No. 14-114

IN THE
# Supreme Court of the United States

DAVID KING, ET AL.,
*Petitioners,*
v.
SYLVIA MATTHEWS BURWELL,
SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
*Respondents.*

**On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit**

## BRIEF *AMICI CURIAE* OF MARILYN RALAT-ALBERNAS, R.N., MARCUS SANDLING, M.D., MICHELE EVANS, SERVICE EMPLOYEES INTERNATIONAL UNION, *ET AL.*, SUPPORTING RESPONDENTS

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TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued



STATUTES AND REGULATIONS

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

## INTERESTS OF *AMICI CURIAE*

**Marilyn Ralat-Albernas, R.N.,** of Miami, Florida, is a member of the Service Employees International Union (SEIU) and a nurse in the postpartum division of a hospital maternity unit.[1] Ms. Ralat-Albernas has seen improved health outcomes for mothers and infants since enactment of the Patient Protection and Affordable Care Act (ACA). With improved access to affordable healthcare, more soon-to-be mothers are able to obtain prenatal care and education.

**Marcus Sandling, M.D.,** is a third-year medical resident in Jersey City, New Jersey, and a member of SEIU. Dr. Sandling has noticed positive benefits of the ACA for the low-income patients he treats at an internal medicine clinic. More affordable healthcare and better access to health insurance have made it easier for Dr. Sandling to maintain relationships with his patients and refer them to necessary specialists.

**Michele Evans** is a small business owner in Bozeman, Montana, who has worked with SEIU and a coalition of organizations to advocate for better healthcare for all. In 2009, Ms. Evans was diagnosed with Lyme disease. Because she could not afford health insurance at the time, she had to pay out of pocket for her treatment. At one point, Ms. Evans's husband was forced to leave his job so that he could stay home to care for her. Ms. Evans was able to purchase insurance in December 2014 because of the availability of a premium tax credit. She can now

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[1] Letters of consent from all parties are on file with the Clerk. No counsel for a party authored this brief in whole or in part, and no person or entity other than *amici curiae* made a monetary contribution to the preparation or submission of this brief.

receive regular checkups and routine health screenings.

*Healthcare workers in addition to Ms. Ralat-Albernas and Dr. Sandling*

**Robert Blair, R.N.,** lives in Port St. Lucie, Florida, and is a member of SEIU. He has been a nurse for more than 15 years. Mr. Blair enjoys helping others and believes access to healthcare is a basic human right. In his view, the ACA's expansion of insurance coverage and its tax-credit provisions have helped extend that right to all Floridians.

**Michelle Boyle, R.N.,** is a member of SEIU and a nurse in the Level I Trauma Center at a Pittsburgh, Pennsylvania, hospital. Ms. Boyle's mother-in-law died in 1999 as the result of a chronic illness for which she struggled to receive proper treatment because of her lack of insurance. Ms. Boyle has noticed that since enactment of the ACA, patients are more likely to go to the doctor when ill rather than wait until emergency-room care is necessary.

**Mary Brooks** is a member of SEIU from Portland, Oregon. She has worked as a clinical scheduler for a hospital's mental-health department for 30 years. Ms. Brooks witnessed the devastating consequences of inadequate insurance coverage when a family member nearly went bankrupt after falling down stairs. Ms. Brooks believes that the ACA has not only expanded access to affordable health insurance for all Americans but also forced private insurance companies to cover better quality care.

**Chrysandra Roland** of Atlanta, Georgia, is a secretary in a hospital neonatal intensive care unit. Ms. Roland believes the ACA is one of the most significant and positive improvements to the

healthcare system to occur during her 41 years working in the industry.

*Healthcare consumers in addition to Ms. Evans*

**Rita Adamski** is a member of SEIU and a home-care worker in Salem, Oregon. Prior to enactment of the ACA, Ms. Adamski could not afford health insurance and was uninsured in 2013. Ms. Adamski suffers from depression and had to turn to her church for help paying for the therapy she needed. In 2014, because of a premium tax credit, Ms. Adamski was able to purchase health insurance. She now sees a therapist regularly and, as a result, is able to lead a more productive and meaningful life.

**Jay Joshi** lives in Richardson, Texas, and is part of the Texas Organizing Project, a community organization that works in partnership with SEIU. After Ms. Joshi lost her job as a travel agent, she began working part-time as a yoga instructor for children in an after-care program. Prior to enactment of the ACA, Ms. Joshi was able to purchase individual health insurance on the private market. However, her husband, who is retired, could not buy insurance because of his preexisting diabetic condition and, as a result, could not afford insulin. Because of the availability of a premium tax credit, Ms. Joshi can now afford health insurance for herself, her husband, and her two sons, and her husband is able to get the treatment he needs.

**Deborah McBee** is a retired educator from Tilton, New Hampshire. Her husband is an adjunct professor and a member of SEIU. Ms. McBee's husband is covered by Medicare, but Ms. McBee is not yet eligible. Before enactment of the ACA, Ms. McBee struggled to afford health insurance and often had to reduce her

spending on necessities like food in order to pay for insurance. Because of a tax credit available under the ACA, Ms. McBee's monthly insurance premium was significantly reduced.

**Claudette Newsome** lives in Houston, Texas, and is part of the Texas Organizing Project. Before enactment of the ACA, Ms. Newsome and her family were uninsured. Ms. Newsome's husband received cancer treatment through an experimental trial because the trial was his least costly option, not because it was his preferred choice. He passed away in 2010. Ms. Newsome was recently able to purchase health insurance with a premium tax credit. She feels that health insurance is critical to her family's welfare and financial stability.

**Janet Wolfe** is an SEIU member from Springfield, Oregon, who works as a healthcare aide in both a private home and in an adult foster home for the developmentally disabled. Prior to enactment of the ACA, Ms. Wolfe was uninsured and was unable to afford treatment for problems with her hip. Ms. Wolfe purchased health insurance with a tax credit after enactment of the ACA, got a hip replacement, and now walks without pain.

*Service Employees International Union*

**SEIU** is the largest healthcare union in the United States. More than half of SEIU's two million members work in the healthcare industry. SEIU supports the ACA because it helps to ensure accessible, quality healthcare for all Americans, including SEIU members and their families.

## SUMMARY OF ARGUMENT

As healthcare workers, healthcare consumers, and the largest healthcare union in the country, *amici* have witnessed first-hand the ways in which the ACA has vastly improved access to care, health outcomes, and overall quality of life for millions of Americans.

*Amici* file this brief supporting respondents to address petitioners' argument that their reading of the statute gives effect to Congress's true intent to use tax subsidies as "carrots" (or "sticks") to encourage states to operate their own exchanges. As explained below, petitioners' carrots-and-sticks theory, developed post-hoc for purposes of litigation, should be rejected because it turns the ACA into a statute that is arguably coercive and, at a minimum, disruptive of ordinary federal-state relations, and also because it is contrary to the ACA's text, Congress's stated purposes in enacting the statute, the ACA's legislative history, and evidence of what the states understood when deciding whether to set up their own exchanges, and is not even believed by petitioners' supporters.

