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Section 1: Moot Court: King v. Burwell

Institute of Bill of Rights Law at The College of William & Mary School of Law

I. Moot Court: *King v. Burwell*

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Halbig v. Burwell

Ruling Below: Halbig v. Sebelius, 2014 WL 129023 (D.D.C. 2014).

Individuals and employers in states that had declined to establish health benefit exchanges under Patient Protection and Affordable Care Act (ACA) brought action challenging Internal Revenue Service (IRS) rule authorizing tax credits for insurance purchased on both state-run and federally-facilitated exchanges. The United States District Court for the District of Columbia entered summary judgment in government's favor, and plaintiffs appealed.

Question Presented: Whether the ACA unambiguously restricts the section 36B subsidy to insurance purchased on Exchanges established by the State as opposed to those established by the Federal government.

Jacqueline HALBIG, et al., Appellants

v.

Sylvia Mathews BURWELL, In her Official Capacity as U.S. Secretary of Health and Human Services, et al., Appellees.

United States Court of Appeals, District of Columbia Circuit

Decided on July 22, 2014

[Excerpt; some footnotes and citations omitted.]

GRIFFITH, Circuit Judge:

Section 36B of the Internal Revenue Code, enacted as part of the Patient Protection and Affordable Care Act (ACA or the Act), makes tax credits available as a form of subsidy to individuals who purchase health insurance through marketplaces—known as "American Health Benefit Exchanges," or "Exchanges" for short—that are "established by the State under section 1311" of the Act. On its face, this provision authorizes tax credits for insurance purchased on an Exchange established by one of the fifty states or the District of Columbia. But the Internal Revenue Service has interpreted section 36B broadly to authorize the subsidy also for insurance purchased on an Exchange established by the federal government under section 1321 of the Act. (hereinafter "IRS Rule").

Appellants are a group of individuals and employers residing in states that did not establish Exchanges. For reasons we explain more fully below, the IRS's interpretation of section 36B makes them subject to certain penalties under the ACA that they would rather not face. Believing that the IRS's interpretation is inconsistent with section 36B, appellants challenge the regulation under the Administrative Procedure Act (APA), alleging that it is not "in accordance with law."

On cross-motions for summary judgment, the district court rejected that challenge, granting the government's motion and denying appellants'. After resolving several threshold issues related to its jurisdiction, the district court held that the ACA's text, structure, purpose, and legislative history make "clear that Congress intended to make premium tax credits available on both state-run and federally-facilitated Exchanges." Furthermore, the court held that even if the ACA were ambiguous, the IRS's regulation would represent a permissible construction entitled to deference under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*

Appellants timely appealed the district court's orders, and we have jurisdiction. Our review of the orders is de novo, and "[o]n an independent review of the record, we will uphold an agency action unless we find it to be 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.' " Because we conclude that the ACA unambiguously restricts the section 36B subsidy to insurance purchased on Exchanges "established by the State," we reverse the district court and vacate the IRS's regulation.

I

Congress enacted the Patient Protection and Affordable Care Act in 2010 "to increase the number of Americans covered by health insurance and decrease the cost of health care." The ACA pursues these goals through a complex network of interconnected policies focused primarily on helping individuals who do not receive coverage through an employer or government program to purchase affordable insurance directly. Central to this effort are the Exchanges. Exchanges are "governmental agenc[ies] or nonprofit entit[ies]" that serve as both gatekeepers and gateways to health insurance coverage. Among their many functions as gatekeepers, Exchanges determine which health plans satisfy federal and state standards, and they operate websites that allow individuals and employers to enroll in those that do. Section 1311 of the ACA delegates primary responsibility for establishing Exchanges to individual states. However, because Congress cannot require states to implement federal laws, if a state refuses or is unable to set up an Exchange, section 1321 provides that the federal government, through the Secretary of Health and Human Services (HHS), "shall ... establish and operate such Exchange within the State." As of today, only fourteen states and the District of Columbia have established Exchanges. The federal government has established Exchanges in the remaining thirty-six states, in some cases with state assistance but in most cases not.

