UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, et al., Plaintiffs, v. KATHLEEN SEBELIUS, et al., Defendants.	Case No. 1:13-cv-00623-PLF

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

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INTEREST OF THE *AMICI CURIAE*[1]

Amici were among the first to consider the federal government's authority to extend subsidies for coverage purchased through federally established marketplaces. They have since, separately and together, published numerous articles, delivered lectures and testimony, and advised government officials on that issue and, in particular, on the regulation challenged here. They are the authors of the leading scholarly treatment of this issue, Jonathan H. Adler and Michael F. Cannon, Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA, 23 Health Matrix J. L. Med. 1, 119 (2013).

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

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act of 2010 ("PPACA" or "Act") provides "premium assistance tax credits" for the purchase of qualifying health insurance plans in health insurance Exchanges established by states under PPACA Section 1311, 42 U.S.C. § 18031. The Internal Revenue Service rule purporting to implement those premium-assistance tax credits is contrary to the plain language of the PPACA and cannot be justified on other grounds. The rule exceeds the agency's authority and subverts congressional intent by subverting the balance Congress struck between the Act's competing goals.

The PPACA mandates the creation of health insurance "exchanges" to regulate health insurance within each state; declares that "Each State shall . . . establish" an Exchange; directs the federal government to establish one in states that do not; and offers health insurance subsidies to certain qualified taxpayers who enroll in a qualified health plan "through an Exchange established by the State under Section 1311." This language originated in the Senate Finance Committee, was clarified and strengthened thereafter in the Senate, and was approved by both chambers of Congress and the President. The legislative history of the PPACA is fully consistent with the plain text of these provisions.

The authors of the PPACA conditioned premium-assistance tax credits on states establishing Exchanges to induce state cooperation. Specifically, to avoid "commandeering" the states, the PPACA's authors offered premium-assistance tax credits as one among a number of financial inducements for states to perform this task for the federal government. Congress routinely conditions federal benefits to individuals—both via direct spending and the tax code—on their states' carrying out congressional priorities. Indeed, conditioning premium-assistance

tax credits on states' establishing Exchanges (and enacting other health insurance measures) is far from the largest financial inducement that Congress created for states in the PPACA.

Contrary to the clear language and purpose of the statute, and without any reasoned basis, the IRS rule attempts to dispense premium-assistance tax credits in the 34 states that have opted not to establish an Exchange. Under the PPACA, those tax credits directly trigger penalties against employers and indirectly (but no less clearly) trigger penalties against individual taxpayers. The IRS rule therefore has the effect of triggering spending and imposing financial penalties that Congress never authorized. On that basis, the Plaintiffs' challenge to that rule should be sustained.

ARGUMENT

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

The premium-assistance tax credit provisions of the Patient Protection and Affordable Care Act of 2010 clearly, consistently, and unambiguously authorize tax credits only in states that establish a health insurance "exchange" that complies with federal law.

A. The Text's Meaning Is Plain

As written, the PPACA only provides for the issuance of tax credits for the purchase of qualifying health insurance plans in Exchanges established by states under PPACA Section 1311. The tax credits for the purchase of qualifying health insurance plans are provided for under PPACA Section 1401, which creates a new section of the Internal Revenue Code—Section 36B. 26 U.S.C. § 36B. This provision authorizes tax credits for each month in a given year in which a taxpayer has obtained qualifying health insurance through a state-run Exchange. As defined by Section 1401, a "coverage month" is any month in which the taxpayer is "covered by a qualified health plan . . . that was enrolled in through an Exchange established by the State under section

1311." 26 U.S.C. § 36B(c)(2). The amount of the tax credit is also calculated with reference to either a qualifying health insurance plan "enrolled in through an Exchange established by the State under [Section] 1311 of the Patient Protection and Affordable Care Act" or the "second lowest cost silver plan . . . offered through the same Exchange." 26 U.S.C. §§ 36B(b)(2)(A), 36B(b)(3)(B). Indeed, every explicit or implicit reference or cross-reference to an Exchange in the tax-credit eligibility rules of Section 36B is to an Exchange "established by the State under Section 1311." 26 U.S.C. §§ 36B(b)(2)(A), 36B(b)(3)(B)(i), 36B(b)(3)(C), 36B(c)(2).

Section 1311 further establishes the "requirement" that for purposes of that Section an "Exchange" be "a government agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(d)(1). To further erase any doubt, PPACA Section 1304 also defines "State" as "each of the 50 states and the District of Columbia." 42 U.S.C. § 18024(d). *Accord* 45 C.F.R. 155.20 (defining "State" as "each of the 50 States and the District of Columbia"). The cost-sharing subsidies provided under Section 1402 are similarly limited, as that provision expressly provides that cost-sharing reductions are only allowed for "coverage months" for which the aforementioned tax credits are allowed. 42 U.S.C. § 18071(f)(2).

Section 1311 makes no reference to federally facilitated Exchanges. Authority to create such Exchanges comes from a separate provision, Section 1321, 42 U.S.C. § 18041. Specifically, if the State has not established its own Exchange under Section 1311; or if the State fails to have "any required Exchange operational by January 1, 2014"; or if the State "has not taken the actions the Secretary [of Health and Human Services] determines necessary to implement" the "regulations setting standards for meeting the requirements under [Title I] with respect to the establishment and operation of Exchanges (including SHOP Exchanges)[,] the offering of qualified health plans through such Exchanges; the establishment of the reinsurance and risk

adjustment programs under part V[,] and such other requirements as the Secretary determines appropriate"; or if the State "has not taken the actions the Secretary determines necessary to implement . . . the requirements set forth in subtitles A and C" of Title I; then Section 1321(c) requires "the Secretary shall . . . establish and operate such Exchange within the State . . . ." PPACA § 1321.

Portions of the PPACA may not be models of clear legislative drafting, but the provisions authorizing tax credits for the purchase of qualified health insurance plans are abundantly clear. Tax credits are only authorized for qualifying coverage, and such coverage must be obtained through an Exchange "established by the State under section 1311." This language identifies two conditions for the issuance of tax credits—that the Exchange is established "by the State" and that it is established "under section 1311"—each of which requires purchase of the qualifying health coverage in a state-established Exchange. The remainder of the statute supports the plain language of the tax credit provisions. *See* Jonathan Adler & Michael Cannon, Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA, 23 Health Matrix J. L. Med. 1, 119 (2013) ("Adler & Cannon").