## ARGUMENT

To shore up their purported "plain meaning" argument, which in fact contravenes the ACA's text, Respondents' Br. 19–35, and has been anything but "plain" to either the statute's proponents or its detractors, *infra* Parts IV–VI, petitioners have developed a post-hoc theory that Congress intended to use subsidies as "carrots" (or "sticks") to encourage state-operated exchanges. Petitioners' carrots-and-sticks theory raises serious constitutional and

federalism questions such that it should not be accepted unless supported by unmistakably clear evidence of congressional intent, which is not present here. Petitioners' theory in fact is contradicted by the statute, its legislative history, the record of ACA-related state decision-making, and even the public statements of petitioners' supporters.

## I. PETITIONERS' CARROTS-AND-STICKS THEORY RAISES SERIOUS CONSTITUTIONAL AND FEDERALISM QUESTIONS THAT DEMAND A CLEAR STATEMENT OF CONGRESSIONAL INTENT, WHICH IS NOT PRESENT HERE.

Petitioners' theory raises serious constitutional and federalism questions because it turns the ACA into an arguably coercive statute that disrupts ordinary federal-state relations. The Court should not accept a statutory construction that raises unnecessary constitutional questions and disturbs normal federal-state relations absent clear evidence that the proffered construction is consistent with Congress's intent, and there is no such evidence here.

As an initial matter, Congress may not constitutionally compel states to participate in a federal program by presenting them with what appears to be a free choice but is in fact a choice "so coercive as to pass the point at which pressure turns into compulsion." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604 (2012) (*NFIB*) (Roberts, C.J., joined by Breyer and Kagan, JJ.) (internal quotation marks omitted). Construed as petitioners urge, the ACA would present significant questions of unconstitutional compulsion because states, by refusing to create exchanges, would not only forfeit subsidies but would also subject their

insurance markets to the "death spiral" caused by the ACA's market reforms in the absence of subsidies. *See, e.g.*, Respondents' Br. 3–8. The doctrine of constitutional avoidance requires rejecting such an interpretation unless doing so would be "plainly contrary to the intent of Congress," which is not the case here, as demonstrated below. *New York v. United States*, 505 U.S. 144, 170 (1992) (internal quotation marks omitted).

Moreover, even if petitioners' view of the statute did not raise serious questions of unconstitutional compulsion, this Court in construing federal statutes relies on "background principles . . . grounded in the relationship between the Federal Government and the States," *Bond v. United States*, 134 S. Ct. 2077, 2088 (2014), that are contravened by petitioners' reading. Among those principles, which apply even when no specific constitutional federalism restriction is implicated, *see, e.g.*, *id*. at 2087–94, is that the Court will not adopt a construction that "upset[s] the usual constitutional balance of federal and state powers" unless its correctness is "unmistakably clear." *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991) (internal quotation marks, citations omitted). This rule "assures that the legislature has in fact faced, and intended to bring into issue, the critical matters involved in the judicial decision." *United States v. Bass*, 404 U.S. 336, 349 (1971).

Before construing statutes to "alter sensitive federal-state relationships," *Rewis v. United States*, 401 U.S. 808 (1971), and to determine whether the legislature has in fact made its intent "unmistakably clear," *Gregory*, 501 U.S. at 460, this Court has examined whether the overall statutory policies and context are consistent with the proffered construction,

*see, e.g.*, *Bond*, 134 S. Ct. at 2090; the degree to which the construction conforms to traditional statutory approaches taken by Congress, *see, e.g.*, *New York*, 505 U.S. at 167–68; whether legislative history validates the construction, *see, e.g.*, *Nixon v. Missouri Mun. League*, 541 U.S. 125, 140–41 (2004); and whether the statute puts states on clear notice of the consequences of their choices, especially of possible "massive financial" costs. *See, e.g.*, *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 16–17, 24–25 (1981); *cf. NFIB*, 132 S. Ct. at 2602 (Roberts, C.J., joined by Breyer and Kagan, JJ.) (*Pennhurst* requirement that states be given clear statement of potential costs "is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system").

As shown below, petitioners' reading of the ACA represents a severe deviation from the presumed relationship between the federal government and the states but is not supported by any of the expected indicia of congressional intent. On petitioners' view, Congress coerced state decisions about their internal operations by threatening the states with severe injury. Yet we are to believe that Congress did so in a manner never before seen in a federal statute, *i.e.*, by promising to establish intentionally ineffective and destructive federal institutions within those states that do not do what Congress wants, and legislated that unprecedented scheme using language buried in a technical provision not directed to the states' attention, which is surrounded by other provisions indicating that the language does not mean what petitioners claim, and which failed to give the states full and fair notice of the serious consequences they faced.

## II. PETITIONERS' CARROTS-AND-STICKS THEORY IS NOT SUPPORTED BY, AND INDEED CONTRADICTS, THE ACA'S TEXT.

### A. When Congress Incentivizes State Action, It Does So In Clear Terms And Not At All As In The ACA.

Petitioners' theory is that Congress intended the ACA's tax subsidies to be "carrots" (or their potential unavailability, and ensuing death spiral, a "stick") to encourage state-operated exchanges. If petitioners' theory were correct, one would expect to find that subsidy-as-incentive scheme articulated clearly in the statute's text, but the ACA defies such expectations: It contains none of the clear language one would anticipate if petitioners' theory were true, and its provisions seem, if anything, designed to hide the incentive petitioners claim to have identified. The illogic of this approach undermines petitioners' theory, as does the fact that Congress has always spoken clearly in the past when it has incentivized state action.

If Congress in fact intended to use tax subsidies as carrots or sticks to encourage states to set up their own exchanges, one would expect to find that incentive scheme articulated clearly in the ACA's text because just as a threat is effective only if communicated, an incentive to the states is effective only if state officials understand what they are being encouraged to do and what their states' citizens stand to gain or lose depending on their decisions. In short, Congress has every reason, if it intends to use a carrot or stick to incentivize the states, to make that intention unmistakably clear.

The ACA's exchange provisions, however, contain none of the clear language one would expect if petitioners' theory were true. For example, if Congress had actually intended to use subsidies as an incentive for state-operated exchanges, it could and would likely have made that intention clear by stating, as part of ACA §1321, 42 U.S.C. §18041, that "tax credits under section 36B of the Internal Revenue Code shall not be available to anyone purchasing insurance on an Exchange operated by the Secretary." *Cf., e.g.*, 42 U.S.C. §1396c. Or in the tax credit provision itself, Congress could have defined an "eligible taxpayer" to exclude anyone who purchases insurance on an "exchange operated by the Secretary." *Cf., e.g.*, 26 U.S.C. §223. *Contra* Petitioners' Br. 20 (claiming that Congress "could not have chosen clearer language").

Either of these formulations would have been much clearer than the language on which petitioners rely, yet the ACA, rather than using any of the above language, seems if anything designed to obscure petitioners' imagined incentive scheme. Not only did Congress fail to mention any subsidy-related difference between state-operated exchanges and federally facilitated exchanges (FFEs) in the statutory sections that provide for exchanges, *see* 42 U.S.C. §§18031, 18041, but also Congress (accepting petitioners' theory) hid its threat to withhold subsidies from FFEs in at-best ambiguous language in a definition of "coverage month" where no one would expect to find it. And Congress (again accepting petitioners' theory) further disguised its threat with language assuring states that they have the "flexibility" to "elect" whether to set up their own exchanges, without even hinting at any significant consequences flowing from

those decisions. *Id*. §18041(c); *see also* Respondents' Br. 22–23.