Under section 36B, Exchanges also serve as the gateway to the refundable tax credits through which the ACA subsidizes health insurance. Generally speaking, section 36B authorizes credits for "applicable taxpayer[s]," defined as those with household incomes between 100 and 400 percent of the federal poverty line. But section 36B's formula for calculating the credit works further limits on who may receive the subsidy. According to that formula, the credit is to equal the sum of the "premium assistance amounts" for each

"coverage month." The "premium assistance amount" is based on the cost of a "qualified health plan ... enrolled in through an Exchange established by the State under [section] 1311 of the [ACA]." … In other words, the tax credit is available only to subsidize the purchase of insurance on an "Exchange established by the State under section 1311 of the [ACA]."

But, in a regulation promulgated on May 23, 2012, the IRS interpreted section 36B to allow credits for insurance purchased on either a state- or federally-established Exchange. Specifically, the regulation provided that a taxpayer may receive a tax credit if he "is enrolled in one or more qualified health plans through an Exchange," which the IRS defined as "an Exchange serving the individual market for qualified individuals ..., *regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.* In promulgating this broader rule, the IRS acknowledged that "[c]ommentators disagreed on whether the language in section 36B(b)(2)(A) limits the availability of the premium tax credit only to taxpayers who enroll in qualified health plans on State Exchanges," but asserted without elaboration that "[t]he statutory language of section 36B and other provisions of the [ACA]," as well as "the relevant legislative history," supported its view.

This broader interpretation has major ramifications. By making credits more widely available, the IRS Rule gives the individual and employer mandates—key provisions of the ACA—broader effect than they would have if credits were limited to state-established Exchanges. The individual mandate requires individuals to maintain "minimum essential coverage" and, in general, enforces that requirement with a penalty. The penalty does not apply, however, to individuals for whom the annual cost of the cheapest available coverage, *less any tax credits*, would exceed eight percent of their projected household income. By some estimates, credits will determine on which side of the eight-percent threshold millions of individuals fall. Thus, by making tax credits available in the 36 states with federal Exchanges, the IRS Rule significantly increases the number of people who must purchase health insurance or face a penalty.

The IRS Rule affects the employer mandate in a similar way. Like the individual mandate, the employer mandate uses the threat of penalties to induce large employers—defined as those with at least 50 employees—to provide their full-time employees with health insurance. Specifically, the ACA penalizes any large employer who fails to offer its full-time employees suitable coverage *if* one or more of those employees "enroll[s] ... in a qualified health plan with respect to which an applicable tax credit ... is allowed or paid with respect to the employee." Thus, even more than with the individual mandate, the employer mandate's penalties hinge on the availability of credits. If credits were unavailable in states with federal Exchanges, employers there would face no penalties for failing to offer coverage. The IRS Rule has the opposite effect: by allowing credits in such states, it exposes employers there to

penalties and thereby gives the employer mandate broader reach.

II

Before we can turn to the merits of the parties' dispute, we must first address the government's argument that all appellants lack standing and that, even if they have standing, the APA does not provide them with a cause of action to challenge the IRS Rule. Because we find that appellant David Klemencic has standing and a cause of action under the APA, we do not reach the issue of our jurisdiction over the remaining appellants' claims.

A

The " 'irreducible constitutional minimum' " a plaintiff must show to establish standing is (1) an injury in fact (2) fairly traceable to the alleged conduct of the defendant (3) that is likely to be redressed by the relief the plaintiff seeks." The district court determined that at least one of the appellants, David Klemencic, has standing. Klemencic resides in West Virginia, a state that did not establish its own Exchange, and expects to earn approximately $20,000 this year. He avers that he does not wish to purchase health insurance and that, but for federal credits, he would be exempt from the individual mandate because the unsubsidized cost of coverage would exceed eight percent of his income. The availability of credits on West Virginia's federal Exchange therefore confronts Klemencic with a choice he'd rather avoid: purchase health insurance at a subsidized cost of less than $21 per year or pay a somewhat greater tax penalty.