B. There Is Widespread Agreement that the Text's Meaning Is Plain

Notably, there is little disagreement within the legal and policy communities on the plain meaning of these provisions. The non-partisan Congressional Research Service, for example, acknowledges that the tax-credit eligibility provisions are clear. Cong. Res. Serv., Legal Analysis of Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act (Jul. 23, 2012) ("a strictly textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS's authority to issue the premium tax credits is limited only to situations in which the taxpayer is enrolled in a state-established

exchange. Therefore, an IRS interpretation that extended tax credits to those enrolled in federally facilitated exchanges would be contrary to clear congressional intent, receive no *Chevron* deference, and likely be deemed invalid"). Even defenders of the IRS rule have acknowledged the statute's eligibility rules "clearly say" that tax credits are authorized only for those who buy health insurance through state-established Exchanges. *See, e.g.*, Timothy Jost, *Yes, the Federal Exchanges Can Offer Premium Tax Credits* (Sep. 11, 2011), http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

Indeed, in its own regulations HHS has recognized that an Exchange established by the Secretary under Section 1321 of the Act is *neither* an Exchange "established by the State" nor is it "established . . . under Section 1311." *See* 45 C.F.R. 155.20 (defining a "federally facilitated Exchange" as meaning "an Exchange established and operated *within* a State by *the Secretary* under *section 1321(c)(1)* of the Affordable Care Act") (emphases added). Thus did Congress condition the availability of premium-assistance tax credits on states taking each of the actions specified in Section 1321, including but not limited to the establishing of Exchanges.

When the IRS promulgated the regulation purporting to authorize the issuance of tax credits and cost-sharing subsidies for the purchase of qualified health insurance plans in federal Exchanges, it did not identify any statutory language to justify its interpretation. There is a simple explanation for this: there is no supporting language. In the absence of such language, the IRS lacks the authority to extend tax credits where Congress has failed to do so. As the Supreme Court has been repeatedly forced to explain, "[i]t is axiomatic than an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988).

C. The PPACA Precludes IRS's Deviation from the Plain Meaning of the Text

After IRS promulgated its final rule, some federal officials attempted to offer *post hoc* rationales for its deviation from the statutory text. *Amici* here address the two most prominent, in turn.

1. The Purported Equivalence Between State and Federal Exchanges

A common rationale is that a federal Exchange stands in the shoes of a state one and so should be treated in the same manner. But the language in Section 1321 requiring the Secretary to establish and operate "such exchange within the State" does not establish an equivalence between state and federally facilitated Exchanges. A federal Exchange created under Section 1321 is subject to the same regulatory requirements as a state Exchange created under Section 1311, but the two remain distinct. As noted above, Section 1311 expressly requires that an authorized Exchange must be "established by a State," 42 U.S.C. § 18031(d)(1), and Section 1304(d) also expressly defines "State" as "each of the 50 States and the District of Columbia." 42 U.S.C. § 18024(d). Section 1321 also recognizes that federal Exchanges are distinct. It provides, "the Secretary shall . . . establish and operate such Exchange within the State *and the Secretary shall take such actions as are necessary to implement such other requirements*," a reference to the requirements of Title I of the PPACA, which include those limiting tax-credit eligibility to states that establish Exchanges. PPACA § 1321 (emphasis added). Later amendments to the PPACA provide that Exchanges created by territories are to be treated as the equivalent of state-run Exchanges, but there is no such language concerning federally run Exchanges. 42 U.S.C. § 18043(a). *See also* 26 U.S.C. § 36B(f)(3) (mentioning Section 1311 and Section 1321 Exchanges separately). If the language of Section 1321 made federal Exchanges the equivalent of Section 1311 Exchanges, there would have been no reason to adopt this

additional language in the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, § 1004, 124 Stat. 1029, 1035 (2010) ("HCERA").

Even assuming *arguendo* that a Section 1321 Exchange is the equivalent (or "stands in the shoes") of a Section 1311 Exchange, that still does not justify the extension of tax credits in federal Exchanges. This is because, as noted above, when Section 1401 defines the coverage for which tax credits may be provided, it identifies two relevant conditions: (1) that the insurance is purchased in a Section 1311 Exchange, and (2) that the insurance is purchased in an Exchange "established by the State." So even if one were to read the reference to an Exchange "established . . . under Section 1311" as incorporating those established by the federal government under Section 1321, this would not make such an Exchange one "established by the State" as expressly and repeatedly required by Section 1401.

2. Reporting Requirements

Federal officials have argued, as well, that Congress indicated its intention to provide tax credits in federal Exchanges by imposing reporting requirements on both state and federal Exchanges that include a requirement to report information related to tax credit payment and eligibility. This argument also fails, for at least four reasons.

First is the statutory text. The information reporting provisions make express reference to both Section 1311 and Section 1321 Exchanges. 26 U.S.C. § 36B(f)(3). The fact that the authors of the HCERA felt the need to expressly identify both Section 1311 and Section 1321 Exchanges shows that the two are not equivalent. If the "such exchange" language noted above were sufficient to make a Section 1321 Exchange equivalent to a Section 1311 Exchange in all respects, it would have been unnecessary to mention both.

Second, the relevant HCERA provisions require substantial reporting of information that will be of use to federal authorities even apart from the provision of tax credits, including the level of coverage obtained and premiums charged. Insofar as the PPACA is designed to encourage states to create their own Exchanges, the collection of information in federal Exchanges indicating the level of tax credits or subsidies for which individuals would be eligible under a state Exchange would be useful. Such reporting certainly does not suggest that Congress intended to neutralize the powerful incentive to states to establish their own Exchanges—quite the opposite, it lets the states know that they are leaving money on the table and should get with the program.

Third, even were this not the case, providing a single list of reporting requirements for all Exchanges is easier and more efficient than trying to separately delineate what information must be reported by what sort of Exchange. Such a provision does not even speak to any equivalence between state and federal Exchanges in other respects, such as the availability of subsidies.

Fourth, Congress applied these reporting requirements to "[e]ach Exchange," encompassing both American Health Benefits Exchanges, where the relevant tax credits are available, and Small Business Health Options Program or ''SHOP" Exchanges, in which the relevant tax credits are not available. 26 U.S.C. § 36B(f)(3); 42 U.S.C. § 18031(b). The adoption of these reporting requirements therefore cannot establish that tax credits and cost-sharing subsidies are available in *all Exchanges* subject to these requirements.

* * *

In sum, the plain text of the PPACA clearly provides that premium-assistance tax credits are only available for the purchase of qualified health insurance plans in state-established

Exchanges. This text is unambiguous and fully consistent with all of the relevant statutory provisions.

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

Nothing in the statute or legislative history should lead the Court to doubt the plain meaning of the statutory text. To the contrary, all of the relevant provisions of the PPACA and the statute's legislative history are fully consistent with the plain meaning of Section 36B. *See generally* Adler & Cannon, *supra*, at 142-65. When promulgating this regulation, the IRS failed to cite any legislative history in support of its interpretation. There is none.