Of course it makes no sense for Congress to have hidden a key incentive (indeed, a threat of serious harm) in such a way. Nor, in this Court's words, does Congress usually "hide elephants in mouseholes." *Whitman v. American Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001).

Furthermore, if Congress did hide its key incentive as petitioners claim, then the ACA stands in sharp contrast to other federal statutes. When Congress has in the past conditioned receipt of federal funds on particular state action, it has done so in clear terms. For example, the Medicaid statute provides that if a state plan fails to meet federal requirements, "the Secretary shall notify such State agency that further payments will not be made to the State." 42 U.S.C. §1396c. And the other federal-funding programs cited by petitioners' *amici* as comparators contain similarly clear language, unlike the language in the ACA on which petitioners rely.[2] Even the ACA itself is clear about offering grants to states to set up their own exchanges; the statute's plain grant language, *see* 42 U.S.C. §18031(a), is entirely unlike the buried subsidy incentive petitioners claim to find in the statute's definition of "coverage month."

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[2] *See* 7 U.S.C. §§2013(a), 2020(g) (Supplemental Nutrition Assistance Program); 20 U.S.C. §6311(g) (No Child Left Behind); 42 U.S.C. §280g-15(c) (medical malpractice program); 42 U.S.C. §§602, 603, 609 (Temporary Assistance for Needy Families); 42 U.S.C. §§654, 655(a)(4)–(5) (child support program); 42 U.S.C. §§1397aa(b), bb, ff (Children's Health Insurance Program); 20 U.S.C. §1412 (Individuals with Disabilities Education Act).

As is true of the other statutes just discussed, the health coverage tax credits (HCTC) statute cited as a comparator by *amici* Adler and Cannon is more unlike the ACA than like it. The health-coverage credits are stand-alone tax provisions, not part of a complex, interconnected statutory scheme like the ACA. Thus, while it may have made sense given the HCTC statute's structure for Congress to put the conditions on those credits in the tax provisions alone, that does not support *amici*'s claim that it made sense for Congress to hide petitioners' purported subsidy incentive in 26 U.S.C. §36B in the very differently structured ACA without mentioning that incentive in the statute's exchange provisions.

Congress also used much clearer language in the HCTC statute. In providing credits for certain kinds of "state-based insurance plans," among others, Congress introduced its "state-based" language not in a definition of "coverage month" but in a section titled "[q]ualified health insurance"—a logical location. 26 U.S.C. §35(e)(1). And Congress did not rely on the phrase "state-based" alone: it described qualified state-based plans with specificity and devoted a sub-section to explaining what qualified "state-based" plans must be. *See id*. §35(e)(2). All very much unlike the ACA language on which petitioners rely.[3]

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[3] *Cf. also* 26 U.S.C. §223(a), (c) (a health-savings-account deduction will be "allowed" to "eligible individual[s]," defined to mean, *inter alia*, individuals enrolled in high-deductible plans); 26 U.S.C. §§3302(a), 3305(j) (Federal Unemployment Tax Act, providing credit for money paid "into an unemployment fund . . . under the unemployment compensation law of a State which is certified" as meeting certain requirements, and for the "[d]enial of credits" in states without certified laws).

In sum, accepting petitioners' theory means accepting that Congress hid and disguised its key incentive (indeed, a threat of serious harm)—an approach that is illogical and contrary to Congress's past practice and that falls far short of the requirement that a statute be "unmistakably clear" before it may be construed to alter the federal-state balance of power. *See Gregory*, 501 U.S. at 460.

### B. Congress's Provision For FFEs Makes No Sense Under Petitioners' Theory.

Petitioners' theory is also inconsistent with the ACA's provisions calling for the creation of FFEs.

If petitioners' theory is correct, then FFEs, which appear on the ACA's face to be an effective federal "backup" for states that choose not to set up their own exchanges, are in fact not effective at all but infected with a fatal flaw, *i.e.*, the unavailability of subsidies. Congress has never created that kind of false fallback before, and doing so makes no sense even under petitioners' theory. A federal backup that appears legitimate to the states (and even to members of this Court) will blunt any incentive to the states to set up their own exchanges, not encourage state-operated exchanges.

Congress has in the past employed two different strategies for encouraging states to implement federal programs. Congress sometimes encourages state action by conditioning federal grants on state implementation of a federal regime, *see New York*, 505 U.S. at 167, as in the Medicaid statute. *See* 42 U.S.C. §1396c. Congress has also encouraged state action by giving states a choice between regulating an activity themselves and having the federal government regulate instead, in essence providing alternative

federal and state means for furthering the federal government's policy objectives. *See New York*, 505 U.S. at 167–68.

The ACA's provision for FFEs appears on its face to be an example of the latter, federal-fallback approach. As explained in a dissenting opinion in *NFIB*: "[B]ecause Congress thought that some States might decline federal funding for the operation of a 'health benefit exchange,' Congress provided a backup scheme; if a State declines to participate . . ., the Federal Government will step in and operate an exchange in that State." *NFIB*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas and Alito, JJ., dissenting).

Petitioners' carrots-and-sticks theory, however, leads to the conclusion that the ACA's exchange system is not the federal "backup" everyone has understood it to be but is instead an entirely new scheme, previously unknown: A coercive choice *masquerading* as a federal fallback. Without subsidies, FFEs will never function as effective exchanges, leaving FFE states worse off than before the ACA's enactment by exposing their individual insurance markets to "death spiral" pressures. *See, e.g.*, Br. *Amicus Curiae* of Am.'s Health Ins. Plans (AHIP). Thus, although ACA Title I appears to give states a classic choice between setting up their own exchanges or having an equally effective federal "backup" set up for them, under petitioners' theory the ACA's federal-fallback option is essentially a sham disguising a "set-up-exchanges-or-else" coercive choice.

Petitioners do not cite any examples of similar false-fallback regimes in other statutes, and *amici* are not aware of any. Petitioners' *amici* do cite some prototypical federal "backup" provisions, but in all

those statutes the federal fallbacks are real: If states decline to regulate themselves, the federal government steps in in a manner that achieves Congress's policy goals and ensures no state's citizens are "left out in the cold." *NFIB*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas and Alito, JJ., dissenting); *see* 42 U.S.C. §7410(c)(1) (Clean Air Act); 47 U.S.C. §252(e)(5) (Telecommunications Act); 21 U.S.C. §661(c) (Wholesome Meat Act (WMA)); 29 U.S.C. §667 (OSHA).[4] In none of the cited statutes does the federal government leave a state's citizens unprotected and outside of the federal scheme—or, indeed, worse off—as a consequence of the state's allowing for federal regulation.