The government primarily questions whether Klemencic has suffered an injury in fact… The government characterizes Klemencic's injury as purely ideological and hence neither concrete nor particularized. But, although Klemencic admits to being at least partly motivated by opposition to "government handouts," he has established that, by making subsidies available in West Virginia, the IRS Rule will have quantifiable economic consequences particular to him. Those consequences may be small, but even an " 'identifiable trifle' " of harm may establish standing. Klemencic thus satisfies the requirement of establishing an injury in fact, and because that injury is traceable to the IRS Rule and redressable through a judicial decision invalidating the rule, we find that he has standing to challenge the rule. We therefore proceed to consider whether Klemencic may mount his challenge under the APA.

B

The APA provides a cause of action to challenge final agency action "for which there is no other adequate remedy in a court." The government argues that even if Klemencic has standing to challenge the IRS Rule, he cannot do so under the APA because he has an adequate alternative remedy in the form of a tax-refund suit: Klemencic could violate the individual mandate, pay the penalty, and then sue for a refund, raising the same arguments he makes here. Such a remedy is adequate, the government contends, because if Klemencic were successful, the suit would make him financially whole.

The APA "embodies the basic presumption of judicial review" of agency action. Therefore, in determining whether an alternative remedy is adequate, we must give the APA's "generous review provisions" a "hospitable interpretation," such that "only upon a showing of clear and convincing evidence of a contrary legislative intent should the courts restrict access to judicial review." Under this standard, "[a]n alternative remedy will not be adequate ... if the remedy offers only 'doubtful and limited relief' " Although "the alternative remedy need not provide relief identical to relief under the APA," it must "offer[ ] relief of the 'same genre.' "

In arguing that a tax refund suit provides an adequate alternative remedy, the government emphasizes Klemencic's ability to recover any assessed overpayment, plus interest. But that backward-looking relief differs in kind from the prospective relief Klemencic could obtain under the APA. Specifically, requiring Klemencic to proceed via refund suit would deprive him of the opportunity to obtain a "certificate of exemption." Such certificates are a form of safe harbor, allowing an individual to obtain an exemption from the mandate's penalty on the basis of projected income, "notwithstanding any [subsequent] change in an individual's circumstances." Unlike the "prospective[ ]" assurance such certificates offer, a refund suit would require Klemencic to violate the law as it now stands, pay a penalty, and only then challenge the assessment of the penalty for that previous year based on his actual income. And even if Klemencic were to prevail, his relief-financial restitution would be backwards looking, meaning that Klemencic would have to repeat the cycle the following year. The government offers no suggestion that he could obtain a certificate of exemption through a refund action.

Furthermore, it is not clear that Klemencic could obtain any prospective relief through a refund action, let alone that which he seeks under his APA claim—namely, a declaration that the IRS Rule is invalid and an injunction barring its implementation. As we explained in *Cohen v. United States*, the provision authorizing refund suits "does not, at least explicitly, allow for prospective relief." … We must therefore conclude that a tax refund suit is inadequate as an alternative remedy: it is "doubtful" that it offers prospective relief at all, and the monetary relief it does offer is clearly not "of the same genre" as the relief available to appellants under the APA. Because a tax refund suit thus offers Klemencic only "doubtful and limited relief," we hold that the APA provides him with a cause of action to challenge the IRS Rule and turn to the merits of his claim.

III

On the merits, this case requires us to determine whether the ACA permits the IRS to provide tax credits for insurance purchased through federal Exchanges. To make this determination, we begin by asking "whether Congress has directly spoken to the precise question at issue," for if it has, we must give effect to its unambiguously expressed intent. The text of section 36B is only the starting point of this analysis. That provision is but one piece of a vast, complex statutory scheme, and we must consider it

both on its own and in relation to the ACA's interconnected provisions and overall structure so as to interpret the Act, if possible, "as a symmetrical and coherent scheme."