A. The Legislative History Demonstrates That, Consistent with the Statutory Text's Plain Meaning, Congress Intended Subsidies To Induce the States To Establish Exchanges

Supporters of comprehensive health reform had begun to coalesce around broad reform principles by late 2008, though disagreements about key elements, such as the role states could or should play in any reforms, remained. These disagreements would continue throughout the development of the various legislative proposals, including the Senate bill that would eventually become the PPACA. The legislation that eventually passed reflects numerous compromises and an ultimate decision that enacting a bill that many supporters considered to be flawed was better than not passing any bill at all.

Senate Finance Committee Chairman Max Baucus (D-MT) was one of the primary authors of the bill containing the Exchange and premium-assistance tax-credit provisions that would become law under the PPACA. *See* Kate Pickert, Max Baucus, Obamacare Architect, Slams Healthcare.gov Rollout, TIME.com (November 6, 2013) (describing Baucus as "a key architect of the law" and quoting Baucus, "I spent two years of my life working on the Affordable Care Act"). In November 2008, Baucus released a "white paper" that, among other

things, proposed a health-insurance tax credit for certain small businesses and a "nationwide insurance pool called the Health Insurance Exchange." *See* Senator Max Baucus, Call to Action: Health Reform 2009, Senate Finance Committee White Paper (Nov. 12, 2008).

Senator Baucus modeled his small-business tax credit proposal on a bipartisan bill that had been referred to the Finance Committee in 2008, which conditioned credits on states establishing Exchanges and enacting other health insurance laws. *See* Small Business Health Options Program Act, S. 2795, 110th Cong. (2nd Sess. 2008) (offering tax credits to "'qualified small employers" that "purchas[e] health insurance coverage for [their] employees in a small group market in a State which . . . maintains a State-wide purchasing pool that provides purchasers in the small group market a choice of health benefit plans, with comparative information provided concerning such plans and the premiums charged for such plans made available through the Internet"); Baucus, Call to Action, *supra*, at 20 ("Initially, the credit would be available to qualifying small businesses that operate in states with patient-friendly insurance rating rules."); *id*. at 32 n.10.

In 2009, Baucus continued to model his proposal on a re-introduced version of S. 2795 called the Small Business Health Options Program Act of 2009 (S. 979). *See* Small Business Health Options Program Act of 2009, S. 979, 111th Cong. (1st Sess. 2009) (identical language to S. 2795). *See also* Senator Max Baucus, Description of Policy Options – Expanding Health Care Coverage: Proposals to provide affordable coverage to all Americans, S. Comm. Fin. White Paper (May 14, 2009) ("Micro-groups (2-10 employees) could purchase insurance through the Health Insurance Exchange immediately. The remainder of small employers can purchase through the Health Insurance Exchange once the federal rating rules are fully phased in by their state."); S. Comm. Fin., Framework for Comprehensive Health Reform 3 (Sept. 8, 2009)

(proposing small-business tax credits available through "a SHOP exchange modeled after S. 979, the 'Small Business Health Options Program Act'"); S. Comm. Fin., America's Healthy Future Act, Chairman's Mark (Sept. 22, 2009) ("If a State has not yet adopted the reformed rating rules, qualifying small employers in the state would not be eligible to receive the credit"); America's Healthy Future Act of 2009, S. 1796, 111th Cong. 182-83 (1st Sess. 2009) ("STATE FAILURE TO ADOPT INSURANCE RATING REFORMS.—No credit shall be determined under this section with respect to contributions by the employer for any qualified health benefits plans purchased through an exchange for any month of coverage before the first month the State establishing the exchange has in effect the insurance rating reforms described in subtitle A of title XXII of the Social Security Act"); S. Rep. No. 111-89 (2009) ("If a State has not yet adopted the reformed rating rules, qualifying small business employers in the State are not eligible to receive the credit").

Supporters disagreed over whether health insurance Exchanges should be state-operated. Many observers, including state officials, favored a system of 50 state-run Exchanges rather than a single, nationwide Exchange operated by the federal government. *See* Adler & Cannon, *supra*, 148-49 n.107; *see also* NAIC Ltr. to Speaker Pelosi and Majority Leader Reid (Jan. 6, 2010) ("We urge Congress to take advantage of state expertise, experience, and resources in implementing this legislation by ensuring that states retain primary responsibility for regulating the business of insurance and that health insurance Exchanges be established and administered at the state level with the flexibility to meet the needs of our local markets and consumers."). Key U.S. senators also favored state-run Exchanges. *See* Patrick O'Connor & Carrie Brown, Nancy Pelosi's Uphill Health Bill Battle, Politico (Jan. 9, 2010) ("Two key moderates—Sen. Ben Nelson (D-Neb.) and Sen. Joe Lieberman (I-Conn.)—have favored the state-based exchanges

over national exchanges."). *See also* Reed Abelson, Proposals Clash on States' Roles in Health Plans, N.Y. Times (Jan. 13, 2010) ("The state-federal divide between the House and Senate could be a difficult gap to bridge. One possible compromise would be to have a federal exchange set up alongside the state exchanges. Senator Ben Nelson, Democrat of Nebraska, is a former governor, state insurance commissioner and insurance executive who strongly favors the state approach. His support is considered critical to the passage of any health care bill."); Carrie Brown, Nelson: National Exchange a Dealbreaker, Politico (Jan. 25, 2010).

Washington & Lee University law professor Timothy Jost was a frequent participant in the health care reform debate who appears to have had some influence over the process. Press Release, W&L Law's Jost Invited to Health Care Bill Signing Ceremony (March 23, 2010), http://law.wlu.edu/news/storydetail.asp?id=758 (quoting Jost as having attended the ceremony with "secretaries and Congress people and various other leaders who had worked on the bill"). In early 2009, Jost noted a problem Congress would encounter if it chose state-run Exchanges, and offered a solution that mirrored the approach taken by S. 2795 and Baucus's white paper with regard to small-business tax credits:

> The Constitution has been interpreted to preclude Congress from passing laws that "commandeer" the authority of the states for federal regulatory purposes. That is, Congress cannot require the states to participate in a federal insurance exchange program by simple fiat. This limitation, however, would not necessarily block Congress from establishing insurance exchanges. Congress could invite state participation in a federal program, and provide a federal fallback program to administer exchanges in states that refused to establish complying exchanges. Alternatively it could exercise its Constitutional authority to spend money for the public welfare (the "spending power"), either *by offering tax subsidies for insurance only in states that complied with federal requirements (as it has done with respect to tax subsidies for health savings accounts)* or by offering explicit payments to states that establish exchanges conforming to federal requirements.

