shockwaves through the statute. For example, to be a "qualified health plan" under the Act, the plan must be certified 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." Appellants cannot assume away this plain language, which on their theory would leave no "qualified individuals" in States with Federally-facilitated Exchanges. Consequently, if Appellants were correct, Federally-facilitated Exchanges would have nothing to sell and no one to buy it.

The ACA does not require the Court to deduce or intuit some unarticulated statutory purpose. Congress stated the purpose directly, in statutory headings, substantive text, and legislative findings. It is to make affordable health insurance available to all Americans. Appellants propose an interpretation of the ACA that is, at once, inimical to this express purpose, divorced from the 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, IN DEROGATION OF THE FUNDAMENTAL PURPOSES OF THE ACA

From the moment the ACA became law on March 23, 2010, political opponents repeatedly tried and failed to overturn it. Those attempts, which persist, have included some 46 repeal votes and a 16-day shutdown of much of the Federal government.

Inevitably, the political efforts to snuff out the ACA spilled into the courts. That battle on that front failed, too, when in 2012, the Supreme Court upheld the Act as constitutional in *National Federation of Independent Business v. Sebelius* ("*NFIB*").[6] However, the war did not end. It merely shifted to subverting rather than overturning the law. This case is the forward edge of that assault. Brought by the same counsel, with one of the same plaintiffs as in *NFIB*, it rests on a reading

[6] 132 S.Ct. 2566 (2012).

of the statute so artificial that no one thought of it until nine months after the bill became law, and so extreme that its progenitors have hailed it as a "threat [to the Act's] survival."[7] According to Appellants, a statute designed to extend health insurance to millions of uninsured, low-income families, denies them the tax relief they need in order to pay for it, based solely on geography, and on top of that, fines many of them if they do not obtain insurance.

The implausibility of this premise, and the unreasonable textual exegesis on which it rests, 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.[8] Federal courts have long sought to shut

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[7] 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/. Michael Cannon, one of the original expositors of Appellants' theory, has written many articles on how to undermine the ACA. *See, e.g.*, Michael Cannon, *50 Vetoes: How States Can Stop the Obama Health Law*, Cato Institute, *available at* http://object.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper_1.pdf.

[8] *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 Appellants. 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

out such partisan strife.[9] One reason is that the people affected by the legislation, though represented in Congress, may not be (and here, are not) before the Court. 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.[10] 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. For example, the Complaint describes with anodyne formalism the relief Appellants seek: "a preliminary and permanent injunction prohibiting the application or enforcement of the IRS Rule."[11] The impassive language, however, cannot obscure the practical import of this request. Appellants would take money away from more than 17.2 million people at the bottom of the economic ladder—

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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.

[9] *United States. v. Rutherford*, 442 U.S. 544, 555 (1979); *City of Arlington v. FCC*, 133 S.Ct. 1863 (2013); *see also Pennsylvania v. Wheeling & Belmont Bridge Co.*, 59 U.S. 421 (1855).

[10] States, too, are not suitable representatives for these affected individuals and families, as evidenced by the *amicus* brief of several States seeking to deny their own low-income citizens the tax relief that would enable them to afford health insurance. The position taken by these States would deny tax relief to 96,331 low income people who have already enrolled on the Federally-facilitated exchange in Michigan, 17,014 low-income enrollees in Kansas, and 17,550 low-income enrollees in Nebraska. *See* HHS February 2014 Enrollment Report at 22-23, available at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf.

[11] Compl., Pt. 5, ¶ 2.

individuals making as little as $11,490 a year.[12] Of the 3.3 million people who already have selected insurance on an Exchange, 82 percent qualify for the subsidy.[13] The Federal Government has provided that money to enable these families to buy health insurance, and millions already have taken the Government up on its offer. These individuals and their families are not combatants in the health care reform wars. They are not attempting to make some political or ideological 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 two-and-a-half 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

[12] 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.