Although both appellants and the government argue that the ACA, read in its totality, evinces clear congressional intent, they dispute what that intent actually is. Appellants argue that if taxpayers can receive credits only for plans enrolled in "through an Exchange established by the State under section 1311 of the [ACA]," then the IRS clearly cannot give credits to taxpayers who purchased insurance on an Exchange established by the federal government. After all, the federal government is not a "State," and its authority to establish Exchanges appears in section 1321 rather than section 1311. The government counters that appellants take a blinkered view of the ACA and that sections 1311 and 1321 of the Act establish complete equivalence between state and federal Exchanges, such that when the federal government establishes an Exchange, it does so standing in the state's shoes. Furthermore, the government argues, whereas appellants' construction of section 36B renders other provisions of the ACA absurd, its own view brings coherence to the statute and better promotes the purpose of the Act.

We conclude that appellants have the better of the argument: a federal Exchange is not an "Exchange established by the State," and section 36B does not authorize the IRS to provide tax credits for insurance purchased on federal Exchanges. We reach this conclusion by the following path: First, we examine section 36B in light of sections 1311 and 1321, which authorize the establishment of state and federal Exchanges, respectively, and conclude that section 36B plainly distinguishes Exchanges established by states from those established by the federal government. We then consider the government's arguments that this construction generates absurd results but find that it does not render other provisions of the ACA unworkable, let alone so unreasonable as to justify disregarding section 36B's plain meaning. Finally, turning to the ACA's purpose and legislative history, we find that the government again comes up short in its efforts to overcome the statutory text. Its appeals to the ACA's broad aims do not demonstrate that Congress manifestly meant something other than what section 36B says.

A

The crux of this case is whether an Exchange established by the federal government is an "Exchange established by the State under section 1311 of the [ACA]." We therefore begin with the provisions authorizing states and the federal government to establish Exchanges. Section 1311 provides that states "shall" establish Exchanges. But, as the parties agree, despite its seemingly mandatory language, section 1311 more cajoles than commands. A state is not literally required to establish an Exchange; the ACA merely encourages it to do so. And if a state elects not to (or is unable to), such that it "will not have any required Exchange operational by January 1, 2014," section 1321 directs the federal government, through the Secretary of Health

and Human Services, to "establish and operate *such Exchange* within the State."

The phrase "such Exchange" has twofold significance. First, the word "such"—meaning "aforementioned,"—signifies that the Exchange the Secretary must establish is the "required Exchange" that the state failed to establish. In other words, "such" conveys what a federal Exchange is: the equivalent of the Exchange a state would have established had it elected to do so. The meaning of "Exchange" in the ACA reinforces and builds on this sense. The ACA defines an "Exchange" as "an American Health Benefit Exchange established under [section 1311 of the ACA]." If we import that definition into the text of section 1321, the provision directs the Secretary to "establish ... such American Health Benefit Exchange established under [section 1311 of the ACA] within the State." This suggests not only that the Secretary is to establish the type of exchange described in section 1311, but also that when she does so, she acts under section 1311, even though her authority appears in section 1321. Thus, section 1321 creates equivalence between state and federal Exchanges in two respects: in terms of what they are and the statutory authority under which they are established.

The problem confronting the IRS Rule is that subsidies also turn on a third attribute of Exchanges: who established them. Under section 36B, subsidies are available only for plans "enrolled in through an Exchange *established by the State* under section 1311 of the [ACA]." Of the three elements of that provision—(1) an Exchange (2) established by the State (3) under section 1311—federal Exchanges satisfy only two: they are Exchanges established under section 1311. Nothing in section 1321 deems federally-established Exchanges to be "Exchange[s] established by the State." This omission is particularly significant since Congress knew how to provide that a non-state entity should be treated as if it were a state when it sets up an Exchange. In a nearby section, the ACA provides that a U.S. territory that "elects ... to establish an Exchange ... shall be treated as a State ." The absence of similar language in section 1321 suggests that even though the federal government may establish an Exchange "within the State," it does not in fact stand in the state's shoes when doing so.

The dissent attempts to supply this missing equivalency by pointing to section 1311(d)(1), which provides: "An Exchange shall be a governmental agency or nonprofit entity that is established by a State." According to the dissent, (d)(1) means that an Exchange established under section 1311 is, by definition, established by a state. Therefore, the dissent argues, because federal Exchanges are established under section 1311, they too, by definition, are established by a state.