Timothy Jost, O'Neill Institute Legal Solutions in Health Reform, Health Insurance Exchanges: Legal Issues 7 (2009) (emphasis added). As Jost observed, conditioning tax credits or other benefits on state cooperation could induce otherwise reluctant states to establish health insurance Exchanges in accordance with federal requirements.

By late 2009, the authors of both leading Senate bills had abandoned the idea of a single, nationwide Exchange in favor of 50 state-run Exchanges, with the federal government operating Exchanges only in those states that declined to do so. *See, e.g.,* S. Comm. Fin., Framework for Comprehensive Health Reform (Sept. 8, 2009); *see also* S. Comm. Fin., America's Healthy Future Act, Chairman's Mark, (Sept. 22, 2009). The Finance Committee-reported bill expressly conditioned its "premium-assistance credits" on the recipient having enrolled in a health plan "through an exchange established by the State." America's Healthy Future Act of 2009, S. 1796, 111th Cong., 147, 152 (1st Sess. 2009) (specifying that the "premium assistance amount" can only be calculated using premiums from qualified health plans offered in "an Exchange established by the State"; and further providing that taxpayers are eligible for tax credits only during "coverage months," defined by cross-reference as months during which the taxpayer is enrolled in a qualified health plan purchased through "an exchange established by the State"). The bill of the U.S. Senate Committee on Health, Education, Labor, & Pensions ("HELP Committee") revoked "premium credits" from taxpayers who had already been receiving them if their state's "gateways" (i.e., Exchanges) fell out of compliance with federal requirements. Affordable Health Choices Act, S. 1679, 111th Cong. § 3104(b) (2009). This bill also permanently withheld credits from all residents until their state enacted legislation implementing the bill's employer mandate. *Id*. at § 3104(d) (2009). *See also* Adler & Cannon, *supra*, at 154-155.

The decision to condition tax credits on states establishing Exchanges and enacting various health insurance regulations solved an additional problem confronting the Finance Committee. The Finance Committee does not have jurisdiction over non-group health insurance markets. *See* Senate Finance Committee, Jurisdiction, http://www.finance.senate.gov/about/jurisdiction/, accessed November 16, 2013 (jurisdiction includes various government health insurance programs, "health and human services programs financed by a specific tax or trust fund," and "ERISA group health plans"). Such matters lie within the jurisdiction of the HELP Committee. *See* Senate Health, Educ., Labor, and Pensions Comm., About the HELP Committee, http://www.help.senate.gov/about/, accessed November 16, 2013 (jurisdiction broadly includes "[m]easures relating to education, labor, health, and public welfare"). It was not sufficient for the Finance Committee to direct the federal government to establish Exchanges whenever states failed to do so. Such a provision may have avoided an unconstitutional commandeering, but the Committee would still lack jurisdiction to legislate in the area of non-group health insurance in the first place. Tax credits, however, are within the Finance Committee's jurisdiction, as are the conditions Congress imposes on them. Conditioning tax credits on states establishing Exchanges therefore created a jurisdictional hook that enabled the Finance Committee to legislate in an area that would otherwise lie beyond its reach.[2]

[2] *See* Executive Committee Meeting to Consider Health Care Reform: Before the Senate Committee on Finance, 111th Cong. 326 (2009), http://www.finance.senate.gov/hearings/hearing/download/?id=c6a0c668-37d9-4955-861c-50959b0a8392 (Sen. Baucus explains, in response to an objection by Sen. John Ensign (R-NV), that the Finance Committee has jurisdiction to direct states to establish Exchanges and enact other health-insurance measures because the bill "conditions" tax credits on same). Note the official transcript erroneously quotes Baucus as saying, "Taxes *aren't* the jurisdiction of this committee." Video of the markup shows Baucus correctly said "are in." Executive Committee Meeting to Consider an Original Bill Providing for Health Care Reform: Before the S. Comm. on Finance, C-SPAN (starting at 2:53:21) (Sept. 23, 2009), http://www.c-

When Senate leaders merged the Finance and HELP bills to create the PPACA, they retained the Finance Committee's language restricting eligibility for "premium-assistance tax credits" to taxpayers in states that establish Exchanges. Indeed, at the same time the PPACA's authors dropped the Finance Committee language conditioning *small-business* tax credits on states enacting certain health-insurance laws, they *strengthened* the language conditioning premium-assistance tax credits on states establishing an Exchange. *Compare* America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 1205 *with* PPACA § 1401 and 26 U.S.C. § 36B (cross-reference in "coverage months" definition augmented with explicit requirement that tax credit recipients be enrolled in a qualified health plan "through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act"). The Senate approved the PPACA on December 24, 2009. U.S. Senate Roll Call Votes 111th Congress - 1st Session, H.R. 3590 (Patient Protection and Affordable Care Act) (December 24, 2009), http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396.

The Senate bill differed in that respect from the House's competing legislation. The House had already passed a bill creating a single, nationwide Exchange administered by the federal government. Affordable Health Choices for America Act, H.R. 3962, 111th Cong. (1st Sess. 2009). Like the HELP bill, the House bill would have allowed states to operate Exchanges, generally allowed health-insurance subsidies through either type of Exchange, and contained explicit language creating full equivalence between Exchanges operated by states and the federal government. *See* Adler & Cannon, *supra*, at 159.

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spanvideo.org/program/289085-4. This material error appears uncorrected in the government's Exhibit 30.

Many House members disapproved of the Senate bill's approach to Exchanges. In a letter to the President and the House leadership, for example, 11 members from Texas noted that their state had failed to take advantage of a conditional benefit Congress had offered under the Children's Health Insurance Program Reauthorization Act of 2009, leaving the intended beneficiaries of that law "no better off." The letter's authors warned that under the Senate bill, residents of recalcitrant states likewise would be left "no better off." U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans, My Harlingen News (Jan. 11, 2010) ("A state-based plan . . . relies on laggard state leadership that, in Texas, would be unwilling or unable to administer the exchange, leaving millions of Texans no better off . . . . Not one Texas child has yet received any benefit from the Children's Health Insurance Program Reauthorization Act (CHIPRA), which we all championed, since Texas declined to expand eligibility or adopt best practices for enrollment . . . . The Senate approach would produce the same result—millions of people will be left no better off than before Congress acted."). *See also* Julie Rovner, House, Senate View Health Exchanges Differently, Nat'l Public Radio (Jan. 12, 2010) (the letter's authors "worry that because leaders in their state oppose the health bill, they won't bother to create an exchange, leaving uninsured state residents with no way to benefit from the new law").