Nor do petitioners explain why Congress would have acted so illogically—and would have wasted its time—by creating a false federal fallback. For one thing, it is an inefficient and confusing waste of resources to legislate an at-best useless institution. For another, a federal backup, like an FFE, that appears effective will blunt any incentive for states to set up their own exchanges: if states believe there is a federal-fallback option on which they can rely, they have less reason to incur the cost and responsibility of implementing the federal regime themselves. Thus, if Congress's goal was, as petitioners claim, to use subsidies as an incentive, it was illogical for Congress to provide a

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[4] *See also, e.g.*, *Fargo Packing Corp. v. Hardin*, 312 F. Supp. 942, 945 (D.N.D. 1970) (federal government subjected state to regulation under WMA); *In re Starpower Commc'ns, LLC*, 15 F.C.C.R. 11277 (2000) (FCC asserted jurisdiction under Telecommunications Act after state failed in its responsibility); 79 Fed. Reg. 49,465 (Aug. 21, 2014) (proposed rejection of Arizona safety standard "to allow OSHA to enforce Federal . . . standards"); 71 Fed. Reg. 25,328 (Apr. 28, 2006) (federal emissions regulation following states' failure to regulate).

federal fallback, especially one that appeared even to members of this Court to play an effective operational role. *See NFIB*, 132 S. Ct. at 2664–65.

### C. Other ACA Provisions Make No Sense Under Petitioners' Theory.

Several more of the ACA's provisions are inconsistent with petitioners' theory.

First, ACA §1321 informs the states that they have the "flexibility" to "elect" whether to set up their own exchanges and indicates as well, using the word "such" to refer back to "required Exchange," that states will not face adverse consequences for deciding against state-operated exchanges. 42 U.S.C. §18041. Under petitioners' theory, however, these references to "flexibility," state "elect[ion]," and equally effective FFEs are false and misleading: FFEs are not equally effective, and the "flexibility" to choose between a functioning healthcare system and an insurance-market death spiral is no real flexibility at all.

Second, the ACA's employer mandate is at odds with petitioners' theory.

If petitioners' argument is correct, then the ACA gives many large employers an incentive to lobby *against* state-operated exchanges, which makes no sense if Congress so strongly preferred them. As petitioners point out, under their theory penalties for violating the ACA's employer mandate will not apply in FFE states because the penalties are imposed only if a "tax credit or cost-sharing reduction is allowed or paid" to an employee. 26 U.S.C. §4980H(a), (b). This gives employers an incentive to lobby for FFEs and against state-operated exchanges, and petitioners never explain why Congress would

have created that incentive if it in fact wanted to encourage such exchanges.

And the way petitioners' theory interacts with the employer mandate is even more irrational and counterproductive than that. For an employer will still face penalties for its entire operation if even one of its employees receives a subsidy. This means, under petitioners' theory, that an FFE-state employer employing anyone who resides in a state that operates its own exchange risks substantial penalties (*i.e.*, if that out-of-state employee receives a subsidy), while another employer in the same state risks no penalties if it employs only in-state residents. This outcome makes no sense in relation to any imaginable policy goals, and Congress cannot be assumed to have intended such a bizarre result, which would present employers with irrational competitive advantages or disadvantages based on location within a state (*i.e.*, near or far from state borders) and on the happenstance of where employees reside, and would undermine efficient operation of interstate labor markets by promoting job discrimination on the basis of state residence.[5]

Third, the ACA's provisions regarding "qualified individual[s]" provide more evidence against petitioners' theory, as demonstrated by the fact that petitioners abandon any effort at consistent statutory construction in explaining those provisions. Petitioners' leading argument on the qualified-individual issue is that the term "Exchange" should be

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[5] *Cf. Rewis*, 401 U.S. at 812 (rejecting idea that Congress would "produce situations in which the geographic origin of customers, a matter of happenstance" would define significant federal liabilities given "the ease . . . [of] travel and the existence of many multi-state metropolitan areas").

equated with "state established" for purposes of the qualified-individual definition, *see* Petitioners' Br. 48, but not equated with "state established" in the statutory provision for FFEs. *Id*. 12. *Contra, e.g.*, *Maracich v. Spears*, 133 S. Ct. 2191, 2205 (2013) (statutory terms should be read consistently with one another). And petitioners' next argument—that non-qualified individuals may purchase insurance on the exchanges—flies in the face of ACA §1331(e)(2), 42 U.S.C. §18051(e)(2), which equates being "treated as a qualified individual" with being "eligible for enrollment . . . through an Exchange." *Contra, e.g.*, *Maracich*, 133 S. Ct. at 2205.

Fourth, ACA §1311(d)(1) must be re-written to accommodate petitioners' theory. Section 1311(d)(1) "require[s]" that "[a]n Exchange shall be a governmental agency or nonprofit entity *that is established by a State*." 42 U.S.C. §18031(d)(1) (emphasis added). That requirement is consistent with §1321(c)(1)'s provision for FFEs if, as respondents argue, FFEs are "established by a State" for purposes of the statute such that creation of an FFE complies with §1311(d)(1)'s state-establishment requirement. For §1311(d)(1) to make sense under petitioners' theory, however, the section's reference to "established by the State" must be deleted entirely and (d)(1)'s verb changed from "shall be" to "shall operate." *See Halbig v. Burwell*, 758 F.3d 390 (D.C. Cir. 2014), *vacated*, No. 14-5018 (Sept. 4, 2014) (re-writing §1311(d)(1) to require only that "[a]n Exchange shall operate as a governmental agency or nonprofit entity"). *Contra, e.g.*, *Hall v. United States*, 132 S. Ct. 1882, 1893 (2012) ("[I]t is not for us to rewrite the statute."); *Ransom v. FIA Card Servs., N.A.*, 131 S. Ct. 716, 724 (2011) ("[W]e must give effect to every word of a statute

wherever possible.") (quoting *Leocal v. Ashcroft*, 543 U.S. 1, 12 (2004)).

Fifth, the ACA's interim high-risk pool for consumers with pre-existing conditions is yet another statutory provision that makes no sense under petitioners' theory. To ensure "[i]mmediate access" to insurance for consumers with pre-existing conditions, Congress created a temporary high-risk pool for that group. 42 U.S.C. §18001. Congress provided that the pool would sunset in January 2014 when consumers could "[t]ransition to exchange" coverage and instructed the Secretary to adopt transition procedures to "ensure . . . no lapse in coverage." *Id*. §18001(g)(3).

Congress's plan for high-risk consumers works if subsidies are available in all states because consumers with pre-existing conditions can use subsidies to transition to affordable exchange coverage everywhere. But Congress's plan falls apart under petitioners' theory because if subsidies are unavailable in FFE states, then the cost of insurance in those states will skyrocket, effectively guaranteeing the "lapse in coverage" Congress promised to prevent. *See also* 42 U.S.C. §18002(a)(1) (similar January 1, 2014 sunset for temporary reinsurance program for early retirees).

Sixth, the ACA's "[t]ransitional" reinsurance, risk corridor, and risk adjustment programs cannot operate as intended under petitioners' reading. Congress created those programs to help "stabilize premiums . . . during the first 3 years of operation of an Exchange." 42 U.S.C. §§18061(a), (c)(1)(A). The programs operate identically in every state, which makes sense if subsidies are available everywhere but not if subsidies are unavailable in FFE states such that insurance markets will function and premiums

fluctuate much differently in FFE states than in states with their own exchanges.