The premise that (d)(1) is definitional, however, does not survive examination of (d)(l)'s context and the ACA's structure. The other provisions of section 1311(d) are operational requirements, setting forth what Exchanges must (or, in some cases, may) do. Read in keeping with that theme, (d)(1) would simply require that an Exchange operate as either a governmental agency or nonprofit entity. But the dissent would have

us construe (d)(1) differently. In its view, (d)(1) plays a definitional role unique among section 1311(d)'s otherwise operational provisions, creating a legal fiction that any Exchange is, by definition, established by a state, even when, as a matter of fact, it is not. That reading, however, would render (d)(1) the odd man out twice over: both within section 1311(d) and among the ACA's other definitional provisions, which, unlike (d)(1), employ the (unmistakably definitional) formula of "The term 'X' means...."

The dissent's reading would also require us to overlook the fact that section 1311(d) would be a strange place for Congress to have buried such a legal fiction. Section 1311, after all, concerns Exchanges that are established by states *in fact;* the legal fiction the dissent urges would matter only to Exchanges established by the federal government. To accept the dissent's construction would therefore transform (d)(1) into the proverbial elephant in the mousehole—the "ancillary provision[ ]" that "alter[s] the fundamental details of a regulatory scheme." The Supreme Court has repeatedly held that Congress does not legislate in this manner, and we see no evidence that it did so here. Indeed, we are particularly loath to accept the dissent's construction given that there are far more natural locations to place this fiction, such as section 1321 or the provision defining the term "Exchange."

The dissent's construction of (d)(1) also ignores the structural relationship between sections 1311 and 1321. Just as section 1311(b)(1) assumes that states will establish Exchanges in general, section 1311(d) assumes that states will carry out the specific requirements Exchanges must meet. But if those assumptions prove wrong, section 1321 assigns the federal government responsibility both to establish the Exchange and to ensure that it satisfies the particulars of section 1311(d). In other words, section 1321 creates a limited scheme of substitution: the requirements assigned to states by 1311(d) are transferred to the federal government if a state fails to establish an Exchange. The specific requirement that (d)(1) assumes each state will fulfill is to establish an Exchange in the form of "a governmental agency or nonprofit entity." So if a state elects not to participate in the creation of an Exchange, section 1321 directs the federal government that *it* must create "a governmental agency or nonprofit entity" to serve as the Exchange. Crucially, this construction does not entail ignoring the plain meaning of "established by a State" in section 1311(d)(1); here, section 1321 *tells* us to substitute the federal government for the state under a certain scenario. But there is nothing comparable with respect to section 36B: no analogue to section 1321 says that section 36B should be read to encompass federally-established Exchanges. Accordingly, we reject the dissent's argument that, because federal Exchanges are established under section 1311, they are by definition "established by a State."

Instead, sections 1311 and 1321 lead us to interpret section 36B essentially as appellants do. Those provisions, to be sure, establish some degree of equivalence between state and federal Exchanges—

enough, indeed, that if section 36B had authorized credits for insurance purchased on an "Exchange established under section 1311," the IRS Rule would stand. But section 36B actually authorizes credits only for coverage purchased on an "Exchange *established by the State* under section 1311," and the government offers no textual basis—in sections 1311 and 1321 or elsewhere—for concluding that a federally—established Exchange is, in fact or legal fiction, established by a state. Moreover, as we have noted, that absence is especially glaring given that the ACA elsewhere provides that a federal territory that establishes an Exchange "shall be treated as a State," clearly demonstrating that Congress knew how to deem a non-state entity to be a "State." Thus, at least in light of sections 1311 and 1321, the meaning of section 36B appears plain: a federal Exchange is not an "Exchange established by the State."