[13] HHS February 2014 Enrollment Report, *supra* note 5, at 22-23. The percentage ranges as high at 92% in Mississippi, 90% in North Carolina, 91% in Wyoming, and 90% in Arkansas, all States with Federally-facilitated Exchanges. *Id.* at 22-23.

for a silver level policy. Absent the tax credit, she would pay the full price of $6250, or do without.[14]

Doing without was the status quo that Congress sought to change for millions of people. While the ACA was pending before Congress, legislators in hearings and in town meetings heard heart-rending stories. 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 but didn't qualify for public programs." He suffered a second heart attack and accrued another $100,000 in medical bills. He and his wife exhausted their resources, and "live in fear of a serious illness."[15]

Senator Leahy likewise recounted the anguish of a Vermont constituent whose sister-in-law lost parts of both her feet because she lacked health insurance and therefore deferred getting medical attention: "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."[16]

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[14] *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.

[15] 155 Cong. Rec. S12798 (Dec. 9, 2009).

[16] 156 Cong. Rec. S1841 (Mar. 23, 2010).

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 them to receive, 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.[17] Consequently, as a group, they would be sicker and more likely to die prematurely than people with insurance.[18] A recent example conveys 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 enrolled and qualified for a subsidy that enabled 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."[19] To take away the subsidy now would remove that light for her and many, many others like her.

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[17] *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.

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

[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-

In addition to physical harms, Appellants' requested relief would inflict financial injury on low-income people who are not before the Court. Many of the 1.6 million low-income people who, like the woman in Tennessee, already signed up for insurance in States with Federally-facilitated Exchanges in reliance on the promised tax relief, would suffer the hardship of paying or trying to pay for that purchase without this assistance. Many who bought insurance would drop it. Those who have not yet procured insurance would not do so. One thing, though, would not change—the reality that many of these Americans cannot defer some medical treatments and 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.[20] 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.[21] Congress specifically focused on that risk and sought to abate it.[22]

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health-laws-botched-rollout-is-basic-benefit-for-millions-of-uninsured-americans/2013/12/28/8ae8d93e-68e5-11e3-8b5b-a77187b716a3_story.html.

[20] *Id.* at 14.; Neal J. Meropol *et al*., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007).

[21] Jessica H. May & Peter J. Cunningham, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, Center for Studying Health System Change,

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, from the systemic to the most 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 to courts. The strong presumption mandated by *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*[23] 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, and can best assess claims about Congressional intent, such as the claim here that Congress intended to harm the people the Act was designed to help. 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

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Issue Brief 85 (2004), *available at* http://www.hschange.org/CONTENT/689/689.pdf.

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

[23] 467 U.S. 837 (1984).

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 things, promotes "baby death panels" and fosters a "parasitic" bureaucracy, and who now espouse a theory touted as a stake through the heart of Obamacare.[24]

The *Chevron* presumption ultimately provides an impregnable line of defense around the District Court's opinion, in large part because the Court did not need to rely on it. Without indulging any 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 intended to extend premium assistance tax subsidies only to low-income individuals and families who purchase health

[24] 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.

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 were enrolled in through an Exchange established by the State under [section] 1311."[25]

The ACA is a long, complicated statute. 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*," *three times*, 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' *means* 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.[26]
- ***Second,*** Section 1321(c) directs that if the State does not establish an "Exchange," the Secretary shall "establish and operate such Exchange," with a capital "*E*." There is only one conceivable way the Secretary, a federal official, can establish an "Exchange" that has been defined—

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

[26] *See* 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)).

> *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.[27] 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, or representing, the State. This type of legal substitution happens all the time, with the Federal Government and others acting, for example, as proxies, trustees, lawyers, conservators, guardians, representatives, and agents. Appellants claim to have found no instance in the U.S. Code where such a relationship arises absent explicit statutory authorization. Apparently, they did not look hard enough. To take just one example, Rule 12(a)(1)(A) of the Federal Rules of Civil Procedure provides that "A *defendant* must serve an answer within 21 days after being served with a summons or complaint." If Appellants remained consistent and thus examined only these few words, uninformed by context, they would contend that a lawyer cannot file the answer. The text, they would argue, 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. Plainly, this mode of interpretation would lead the Court astray. No one would argue that the drafters of

[27] *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").

the Federal Rules intended to require the defendant personally to perform this ministerial task.[28]

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 and could end the textual analysis. But Appellants' interpretation also clashes with many other aspects of the law. Although space does not allow enumeration of all these anomalies, a few examples will illuminate the absurd results that flow from Appellants' theory.