Finally, ACA §1311(f), which provides for regional or interstate exchanges, further undercuts petitioners' theory that the phrase "established by the State" in the tax-subsidy provisions excludes FFEs. Section 1311(f) provides that one exchange may operate in multiple states if the states agree and the Secretary approves. *See* 42 U.S.C. §18031(f). But if petitioners' understanding of "established by the State" is correct, then the citizens of some member states in interstate exchanges will likely have no access to subsidies, *e.g.*, if their states joined already-established exchanges. Since that result makes no sense, the better reading of §1311(f) is that Congress intended all exchanges created under the ACA to be "established by the State" for purposes of the tax subsidy provisions.

To say the least, petitioners' carrots-and-sticks theory runs counter to myriad ACA terms.

## III. PETITIONERS' THEORY CONTRAVENES CONGRESS'S PURPOSES IN ENACTING THE ACA.

Petitioners' theory runs counter to Congress's stated purposes in enacting the ACA as well. Congress passed the ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 132 S. Ct. at 2580. Yet, under petitioners' theory, the ACA will lead to fewer insured Americans and more expensive healthcare in FFE states.

As described by respondents and *amicus* AHIP, the ACA's market reforms, which apply in all states, tend to encourage adverse selection if they stand alone. When individuals are guaranteed the ability to purchase insurance at a set price not based on their

individual health, many will "wait to purchase health insurance until they need[] care." 42 U.S.C. §18091(2)(I). The remaining pool of insureds will then skew toward the less healthy.

Adverse selection, in turn, will lead to higher premiums for the entire pool, and higher premiums will drive even more relatively healthy consumers from the insurance market. The dynamic will feed on itself, forcing premiums ever higher and the insured population ever lower.

When the ACA functions as intended, its individual-mandate and tax-subsidy provisions work to prevent this "death spiral." By requiring individual insurance coverage and subsidizing that coverage, the mandate and tax subsidy provisions work together to keep healthy consumers in the market. They curb adverse section and protect states from its adverse consequences.

Under petitioners' carrots-and-sticks theory, however, FFE states are left with unchecked adverse selection. FFE states must abide by the ACA's market reforms but without subsidies and an effective individual mandate. Inevitably, FFE states will experience what Washington State and others experienced in the 1990s, namely, fewer insureds and higher premiums—making the ACA a tool, in FFE states, for achieving the exact opposite of Congress's stated goals.

## IV. PETITIONERS' THEORY IS CONTRARY TO THE ACA'S LEGISLATIVE HISTORY.

Nor can petitioners' carrot-and-sticks theory be reconciled with the ACA's legislative history, which contains no mention of petitioners' posited design, much less the kind of controversy one would expect to

accompany such a novel and heavy-handed effort at state coercion. Rather, the ACA's legislative history shows that Congress both thought it possible that the federal government would set up exchanges and, notwithstanding that possibility, expected subsidies to be available in every state.

On the Senate side, Senators Orrin Hatch and Max Baucus spoke in December 2009 about the ACA's provision for FFEs and made clear that they viewed FFEs as a very real possibility. Senator Hatch objected in strong terms to what he expected to be the federal government's role in operating FFEs and described that federal role as a reason to reject the statute. *See* 155 Cong. Rec. S13,714, 13,726 (daily ed. Dec. 22, 2009). Senator Baucus, on the other hand, emphasized the statute's provision for FFEs as ensuring its constitutionality. 155 Cong. Rec. S13,796, 13,832 (daily ed. Dec. 23, 2009).[6]

Simultaneous with this discussion of FFEs as a very real possibility, various senators made clear their understanding that tax subsidies would be available in each state. *E.g.*, 155 Cong. Rec. S12,356, 12,358 (daily ed. Dec. 4, 2009) (statement of Sen. Bingaman) (ACA creates a "new health insurance exchange in each State which will provide Americans . . . refundable tax credits to ensure that coverage is

[6] Senator Hatch's December 2009 statement also drew a sharp contrast between the ACA's exchange provisions and the type of conditional-grant legislation that petitioners claim those provisions to be. Senator Hatch noted that in the past Congress had "encouraged States to pass legislation, . . . bribed them, . . . even extorted them by threatening to withhold federal funds." *See* 155 Cong. Rec. at 13,726. But he described the ACA as different in that it provides for FFEs as a federal fallback. *Id*.

affordable"); 155 Cong. Rec. S13,345, 13,375 (daily ed. Dec. 17, 2009) (statement of Sen. Johnson) (the ACA "will . . . form health insurance exchanges in every State" that will "provide tax credits to significantly reduce the cost of purchasing . . . coverage."). That understanding makes sense only if the senators expected subsidies to be available via FFEs.

The House record is similar. In March 2010, Representative Phil Roe noted that "[t]hirty-seven States" were "proposing legislation to opt out" of implementing ACA provisions if the statute were to pass. 156 Cong. Rec. H1854, 1888 (daily ed. Mar. 21, 2010). At the same time, House members stated their understanding that citizens would be able to "shop for more affordable coverage on exchanges set up by states or the Federal Government." *Id*. at 1871 (statement of Rep. Maloney). Of course insurance would be "more affordable" only with subsidies.

Petitioners and their *amici* cite ACA precursor bills as legislative history supporting their theory, but those bills, too, aid the government's position. For example, when the Affordable Health Choices Act (AHCA), passed by the Senate HELP Committee, conditioned subsidies on states adopting certain protections for their public employees, it did so in clear language entirely unlike the ACA language on which petitioners rely. *See* AHCA, S. 1679 111th Cong. §142 (2009) (adding §3104 to the Public Health Service Act). In the same section of the bill that called for "federal fallback" exchanges, AHCA provided that citizens in federal fallback states "shall be eligible for credits . . . *if* the State agrees to make employers that are State or local governments subject to sections 162 and 163 of the [AHCA]." *Id*. (§3104(d)(1)(D)) (emphasis added). Moreover, neither AHCA nor America's Healthy

Future Act of 2009 (AHFA), passed by the Senate Finance Committee, drew any distinction between state-operated exchanges and FFEs with respect to subsidies, so neither is a model for petitioners' vision of the ACA. *See* AHCA, S. 1679; AHFA, S. 1796, 111th Cong. (2009) (not providing for FFEs at all).

Against this legislative history supporting respondents' view, petitioners and their *amici* cite two irrelevant documents.

Senator Ben Nelson's statement that he opposed a "national exchange" that might "start us down the road of . . . a single-payer plan," Carrie Budoff Brown, *Nelson: National exchange a dealbreaker*, Politico, Jan. 25, 2010, says nothing at all about support for conditioning subsidies on state-operated exchanges. Senator Nelson plainly opposed a policy solution akin to that found in an earlier House bill, which would have created a single national exchange through which the federal government could "negotiate and enter into contracts with [qualified insurance plans]" on a nationwide basis. H.R. 3962, 111th Cong. §301 (2009) (as introduced in House). But the ACA, unlike that House bill, requires separate state-by-state exchanges, prevents the federal government from negotiating with insurers on a nationwide basis, grants states the first opportunity to create exchanges, and defers to state policies in important areas even in FFE jurisdictions, *see* 42 U.S.C. §§300gg(a)(2), 18021(a)(1)(C)(i), 18023(a)(1). Thus, Senator Nelson's opposition to a solution like that found in the earlier House bill provides no insight into his position regarding the very different ACA.