In a special election for the U.S. Senate on January 19, 2010, Massachusetts voters placed in the Senate Scott Brown, who had vowed to join a filibuster of any compromise between the House bill and the PPACA. With Brown's election, the prospect of enacting anything but the PPACA disappeared. *See* Michael Cooper, G.O.P. Senate Victory Stuns Democrats, New York Times (January 19, 2010), http://www.nytimes.com/2010/01/20/us/politics/20election.html ("Mr. Brown has vowed to oppose the bill, and once he takes office the Democrats will no longer control the 60 votes in the Senate needed to overcome filibusters"). Following Senator Brown's

election, the *only* way Congress could enact a comprehensive health reform bill was if the House accepted the PPACA—including the PPACA's language conditioning premium-assistance tax credits on states establishing Exchanges. In other words, the choice for health care reform supporters was either a Senate bill that many found unsatisfactory or no bill at all.

The House approved the PPACA on March 21, 2010, after receiving assurances the Senate would approve the limited changes the House planned to make to the PPACA bill through the Health Care and Education Reconciliation Act. Pub. L. No. 111-152, § 1204, 124 Stat. 1029, 1055-56 (2010) ("HCERA"). Because the HCERA would be passed by the Senate through the reconciliation process, the range and types of amendments that could be offered to the bill were limited. *See generally* Cong. Res. Serv., The Budget Reconciliation Process: The Senate's "Byrd Rule" (July 2, 2010), *available at* https://opencrs.com/document/RL30862/ (explaining how Senate rules governing the budget-reconciliation process generally disallow legislative provisions not related to deficit reduction, and the reasons House and Senate leaders chose the reconciliation "sidecar" strategy for enacting the PPACA). In other words, health care reform supporters lacked the votes to enact changes many might have wanted. And in particular, due to Senate rules, it would not have been possible in the reconciliation process to provide authority for tax credits in federally established health insurance exchanges. *See* Declaration of Douglas Holtz-Eakin ¶¶14-16. The President signed the PPACA into law on March 23, 2010, and signed the HCERA one week later.

The HCERA amended PPACA § 1401, 26 U.S.C. § 36B, seven times, but it did not alter the law's tax-credit eligibility rules. *See* Adler & Cannon, *supra*, at 162-163. Among other changes, the HCERA provided that Exchanges established by U.S. territories would be treated as if they had been established by states. HCERA § 1204, 124 Stat. at 1055-56 ("A territory that

elects . . . to establish an Exchange in accordance with part II of this subtitle and establishes such an Exchange in accordance with such part shall be treated as a State for purposes of such part."). No amendment was adopted to create equivalence between state-established Exchanges and federal Exchanges.

As noted above, the HCERA also imposed certain reporting requirements on "[e]ach Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act)." HCERA § 1004, 124 Stat. at 1035; PPACA § 1401 (adding § 36B(f) to Title 26). Of note, this amendment separately identified both Section 1311 Exchanges and Section 1321 Exchanges, reflecting the understanding that these two types of Exchanges are legally distinct. Were Exchanges established by a state under Section 1311 and federally facilitated Exchanges created under Section 1321 equivalent, as the government now claims, there would have been no need to identify them separately.

Some PPACA supporters may have *preferred* to authorize tax credits through both state-run and federal Exchanges, but like many proposals that could not command enough votes to pass the Senate, this was no longer an option. *See, e.g.,* Shailagh Murray and Lori Montgomery, Deal on health bill is reached (December 20, 2009), http://articles.washingtonpost.com/2009-12-20/politics/36866199_1_health-bill-gop-yields-government-insurance-option ("Many liberals, however, were bitterly disappointed with the bargains [Senate Majority Leader Harry] Reid [D-NV] struck to win support from moderates in his caucus, any member of which could demand alterations in exchange for his or her support. Democratic leaders dropped a government insurance option and the idea of expanding Medicare to younger Americans. Reid also omitted language that would have eliminated the federal antitrust exemption for health insurers—another

nonstarter for [Senator Ben] Nelson [D-NE].”). The choice faced by health care reform supporters was between a bill many found inadequate and no bill at all. *See* Letter from Henry J. Aaron, Senior Fellow, The Brookings Institution, et al. to Nancy Pelosi, Speaker of the House, et al. (Jan. 22, 2010), available at http://www.newrepublic.com/blog/the-treatment/47-health-policy-experts-including-me-say-sign-the-senate-bill (51 signatories, including “long-standing advocates of progressive causes” and others who “are nonpartisan or identify as political moderates,” acknowledged that the PPACA is “imperfect” but urged House leaders to “adopt the Senate bill, and the President must sign it”). *See generally,* Kate Nocera, Bill Clinton: Obamacare was ‘Best Bill You Could have Passed’, Politico (Feb. 8, 2013), http://www.politico.com/story/2013/02/bill-clinton-obamacare-was-best-bill-you-could-have-passed-87380.html (quoting former President William Clinton telling Democratic congressional caucuses the PPACA “was the best bill you could have passed in the Congress under the circumstances given the filibuster problem in the Senate”).

The federal government would like this Court to believe that the language limiting tax credits and subsidies to state-run Exchanges is a mistake, perhaps even a drafting error. The mistake, if there was one, was not that the text of the PPACA somehow failed to capture congressional intent, but that Congress failed to anticipate the widespread rejection by states of the role the law had assigned them.

As was widely reported at the time of the PPACA’s enactment, PPACA proponents were confident that all states would establish Exchanges and never even contemplated the possibility that numerous states would refuse. *See* Remarks on Health Insurance Reform in Portland, Maine, 2010 Daily Comp. Pres. Doc. 220 (Apr. 1, 2010) (quoting President Barack Obama, ‘‘by 2014, each state will set up what we’re calling a health insurance exchange”). *See also* Dep’ts of Labor,

Health & Human Servs, Educ., & Related Agencies Appropriations for 2011, Hearing Before a Subcommittee on Appropriations, House of Representatives, 111th Cong. 171 (Apr. 21, 2010) (statement of Kathleen Sebelius, Secretary, Department of Health & Human Services), http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg58233/pdf/CHRG-111hhrg58233.pdf (''We have already had lots of positive discussions, and States are very eager to do this. And I think it will very much be a State-based program.''). *See also* Robert Pear, U.S. Officials Brace for Huge Task of Operating Health Exchanges, N.Y. Times (Aug. 4, 2012) ("When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange . . . running them [is] a herculean task that federal officials never expected to perform"). *See also* Tom Howell Jr., After Obamacare Health Exchange Deadline Passes, 26 States Opt In with Feds, Wash. Times (Feb. 16, 2013), http://www.washingtontimes.com/news/2013/feb/16/after-obamacarehealth-exchange-deadline-passes-26/?page=all (''The Obama administration says it will be ready to run exchanges in more than half of the states . . . . 'It's not what the drafters of the bill had hoped would happen,' Timothy S. Jost, a professor at Washington and Lee University School of Law who specializes in health care, said of the outcome on Friday.''). *See also* Ezra Klein and Sarah Kliff, Obama's Last Campaign: Inside the White House Plan to Sell Obamacare, Wash. Post (July 17, 2013) (noting an "internal White House memo" detailing obstacles to PPACA implementation did not even identify "political opposition or widespread state resistance" as potential hurdles). When the President signed the PPACA into law "there was widespread expectation [states] would want to operate the new insurance exchanges." *Id.*