B

The government argues that we should not adopt the plain meaning of section 36B, however, because doing so would render several other provisions of the ACA absurd. Our obligation to avoid adopting statutory constructions with absurd results is well-established… But we do not disregard statutory text lightly. The Constitution assigns the legislative power to Congress, and Congress alone, and legislating often entails compromises that courts must respect. We therefore give the absurdity principle a narrow domain, insisting that a given construction cross a "high threshold" of unreasonableness before we conclude that a statute does not mean what it says. A provision thus "may seem odd" without being "absurd," and in such instances "it is up to Congress rather than the courts to fix it," even if it "may have been an unintentional drafting gap."

i

The government first argues that we must uphold the IRS Rule to avoid rendering language in 26 U.S.C. § 36B(f) superfluous. Titled "Reconciliation of credit and advance credit," section 36B(f) requires the IRS to reduce a taxpayer's end-of-year credit by the amount of any advance payments made by the government to the taxpayer's insurer to offset the cost of monthly premiums. As relevant here, section 36B(f) also requires "each Exchange"—*i.e.*, both state and federal Exchanges—to report certain information to the government. With respect to any health plan it provides, an Exchange must report:

> (A) The level of coverage ... and the period such coverage was in effect.
>
> (B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of [the ACA].
>
> (C) The aggregate amount of any advance payment of such credit or reductions....
>
> (D) The name, address, and [taxpayer identification number (TIN)] of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.
>
> (E) Any information provided to the Exchange, including any change of circumstances, necessary to determine

> eligibility for, and the amount of, such credit.
>
> (F) Information necessary to determine whether a taxpayer has received excess advance payments.

The government contends that these reporting requirements assume that credits are available on federal Exchanges, and it argues that the requirements would be superfluous, even nonsensical, as applied to federal Exchanges if we were to reject that assumption.

Not so. Even if credits are unavailable on federal Exchanges, reporting by those Exchanges still serves the purpose of enforcing the individual mandate—a point the IRS, in fact, acknowledged in promulgating a recent regulation. That regulation exempts insurers from 26 U.S.C. § 6055, which otherwise would require that, for each policy they issue, insurers report to the IRS such information as "the name, address, and TIN of the primary insured," the dates of coverage, and the "amount (if any) or any advance payment ... or of any premium tax credit under section 36B with respect to such coverage." The IRS justified the exemption for insurers on the ground that "Exchanges must report on this coverage under section 36B(f)(3)." The government's claim that section 36B(f)(3)'s reporting requirement serves no purpose other than reconciling credits is therefore simply not true.

Furthermore, holding that credits are unavailable on federal Exchanges would not convert the specific reporting requirements concerning credits into an " 'empty gesture.' " Those requirements would still allow the reconciling of credits on state Exchanges; as applied to federal Exchanges, they would simply be over-inclusive. Over-inclusiveness, however, remains a problem even if we were to agree that section 36B allows credits on federal Exchanges. Section 36B(f)(3), after all, mandates reporting "with respect to *any* health plan provided through the Exchange," even though only plans purchased by taxpayers with incomes between 100 and 400 percent of the federal poverty line may be subsidized. A weakness common to both views of the availability of credits hardly serves as a basis for choosing between them.

ii

The government next points to the supposedly absurd consequences appellants' interpretation of section 36B would have for section 1312 of the ACA, which defines the rights of "qualified individuals." The term " 'qualified individual' means, with respect to an Exchange, an individual who—(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange." If this provision is given its plain meaning, then the 36 states with federal Exchanges (that, obviously, the states did not establish) have no qualified individuals. That outcome is absurd, the government argues, because in its view section 1312 restricts access to Exchanges to qualified individuals alone. The absence of qualified individuals would mean that federal Exchanges have no customers and therefore no purpose. The government urges us to avoid this outcome by construing section 1321 to authorize the

federal government to establish Exchanges "*on behalf of* " states that decline to do so.

The government, however, tilts at windmills. It assumes that when section 1312(a) states that "[a] qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible," it means that *only* a qualified individual may enroll in such a plan. The obvious flaw in this interpretation is that the word "only" does not appear in the provision. We have repeatedly emphasized that it is "not our role" to "engage in a statutory rewrite" by "insert[ing] the word 'only' here and there." Section 1312(a)'s actual language simply establishes the right of a qualified individual to enroll in any qualified health plan, at any level of coverage. On this reading, giving the phrase "established by the State" its plain meaning creates no difficulty, let alone absurdity. Federal Exchanges might not have qualified individuals, but they would still have customers—namely, individuals who are not "qualified individuals."