Indeed, it is counter-intuitive to think that Senator Nelson, who opposed a single national exchange because he feared federal over-reaching, would have

supported a federal power to coerce states to set up their own exchanges by threatening to destroy their insurance markets if they did not.

Petitioners' second document, a letter from Representative Lloyd Doggett and other Texas Democrats, is equally irrelevant. The Doggett letter expresses concern that the Senate version of healthcare reform, unlike the House version that created a "single, national health insurance exchange," would allow "indifferent state leadership" to "administer" "weak, state-based exchanges," which would "fracture the market . . . especially . . . if the state sets up multiple exchanges." *U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans*, My Harlingen News (Jan. 11, 2010), http://www.myharlingennews.com/?p=6426, *archived at* http://perma.cc/2K3C-CFP6. The authors explained that when "states face difficult budget years," they sometimes cut funding for healthcare programs, and the "same result" could befall exchanges. *Id.*

As the text of the letter reflects, Representative Doggett and his co-signatories sought to ensure effective operations even where state officials might not want to operate effective exchanges; their letter supports the need for effective FFEs. The letter, like Senator Nelson's statement, says nothing about the idea of limiting subsidies to states' operating their own exchanges, and its one reference to FFEs implies no difference between them and state-operated exchanges. *Id*.

## V. THE STATES DID NOT INTERPRET THE ACA AS PETITIONERS DO NOW.

If, as petitioners claim, the ACA's tax subsidies are "obvious[ly]" not available in FFE jurisdictions,

Petitioners' Br. 20, one would expect the states to have discussed that important fact at length when deciding whether to set up their own exchanges. Instead, the record of state decision-making indicates that most states never considered the possibility that subsidies might be unavailable in FFE states, and there is no evidence showing that any state made its decision on the basis of petitioners' theory.

Under the ACA, each state had to decide whether to operate its own exchange or to opt for an FFE, and state officials, legislators, and contractors created a written record of their decision-making processes. Most states created committees to consider their options, and in at least 20 States, a comprehensive report was prepared for the governor, state legislature, or other responsible entity. Some state governments also or alternatively published partial or tentative reports, statements to their citizens regarding the state's decision, or other documents related to the exchange issue. *See* App.

The authors of this brief reviewed more than one hundred documents created during the states' decision-making processes, including documents linked to on the "State Exchange Profiles" created by the Kaiser Family Foundation, *see, e.g.*, Kaiser Family Foundation, *State Exchange Profiles: Kansas* (Mar. 21, 2013), http://kff.org/health-reform/state-profile/state-exchange-profiles-kansas/, and documents we found by searching state web domains. In total, we reviewed 190 relevant documents from 46 States (plus the District of Columbia). *See* App. (listing reviewed documents).[7]

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[7] Specifically, we reviewed all Kaiser-linked documents created by or on behalf of state governments before January 1, 2013 that

Fifty of the documents we reviewed pre-date August 17, 2011, when IRS first proposed the rule at issue. Not one of those documents mentions that subsidies might be available only via state-operated exchanges, while many suggest the opposite.

For example, in March 2011, the South Carolina Department of Insurance presented to a state legislative committee about the ACA, and in doing so, explained both that the federal government would establish an exchange if the state did not and, without drawing any distinction between state-operated exchanges and FFEs, identified as a "Minimum Exchange Function[]" the transmission of information about individuals "eligible for a tax credit."[8]

Similarly, an August 15, 2011 Arizona document calling for contract proposals explains that the ACA requires creation of an exchange in "each state, either by the state or by the federal government, [which] would perform a variety of functions, including offering residents of each state the means to . . . receive subsidies if eligible."[9]

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discuss creation of individual exchanges. We then searched each state's web domain for additional documents (*e.g.*, by searching for pages containing "exchange," "insurance," and "subsidy" within kansas.gov) and reviewed those additional documents that appeared most likely to be relevant.

[8] S.C. Dep't of Ins., The ACA's Impact on Ins. Regulation, Presentation to Senate Banking & Ins. Comm., 8, 15 (Mar. 23, 2011), *available at* http://doi.sc.gov/DocumentCenter/View/2472, *archived at* http://perma.cc/4PHV-E4R5.

[9] Ariz. Health Care Cost Containment Sys., Notice of Request for Info. 3 (Aug. 15, 2011), *available at* http://www.azahcccs.gov/commercial/Downloads/Solicitations/Open/RFIs/YH12-0013/YH12-0013.pdf, *archived at* http://perma.cc/W9BN-PE68.

And in January 2011, Alaska's healthcare commission wrote:

> A Health Insurance Exchange will be established for every state by 2014. . . .
>
> . . .
>
> The federal government will establish Exchanges for the states in which the State government chooses not to participate. . . . The premium credits will be advanceable and available for purchase of insurance through *the Exchange*. In addition to premium credits, cost sharing subsidies will be provided to individuals and households whose income is between 100% - 400% FPL.[10]

The Alaska report makes no mention of what would have been, if petitioners are correct, the salient point that subsidies would be available only on state-operated exchanges.[11]

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[10] Alaska Health Care Comm'n, Transforming Health Care in Alaska 15–16 (Jan. 2011) (emphasis added), *available at* http://dhss.alaska.gov/ahcc/Documents/2010_report.pdf, *archived at* http://perma.cc/5R6C-23M7.

[11] *See also* Milliman, Inc., N.C. Health Benefit Exchange Study 19 (Mar. 31, 2011), *available at* http://www.nciom.org/wp-content/uploads/2010/12/Health-Benefits-Exchange-Study-DRAFT-4-2011-03-31-FULL-REPORT.pdf, *archived at* http://perma.cc/Y6FF-64XX (also mentioning FFEs without discussing the asserted unavailability of subsidies); Fed. Healthcare Reform: Exchange Planning Symposium, Background Information and Requested Stakeholder Input 1 (Feb. 14, 2011) (same), *available at* www.politico.com/pdf/PPM170_symposium_background.pdf, *archived at* http://perma.cc/R4GA-LE2F.

Some states consulted business and employer groups during this period, and although such groups were presumably well advised and would have been interested in the issue petitioners raise, none of their comments reflect any understanding that subsidies might be unavailable in FFEs jurisdictions. In New Jersey, for example, employers participated in a series of fora ending in April 2011 and "agreed that New Jersey should create its own exchange" in order to retain "regulatory authority" without mentioning that subsidies might be limited to state-operated exchanges.[12] The same employer perspective is reflected in similar compilations from other states, including statements from the Denver Chamber of Commerce and the National Federation of Independent Businesses.[13]

And the same pattern continues in later state documents. Several states, including *amici* Indiana and Oklahoma, submitted comments after IRS proposed the regulation at issue. None of those comments doubt the proposed regulation's correctness

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[12] *See* Maureen Michael, M.G.A., *et al.*, Stakeholder Views about the Design of Health Ins. Exchanges for N.J.: Volume II i, 19–25 (Aug. 2011), *available at* http://www.cshp.rutgers.edu/Downloads/9000.pdf, *archived at* http://perma.cc/3HN8-NE68.