Indeed, the assumption that states would create their own Exchanges as called for by the PPACA was nearly universal among the PPACA's supporters in Congress and the executive. *But*

see U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans, My Harlingen News, Jan. 11, 2010 (warning that Texas, for one, might not cooperate with the PPACA's approach to Exchanges). The Congressional Budget Office scored the PPACA without considering whether tax credits would be limited to state-run Exchanges, but that was because it also scored the bill as if federal government would not have to spend any money paying to implement federal Exchanges. *See* Adler & Cannon, *supra*, at 186-188. Indeed, the PPACA never authorized money for the creation of federal Exchanges, because bill supporters did not expect that such funds would be necessary. J. Lester Feder, HHS May Have to Get 'Creative' on Exchange, Politico (Aug. 16, 2011, 6:54 PM), http://www.politico.com/news/stories/0811/61513.html ("A quirk in the Affordable Care Act is that while it gives HHS the authority to create a federal exchange for states that don't set up their own, it doesn't actually provide any funding to do so. By contrast, the law appropriates essentially unlimited sums for helping states create their own exchanges. The lack of funding for a federal exchange complicates what is already a difficult task."). This situation is not anomalous. Recent events have shown many PPACA supporters made many misjudgments about how the law would be implemented.

B. Congress Routinely Conditions Federal Benefits On State Action To Induce the States To Carry Out Federal Priorities

The provisions in the PPACA conditioning premium-assistance tax credits on state willingness to establish health insurance Exchanges embody a traditional legislative means of inducing state cooperation. The federal government "may not compel the states to implement, by legislation or executive action, federal regulatory programs." *Printz v. United States*, 521 U.S. 898, 925 (1997). *See also New York v. United States*, 505 U.S. 144, 162 (1992) (''[T]he Constitution has never been understood to confer upon Congress the ability to require States to

govern according to Congress's instructions.''); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012). It can, however, provide various incentives for state cooperation. Accordingly, it is routine for Congress to provide financial incentives to encourage states to enact desired legislation. Such incentives often include direct federal spending, as with the PPACA's expansion of the Medicaid program, but often include tax incentives for state citizens. The following examples of enacted and proposed conditional benefits demonstrate that conditioning federal benefits, in general, and favorable tax treatment for state residents, in particular, is routine and was part of the debate over the PPACA.

1. Medicaid

The largest and best-known example of Congress conditioning direct spending on state laws is the Medicaid program. For 47 years, Congress has conditioned Medicaid grants to states on states enacting and operating a Medicaid program that meets federal specifications. 42 U. S. C. §1396c; *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. at 2601-02. Both the Finance bill and the final PPACA again employed this device with respect to Medicaid. Each conditioned all existing federal Medicaid grants on states expanding their programs to cover all legal residents with incomes below 138 percent of the federal poverty level.[3] America's Healthy Future Act, of 2009, S. 1796, 111th Cong. (1st Sess. 2009); PPACA Section § 2001.

The amount of money Congress originally conditioned on states implementing the PPACA's Medicaid expansion far exceeds the amount it conditioned on states establishing Exchanges. As enacted, the PPACA conditioned all Medicaid grants to states on states' implementing the Act's Medicaid expansion. The tax credits Congress conditioned on states

[3] In *NFIB v. Sebelius*, the Supreme Court ruled that conditioning existing Medicaid grants on states implementing the expansion was coercive and thus unconstitutional. But the court allowed Congress to condition the PPACA's new Medicaid grants on states implementing the expansion. 132 S. Ct. at 2607-08.

establishing Exchanges were small in comparison. *Compare* Office of Management and Budget, Fiscal Year 2014; Historical Tables - Budget of the U.S. Government 163, *available at* http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/hist.pdf (showing federal Medicaid grants to states exceeded $250 billion annually even before the PPACA increased federal Medicaid spending); *and* Cong. Budget Office, The Budget and Economic Outlook: Fiscal Years 2013 to 2023, 16 (2013) (showing Exchange-related subsidies will total just $21 billion in 2014, and will remain less than one-quarter the amount of total federal Medicaid grants through 2023) (with authors' calculations).

This remains the case, even after the Supreme Court's decision in *NFIB v. Sebelius*. *See* 132 S. Ct. at 2607 (allowing states to decline the PPACA's Medicaid expansion without losing the "old" Medicaid grants). The tax credits are comparable to the "new" Medicaid grants that remain conditioned on states implementing the Medicaid expansion. Cong. Budget Office, Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act (March 13, 2012) (showing the "new" Medicaid grants to be roughly equal to the amount the PPACA conditions on states establishing Exchanges).

Indeed, for the first few years, at least, the Medicaid-expansion funds are so substantially larger than the tax credits that it is likely that in 2014, the 25 states that are not implementing the Medicaid expansion will forgo more federal subsidies than the 34 states that have opted not to establish an Exchange. *Compare* Updated Estimates for the Insurance Coverage Provisions, *supra*, at 11, *with* Budget and Economic Outlook, *supra*, at 16.

2. State Children's Health Insurance Program

In 1997, Congress enacted the State Children's Health Insurance Program ("SCHIP"), which conditions federal grants to states on each state's implementation of a health insurance

program for children with low-to-moderate incomes. Congr. Res. Serv., State Children's Health Insurance Program (CHIP): A Brief Overview (March 18, 2009), https://opencrs.com/document/R40444/ ("All states, the District of Columbia, and the five territories have CHIP programs.").

In 2009, Congress reauthorized SCHIP with the Children's Health Insurance Program Reauthorization Act (CHIPRA). *Id*. Over a five-year period, CHIPRA conditioned a total of $100 million in grants on states expanding outreach and enrollment activities, plus $225 million on states taking steps to intended to improve the quality of care for covered children. The Commonwealth Fund, The Children's Health Insurance Program Reauthorization Act: Progress After One Year, States in Action (May 2010).