First, although a court should not bend unequivocal statutory language to serve some assumed but unstated legislative purpose, that limitation does not empower Appellants to ignore the fundamental objectives of the law. As Justice

[28] There are other examples where, by operation of law, one person is deemed to act on behalf of another without the type of statutory billboard Appellants claim is required. To determine income, for example, the IRS frequently deems one party to be 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, whether or not there has been any formal designation. *See* 45 C.F.R. § 160.103. And the FCC recently 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*, 2014 WL 323660, at *1 (D.C. Cir. 2014).

Scalia has stated in supporting deference to administrative interpretation of statutes under *Chevron*:

> [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.[29]

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 the opposite of what Appellants intend. The provision allowing a cutoff of Federal Medicaid funds in fact was not enacted as part of the

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

ACA. It was in the original Medicaid Act adopted in 1965.[30] 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 follow 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.[31] Moreover, the Secretary's decision is laden with procedural protections, such as notice and an opportunity to be heard, and she could in fact take into account the impact of a cutoff on Medicaid beneficiaries.[32]

Nor does the Medicaid statute bury this sanction in the 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

[30] *See* 42 U.S.C. § 1204.

[31] 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.

[32] 42 U.S.C. § 1396c.

enforcement of the requirements imposed under Medicaid.[33] 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.[34] 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, "Quality Affordable Care For *All* Americans," not "Quality Affordable Care for *Some* Americans," or "Quality Affordable Care for Americans *in States that Have*

[33] *Id.*

[34] *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).

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[35]—"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."[36] 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 sub-sub-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 Protection and Affordable Care Act."[37] Appellants focus on the

[35] 26 U.S.C. § 36B(C)(1)(A).
[36] 26 U.S.C. § 36B(a) (emphasis added).
[37] 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).

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.[38]

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."[39] The instruction is fortified by the longstanding canon of construction presuming that Congress uses

[38] The District Court recognized that such a backhanded approach was improbable. *See* 2014 WL 129023, at *17 n.12 (D.D.C. 2014) ("[Congress] does not, one might say, hide elephants in mouseholes," quoting *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001)).

[39] 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.[40] 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 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."[41] 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

[40] *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").

[41] *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. Applied with the constraint of consistency, Appellants' interpretation 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. The claim 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,"[42] or "House" and "House of Representatives."[43] In any event, the ACA defines "Exchange" three times. Once would have sufficed. Avoiding redundancy did not appear to be a high legislative priority with respect to these particular provisions.

Notwithstanding the clear and singular, albeit repetitive, definition of "Exchange" in the statute, Appellants counter that in Section 36B(f)(3) of the Internal Revenue Code, Congress explicitly contemplated two types of Exchanges, distinguishing between Exchanges established by the State under Section 1311 and those established by the Secretary under Section 1321. Appellants misread Section 36B(f)(3). 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, in

[42] *See, e.g.*, 18 U.S.C. § 871.
[43] *See, e.g.*, ACA, § 3403(d)(1)(A).

fulfilling her responsibilities 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.

Finally, Appellants argue (indeed, the employer-plaintiffs predicate standing on the argument) that the tax penalty enforcing the employer mandate turns on whether any employees receive subsidies. Because, on Appellants' 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 plausible, particularly as there is not the slightest indication in the statute that Congress intended to impose disparate obligations on employers in different States, thereby enabling States with Federally-facilitated Exchanges a tax advantage 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.

Even if the Court were to conclude that the District Court's and the IRS's reading of Section 36B is strained, or counterintuitive, or one any of the litany of other pejorative adjectives Appellants muster, it is infinitely less so than Appellants' reading, which wreaks havoc on core provisions of the Act. 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: February 17, 2014

Respectfully submitted,

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Dated: February 17, 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 February 17, 2014.

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