[13] *See* State of Colo., Stakeholder Perspectives: Health Ins. Exchange Governance and Structure 7, 12–13 (Dec. 2010), *available at* http://www.nahu.org/legislative/exchange/HIE%20Governance%20Structure%20Brief%20Final%201_7_11.pdf, *archived at* http://perma.cc/2HLG-68XX; Me. Joint Select Comm. On Health Care Reform Opportunities and Implementation, Health Ins. Exchanges: Written Comments Submitted by Stakeholders 24–32 (Sept. 21, 2010), *available at* http://www.maine.gov/legis/opla/healthreformstakeholdercomments.pdf, *archived at* http://perma.cc/2DWM-2JUS.

with respect to subsidy availability.[14] Other state documents either note that subsidies will be available on both state-operated exchanges and FFEs[15] or imply that they will be available on both without suggesting that the statute supports any other reading.[16]

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[14] *See* Ind. Family & Social Servs. Admin., Comment on Proposed Rule: Health Insurance Premium Tax Credit (Oct. 31, 2011), *available at* http://www.regulations.gov/#!document Detail;D=IRS-2011-0024-0133; Okla. Health Care Authority, Comments on IRS Proposed Rule REG-131491-10 (Oct. 31, 2011), *available at* http://www.regulations.gov/#!documentDetail;D =IRS-2011-0024-0064.

[15] See Ga. Health Ins. Exchange Advisory Comm., Report to the Governor 13 (Dec. 15, 2011), *available at* https:// www.statereforum.org/system/files/179765813ghix_final_report_ to_the_governor.pdf, *archived at* http://perma.cc/9PNY-NX6L ("Georgians will be eligible for . . . subsidies whether the [exchange] in Georgia is established by the state or federal government."); HTMS, Health Benefit Exchange Planning Services: Narrative Summary 5, 46–47 (Dec. 2, 2011), *available at* http://www.nd.gov/ndins/uploads/18/finalhbeplanningnarr ative.pdf, *archived at* http://perma.cc/PSY7-37L6 (report by private firm, contracted by North Dakota Insurance Department, stating that in a "federally-run exchange," the federal government will "transmit[] information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions").

[16] *See, e.g.*, S.C. Health Planning Comm., Improving the Health Care Marketplace in S.C. 17 (Nov. 2011), *available at* http://doi.sc.gov/DocumentCenter/View/2534, *archived at* http://perma.cc/LD8A-ZRX6 ("[A]n exchange will be established in each state; if a state chooses not to create its own exchange, the federal government will operate one in that state. The exchanges will provide . . . premium and cost-sharing subsidies to make health insurance coverage more affordable. . . ."); Okla. Legislature, Final Report of the Joint Comm. on Fed. Health Care Law 18–20 (Feb. 22, 2012), *available at* http://www. oksenate.gov/news/press_releases/press_releases_2012/pr2012 0222b.pdf, *archived at* http://perma.cc/99UF-VW9M (listing

By contrast, the states *did* speak bluntly and often about other perceived advantages and disadvantages of state-operated exchanges, suggesting they would have discussed the subsidy issue as well if they had agreed with petitioners' reading. For example, Mississippi's Insurance Commissioner advocated for a state-operated exchange, while acknowledging that subsidies would be available even on an FFE, so that Mississippi could avoid "ced[ing] the regulation of a large portion of [the] health insurance market to the federal government."[17]

Only four of the 190 state government documents we reviewed mention that subsidies might not be available in FFE states, and none of those documents aids petitioners' argument. Two post-date litigation of the issue so may reflect knowledge of the litigation rather than any independent statutory assessment,

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many reasons for recommending a state-operated exchange without any mention of the subsidy issue); N.C. Inst. of Med., Examining the Impact of the [ACA] in N.C. 37 (Jan. 2013), *available at* http://www.nciom.org/wp-content/uploads/2013/01/FULL-REPORT-2-13-2013.pdf, *archived at* http://perma.cc/5X5C-HN59 (mentioning reasons state-operated exchange was recommended, without mentioning subsidies); South Dakota's Health Insurance Exchange Planning Effort: Report for Governor Dennis Daugaard 19 (Nov. 3, 2011), *available at* http://federalhealthreform.sd.gov/documents/exchange_planning_effort_report.pdf, *archived at* http://perma.cc/223F-G7C3 (describing benefits and advantages of an FFE without mentioning subsidies).

[17] Press Release, Miss. Health Ins. Exchange Op-Ed from Comm'r of Ins. Mike Chaney 1–3 (Nov. 20, 2012), *available at* https://www.mid.ms.gov/pdf/hc-exchange-oped.pdf, *archived at* http://perma.cc/ZEB5-H9PP.

and those two documents are of no help to petitioners in any event.[18]

The two documents that pre-date litigation are equally beside the point. One North Dakota legislator mentioned a "claim" that subsidies might not be available in FFE states but did not indicate whether he agreed with the claim.[19] And a single New Hampshire legislator mentioned the idea in a speech railing against the ACA, long after the New Hampshire Executive Council effectively had ended planning for a state-operated exchange.[20]

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[18] One, an Idaho report, mentions "talk" about the issue without expressing a view. Health Ins. Exchange Working Grp., Findings 48 (Oct. 30, 2012), *available at* http://www.doi.idaho.gov/HealthExchange/Final_report.pdf, *archived at* http://perma.cc/S285-UQWG. Another, a letter from a state official to Secretary Sebelius, mentions the issue but notes that the author's state already had decided not to create an exchange 18 months earlier. Letter, Bruce D. Greenstein to Kathleen Sebelius 1–2 (Nov. 16, 2012), *available at* http://www.dhh.louisiana.gov/assets/media/LA_Declaration_HealthInsuranceExchanges.pdf, *archived at* http://perma.cc/PPS6-AP6Z.

[19] Health Care Reform Review Comm., Minutes 7 (July 25, 2012), *available at* http://legis.nd.gov/assembly/62-2011/interim-info/minutes/hc072512minutes.pdf, *archived at* http://perma.cc/2DE4-CV52 ("[I]f there is truth to the claim that a federally administered health benefit exchange would not allow subsidies, this would be very serious. If this claim is accurate, the State may need to reconsider state administration.").

[20] *Compare* 34 House Record 18, 28–29 (N.H. Mar. 7, 2012), *available at* http://www.gencourt.state.nh.us/house/caljourns/calendars/2012/houcal2012_18.html, *archived at* http://perma.cc/BTZ2-NDXS, *with* Karen Langley, *Council Backs Off Health Exchange*, Concord Monitor (Apr. 14, 2011), *available at* http://www.concordmonitor.com/article/251216/council-backs-off-health-exchange, *archived at* http://perma.cc/KT8Y-RXZH.

In short, we did not find any documents demonstrating that any state made its decision about whether to set up an exchange on the basis of petitioners' theory.