3. Exchanges

The Finance bill and the PPACA created a financial penalty of sorts to induce states to establish Exchanges. Each bill imposed a "maintenance of effort" ("MOE") requirement that required states to keep their Medicaid-eligibility levels for adults exactly where they were on the date of the bills' enactment. The bills conditioned the lifting of this requirement on states establishing fully operational health insurance Exchanges. *See* S. Rep. No. 111-89 (2009). *See also* Ctrs. for Medicare and Medicaid Servs., State Medicaid Dirctor Letter 11-001, ACA 14 (Feb. 25, 2011), http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11001.pdf ("The MOE provisions in the Affordable Care Act specify that existing coverage for adults under the Medicaid program generally remains in place until the Secretary determines that an Exchange *established by the State under section 1311* of the Affordable Care Act is fully operational, which is likely to be January 1, 2014") (emphasis added). This was not only the same sort of financial incentive as the conditions imposed on

premium-assistance tax credits, but it also had the same object: to encourage states to establish Exchanges.

This approach of encouraging the states to establish Exchanges was not uncommon in the run-up to the PPACA. The Finance bill, the HELP bill, and the PPACA all included incentives for states to establish Exchanges, offering unlimited start-up funds to states who agreed to establish a compliant Exchange. *See* America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 2237(c) (2009); Affordable Health Choices Act, S. 1679, 111th Cong. § 3101(a) (2009); 42 U.S.C. § 18031(a)(2). And HELP Committee Republicans offered an alternative bill that would have conditioned new Medicaid payments to states on states' establishing Exchanges meeting that bill's requirements. Patients' Choice Act, S. 1099, 111th Cong. (1st Sess. 2009).

4. Medical Malpractice Liability Reform

The PPACA adopted language from the Finance bill expressing the "sense of the Senate" that Congress should condition grants to states on states' enacting laws to reform medical malpractice liability. S. Rep. No. 111-89. ("This provision would express the sense of the Senate that (1) health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, (2) states should be encouraged to develop and test alternatives to the current malpractice tort system, and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing malpractice tort system with respect to resolution of malpractice claims."). During the Finance Committee's mark-up of S. 1796, Republican senators offered amendments that would have conditioned new Medicaid grants on states enacting medical malpractice reforms. *Id*.

The PPACA created just such a conditional-grant program, as did the House-passed Affordable Health Choices for America Act. PPACA §10607; Affordable Health Choices for America Act, H.R. 3962, § 2531, 111th Cong. (1st Sess. 2009).

5. Employer Mandate

The HELP Committee bill conditioned its version of premium credits on states enacting laws to implement that bill's employer mandate. *See* Affordable Health Choices Act, *supra*, § 3104(d). *See also* Adler & Cannon, *supra*, at 155-56. Under the HELP bill, Prof. Jost has explained, "[a] state's residents will only become eligible for federal premium subsidies, however, if the state provides health insurance for its state and local government employees." Timothy Jost, Health Insurance Exchanges in Health Care Reform Legal and Policy Issues, Washington and Lee Public Legal Studies Research Paper Series (2009). The bill also revoked premium credits from taxpayers who had already been receiving them if their state fell out of compliance. *See* Affordable Health Choices Act, *supra*, § 3104(b)(2).

6. Health Coverage Tax Credit

Congress also routinely conditions tax preferences on states' enacting certain laws. For example, in 2002, Congress created "health coverage tax credits" (HCTCs) under the Trade Adjustment Assistance Reform Act. 26 U.S.C. § 35. The HCTC pays, through a credit, 72.5 percent of qualified health insurance premiums for certain taxpayers. These credits bear many similarities to the premium-assistance tax credits created by the PPACA in Section 36B. For example, like Section 36B, Section 35(b) uses a concept called a "coverage month" to set eligibility rules for the tax credits it creates. In particular, 26 U.S.C. § 35(e)(2) conditions eligibility for certain individuals on whether states have enacted laws ensuring that their coverage meets certain requirements. *See, e.g.,* Congr. Res. Serv., Health Coverage Tax Credit

Offered by the Trade Act of 2002 at ii (January 31, 2008), http://wlstorage.net/file/crs/RL32620.pdf ("The HCTC can be claimed for only 10 types of qualified health insurance specified in the statute, 7 of which require state action to become effective"); Congr. Res. Serv., Health Coverage Tax Credit (January 5, 2011), http://www.taacoalition.com/sites/default/files/HCTC.pdf.

7. Health Savings Accounts

Since 2004, Congress has allowed qualified individuals to make tax-free contributions to health savings accounts (HSAs), but conditioned those tax benefits on states enacting certain laws. 26 USC § 223(c)(2). Prof. Jost explains:

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

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

8. Small Business Tax Credits

As noted above, in the 110th and 111th Congresses, a bipartisan group of senators, including members of the Finance Committee, sponsored legislation that would create tax credits for certain small businesses. The bills explicitly conditioned tax credits on states creating health insurance Exchanges for small businesses, including the self-employed. S. 2795, *supra*; S. 979, *supra*. Senator Baucus initially used these bills as a model for the small-business tax credit in the Finance Committee bill.

10. A "Public Option"

Finally, the Finance Committee's May 2009 "Description of Policy Options" document proposed encouraging states to establish their own "public option" health plans to compete with private insurers. As a means of encouraging states to create their own "public option," Prof. Jost again proposed that Congress condition tax credits on state compliance: "Tax credits could be offered to subsidize the purchase of insurance, but only in states that implemented a public program." Timothy S. Jost, State Run Programs Are Not A Viable Option For Creating A Public Plan (June 16, 2009), http://law.wlu.edu/deptimages/Faculty/Jost%20State%20Run%20Programs.pdf.

CONCLUSION

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

job in terms of how we crafted the law." NBC News, Watch Chuck Todd's full interview with President Obama (November 7, 2013), http://www.nbcnews.com/video/nbc-news/53492840.

If supporters believe the PPACA's premium-assistance tax credit eligibility rules are flawed, the proper way to repair the statute is through the legislative process. But with this regulation, the IRS has arrogated for itself the power to rewrite a federal statute, triggering federal appropriations and financial penalties beyond those authorized by the legislature. Such "administrative hubris" cannot stand. *See Brungart v. BellSouth Telecommunications, Inc.*, 231 F.3d 791, 797 (11th Cir. 2000). If the IRS can offer premium-assistance tax credits to those who purchase health insurance in federally created Exchanges, there is nothing to stop the IRS from offering them to other ineligible categories of individuals, such as households with income below 100 percent, or above 400 percent, of the Federal Poverty Level, Medicare and VA enrollees, workers with employer-sponsored health insurance, undocumented residents, or even those who purchase health insurance plans that to not constitute qualified health plans. As the IRS can identify no textual or other basis for its rule, it can provide no limit to the power it asserts here.

The decision to limit the availability of premium-assistance tax credits to the purchase of qualified health insurance plans in Exchanges established by states under Section 1311 may or may not have been a sound policy decision. That is not the question before this court. The text of the PPACA clearly and unambiguously provides premium-assistance tax credits for the purchase of qualified health insurance in Exchanges established by states under Section 1311, and only in such Exchanges. The remainder of the PPACA's text and legislative history fully support the plain meaning of the text. As a result, the IRS lacks the authority to provide for tax credits in federally facilitated Exchanges.