Petitioners' *amici*'s arguments regarding the state record do not alter the analysis. Six states have submitted a brief claiming, after the fact, that "the States were well aware" of the asserted subsidy incentive, but the brief cites nothing to support the claim. *See* Br. of *Amici Curiae* Oklahoma, *et al.*, 15. Other *amici* cite statements made by Idaho's and Wisconsin's governors, which make no mention of the subsidy issue. *See* Br. of *Amici Curiae* Galen Institute, *et al*., 13. Missouri Liberty Project's (MLP's) claim that Missourians voted against a state-operated exchange with full knowledge that they were declining tax subsidies is also unpersuasive. *See.* Br. of *Amici Curiae, et al.*, MLP 14–15 (citing only one article published after the vote and one op-ed published nine months earlier in a local publication).[21]

The states' ignorance of the threat supposedly made to them undercuts petitioners' claim that the statute is clear, while demonstrating that petitioners' theory would deprive states, retroactively, of the ability to "exercise their choice knowingly, cognizant of the

[21] MLP's brief makes similar claims about several other states, but those claims are also not supported by the evidence MLP cites. *See id.* 15–17 (citing a newspaper article pertaining to New Jersey that makes no mention of subsidies being prohibited in FFE jurisdictions, a New Hampshire article citing only the president of a local think tank, and a Maine article that describes it as at-best unclear whether the state's decision was motivated by petitioners' reading of the statute, even after a review of 2,000 pages of administration documents).

consequences of their participation." *Pennhurst*, 451 U.S. at 17.

## VI. EVEN PETITIONERS' SUPPORTERS DO NOT BELIEVE THE CARROTS-AND-STICKS THEORY.

Although petitioners claim that Congress intended to make subsidies available only through state-operated exchanges, and that a ruling for petitioners will ensure that the ACA operates as planned, many of petitioners' supporters and the statute's opponents have described a ruling in petitioners' favor as a body blow for the ACA that will "take it down" and from which it will never recover—hardly a victory for congressional intent.

Indeed, the death-blow understanding of petitioners' theory seems to be widespread, and it is striking that in discussing a statutory-construction case, petitioners' supporters and ACA opponents describe petitioners' theory (which they did not advance during earlier debate) as a way to destroy the statute, rather than as a way to effectuate Congress's intent. For example, one senator said recently that a victory for petitioners would "take [the ACA] down."[22] Similarly, Senator John Cornyn said that if the Court accepts petitioners' theory, it will deal "a body blow to Obamacare from which I don't think it will ever recover."[23] And Representative Tom Price, Chairman

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[22] Greg Sargent, *Mitch McConnell: We can't repeal Obamacare, but Supreme Court may 'take it down' instead*, Wash. Post: Plum Line (Dec. 2, 2014), http://www.washingtonpost.com/blogs/plum-line/wp/2014/12/02/mitch-mcconnell-we-cant-repeal-obamacare-but-supreme-court-may-take-it-down-instead/.

[23] Humberto Sanchez and Niels Lesniewski, *Cornyn: Obamacare Repeal Vote Should Wait*, Roll Call: #WGDB (Jan. 8,

of the House Budget Committee, has said that this case presents a "great opportunity"—not to fulfill Congress's original intent—but to "unravel[] Obamacare pretty darn quickly."[24]

That many of the people who want this Court to accept petitioners' theory as being consistent with Congress's intent describe it publicly as a way to destroy the statute and undo what Congress intended casts further doubt on petitioners' post-hoc theory.

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2015, 11:16 AM), http://blogs.rollcall.com/wgdb/obamacare-repeal-vote-should-wait-cornyn/.

[24] Tom Howell Jr., *House Budget chairman: Supreme Court could unravel Obamacare 'pretty darn quickly'*, Wash. Times, Jan. 12, 2015, *available at* http://www.washingtontimes.com/news/2015/jan/12/tom-price-supreme-court-could-unravel-obamacare/. *See also, e.g.*, Austin Bordelon *et al.*, *The Stage is Set: Predicting State and Federal Reactions to King v. Burwell* 5 (Jan. 2015), *available at* http://www.healthreformgps.org/wp-content/uploads/the_stage_is_set_federal_and_state_planning_ahead_of_king_v_burwell.pdf (white paper prepared by Leavitt Partners, the firm of former Health and Human Services Secretary Michael Leavitt, stating that "[elimination] of consumer subsidies through the marketplace in 34 states will deliver a crippling blow to the healthcare law"); Daniel Tyson, *W.Va. man plaintiff in health care case*, Register-Herald, Jan. 12, 2015, *available at* http://www.register-herald.com/news/w-va-man-plaintiff-in-health-care-case/article_991503a3-3024-5391-b5a8-28d2e4a59347.html (statement by one of the petitioners that "courts seem to be the only way we are going to eliminate [the ACA]").

## CONCLUSION

Petitioners posit a congressional plan that, if accepted, would raise constitutional questions and have deeply serious consequences for federal-state relations, and thus should be rejected unless supported by clear congressional intent. Given that there is no evidence of such clear intent here, the Fourth Circuit's decision should be affirmed.

Respectfully submitted,

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# APPENDIX

# APPENDIX

## STATE DOCUMENTS REVIEWED

An * indicates a report authored by state officials, or created at their direction, as part of the state's decision-making process regarding exchanges.

ALABAMA

Ala. Office of Consumer Info. and Ins. Oversight, State Planning and Establishment Grants for the ACA's Exchanges, Quarterly Report 2 (Apr. 7, 2011), *available at* http://www.aldoi.gov/PDF/Consumers/SQReport.pdf, *archived at* http://perma.cc/CUZ4-2T4G

*Robert Carey, Ala.'s Ins. Exchange Roadmap (June 2011), *available at* http://www.insurance.alabama.gov/PDF/Consumers/Exchange%20Roadmap%20BMA10T1.pdf, *archived at* http://perma.cc/BY2P-XPX7

Press Release, Governor Bentley Signs Executive Order Creating Ala. Health Ins. Exchange Study Comm'n (June 2, 2011), *available at* http://governor.alabama.gov/newsroom/2011/06/governor-bentley-signs-executive-order-creating-alabama-health-insurance-exchange-study-commission/, *archived at* http://perma.cc/N588-ULR2

Executive Order No. 17 (Ala. June 2, 2011), *available at* https://web.archive.org/web/20110808160101/http://governor.alabama.gov/news/news_detail.aspx?ID=5164, *archived at* http://perma.cc/A2AF-8CTR

Press Release, Ala. Health Ins. Exchange Study Comm'n Holds Organization Meeting (Sept. 14, 2011), *available at* https://web.archive.org/web/20111205201702/http://governor.alabama.gov/news/news_detail.aspx?ID=5603, *archived at* http://perma.cc/VMK4-3HKJ

*Ala. Dep't of Ins., Ala. Health Ins. Exchange Study Comm'n Recommendations (Nov. 2011), *available at* https://web.archive.org/web/20121116202704/http://www.governor.alabama.gov/pdfs/HIXStudyCommissionReport.pdf, *archived at* https://perma.cc/3D3S-RQLR

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