November 18, 2013

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, et al., Plaintiffs, v. KATHLEEN SEBELIUS, et al., Defendants.	Case No. 1:13-cv-00623-PLF

DECLARATION OF DOUGLAS HOLTZ-EAKIN

I, Douglas Holtz-Eakin, do hereby declare:

1. From 2003-2005, I was the sixth Director of the non-partisan Congressional Budget Office (CBO), which provides budgetary and policy analysis to the U.S. Congress. During my tenure, CBO assisted Congress as it addressed numerous policies—notably the Medicare prescription drug bill (MMA) and its budgetary consequences.

2. Currently, I am President of the American Action Forum and most recently was a Commissioner on the congressionally-chartered Financial Crisis Inquiry Commission.

3. During 2001-2002, I was the Chief Economist of the President's Council of Economic Advisers (where I had also served during 1989-1990 as a Senior Staff Economist).

4. At various times, I have held positions in several Washington-based think tanks, including the Peter G. Peterson Institute for International Economics (2007-2008), the Maurice R. Greenberg Center for Geoeconomic Studies, and the Council on Foreign Relations (2006). I also have been a visiting Fellow at the American Enterprise Institute, Heritage Foundation, and American Family Business Foundation.

5. I have a distinguished international reputation as a scholar doing research in areas of applied economic policy, econometric methods, and entrepreneurship, including academic appointments at Columbia University in 1985 and Syracuse University from 1990 to 2001. At Syracuse, I became Trustee Professor of Economics at the Maxwell School, Chairman of the Department of Economics and Associate Director of the Center for Policy Research. From 1986 to 2001, I served as a Faculty Research Fellow and Research Associate at the National Bureau of Economic Research.

6. I am recognized as one of the country's leading experts on federal budget and tax policy, national health care reform policy, and CBO's practices and procedures for estimating the budgetary costs of proposed congressional legislation.

7. My work requires me to understand and explain the workings and requirements of the congressional rules for budget reconciliation.

8. The purpose of budget reconciliation is to change substantive law so that revenue and mandatory spending levels are brought into line with budget resolution policies. Reconciliation generally has been used to reduce the deficit through spending reductions or revenue increases, or a combination of the two

9. In the case of the Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010, an accompanying law, the Health Care and Education Reconciliation Act (HCERA), enacted on March 30, 2010, utilized budget reconciliation procedures to ensure initial passage of PPACA and change a number of provisions in that previous law.

10. Amici have asked me to examine the procedural context in which those two laws were enacted and to comment on whether a hypothetical scenario could be plausible and possible under Senate budget rules at that time. The issue is: If congressional leaders were concerned that

PPACA did not authorize premium assistance tax credits for coverage purchased through health insurance Exchanges established by the federal government, and were worried that such federal Exchanges would be needed because some states would fail to establish their own Exchanges, what is the likelihood they could have used HCERA to amend PPACA to provide that premium assistance tax credits would be available to enrollees in federal Exchanges?

11. To be clear, I am not commenting on what the Senate originally intended regarding this issue when it passed its final, revised version of H.R. 3590 on December 24, 2009, which eventually became the final text of the PPACA that was approved by the House of Representatives on March 21, 2010, and signed into law by President Obama on March 23, 2010. Nor am I commenting on the proper legal construction of that statute. Instead, I have been asked to answer a different question: If congressional leaders had become aware *on, shortly before, or after March 23, 2010*, that PPACA did not authorize tax credits in Exchanges established by the federal government, and were concerned that federally established Exchanges would be required because some states would refuse to establish their own Exchanges, would they have been able to use the HCERA to amend the PPACA to authorize tax credits through federal Exchanges given Senate budget reconciliation rules and a united 41-vote opposition? In particular, would CBO have been required first to "rescore" the higher budgetary costs of such a proposal, in light of a new budgetary baseline created by such information?

12. The answer is that the Senate in particular would have been extremely limited, and for practical purposes essentially blocked, in trying to "fix" through the budget reconciliation process any possible problems it (hypothetically) might have discovered regarding lack of authority for distributing federal premium assistance tax credits through federal Exchanges.

13. Such efforts almost certainly would have been challenged through points of order made during consideration of the reconciliation bill on the Senate floor, under well-established precedents for enforcement of the "Byrd rules" for budget reconciliation, as well as the other pay-as-you-go budgetary rules adopted by both the Senate and House in recent years. In particular, any acknowledgment by congressional leaders that some states would not create Exchanges would have triggered the need for CBO to "rescore" its budget baseline after enactment of PPACA. This new baseline would have found that the new law actually cost potentially hundreds of billions of dollars *less than previously scored* for the period from FY 2010 through FY 2019. Relative to this new baseline, the HCERA's attempt to authorize tax credits through federal Exchanges would *increase* outlays and deficits by potentially hundreds of billions of dollars, exposing the HCERA to a potential Byrd-rule point of order. Had congressional leaders signaled that the PPACA gives states the authority to veto major provisions of the law, and at the same time given opponents of the law the means to block their effort to strip states of that veto power, it is almost certain that opponents of the law would have made a Byrd-rule point of order.

14. The Senate in particular would have been hard pressed to overcome a point of order under the Byrd rules by opponents of the legislation. The very reason that budget reconciliation through HCERA was attempted in March 2010 was that Senate Democrats no longer could obtain 60 votes in favor of any changes in the PPACA through regular floor procedures. That same number of votes would be needed to overcome either such a point of order or a ruling of the presiding officer of the Senate that the Byrd rules had been violated (for increasing the budget deficit in budget reconciliation; either in the 10-year budget window from FY 2010-2019, or in the 11th year just beyond it—in FY 2020).

15. The only other option available to Senate backers of such a change in the PPACA's final spending and revenue levels—through budget reconciliation—would have required coming up with hundreds of billions of dollars in "offsetting" budget savings elsewhere from FY 2010 through FY 2019. Based on my experience in analyzing for several decades not only congressional budget policy but also the political and economic context in which it must operate, I conclude that the likelihood of pursuing, let alone succeeding in, that legislative path was virtually zero. This would have required them to find and enact potentially hundreds of billions of dollars in political pain (i.e., new revenue or spending reductions) with no corresponding benefits.

16. Therefore, I find that the HCERA could not practically amend any lack of authority for tax credits in federally established health insurance exchanges. With respect to the authority of such Exchanges, the House and Senate had no practical alternative to enacting the provisions included in the original Senate bill, H.R. 3590, which became the final version of the PPACA.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on this 16 day of November 2013.

Douglas Holtz-Eakin