…

iii

The government also claims that a plain meaning reading of section 36B would have peculiar effects under 42 U.S.C. § 1396a(gg)(l). That provision states that, as a condition of receiving Medicaid funds, a State may not tighten its Medicaid eligibility standards for adults until "the date on which the Secretary determines that an Exchange established by the State under [section 1311] is fully operational." If a federally-established Exchange is not one "established by the State," the government argues, states with federal Exchanges "would *never* be relieved of th [is] ... requirement," transforming an "interim measure" into a "perpetual obligation." But appellants propose a logical explanation for why the ACA might establish this rule: to preserve Medicaid benefits for the impoverished residents of states where, as a result of having federally-established Exchanges, subsidies are unavailable. In this light, the results produced by giving section 36B its plain meaning seem sensible, not absurd.

iv

The government urges us, in effect, to strike from section 36B the phrase "established by the State," on the ground that giving force to its plain meaning renders other provisions of the Act absurd. But we find that the government has failed to make the extraordinary showing required for such judicial rewriting of an act of Congress. Nothing about the imperative to read section 36B in harmony with the rest of the ACA requires interpreting "established by the State" to mean anything other than what it plainly says.

C

This conclusion places us at a fork in our precedent. One line of cases instructs us to cease our inquiry and give effect to the statute's unambiguous language. Another tells us to wade into the legislative history in the hope of glimpsing "new light on congressional intent." But, though we recognize that our decision about which path to travel implicates substantial theoretical questions of statutory interpretation, its

practical consequences are less momentous here because both paths lead to the same destination. Therefore, assuming *arguendo* that it is proper to consult legislative history when the statutory text is clear, we consider what light the ACA's history offers.

We begin by clarifying the role the ACA's legislative history might play in our analysis… But legislative history is not the sole, or even the primary, source of such evidence. Rather, "[t]he most reliable guide to congressional intent is the legislation the Congress enacted." Where used, legislative history plays a distinctly secondary role… Instead, only when "apparently plain language compels an 'odd result' " might we look to legislative history to ensure that the " 'literal application of a statute will [not] produce a result demonstrably at odds with the intentions of its drafters.' " Thus, accepting for the sake of argument the government's contention that the results of appellants' construction of section 36B are odd, our inquiry into the ACA's legislative history is quite narrow. In the face of the statute's plain meaning-a federal Exchange is not an "Exchange established by the State"—we ask only whether the legislative history provides evidence that this literal meaning is "*demonstrably* at odds with the intentions" of the ACA's drafters. Unless evidence in the legislative record establishes that it is, we must hew to the statute's plain meaning, even if it compels an odd result.

Here, the scant legislative history sheds little light on the precise question of the availability of subsidies on federal Exchanges. The government points, for example, to a Congressional Budget Office report from November 2009, before the ACA's adoption, that calculated the cost of subsidies based on the assumption that they would be available in all states. But that assumption is as consistent with an expectation that all states would cooperate (*i.e.*, establish their own Exchanges) as with an understanding that subsidies would be available on federal Exchanges as well…

The government and its amici are thus left to urge the court to infer meaning from silence, arguing that "during the debates over the ACA, no one suggested, let alone explicitly stated, that a State's citizens would lose access to the tax credits if the State failed to establish its own Exchange." The historical record, however, belies this claim. The Senate Committee on Health, Education, Labor, and Pensions (HELP) proposed a bill that specifically contemplated penalizing states that refused to participate in establishing "American Health Benefit Gateways," the equivalent of Exchanges, by denying credits to such states' residents for four years. This is not to say that section 36B necessarily incorporated this thinking; we agree that inferences from unenacted legislation are too uncertain to be a helpful guide to the intent behind a specific provision. But the HELP Committee's bill certainly demonstrates that members of Congress at least considered the notion of using subsidies as an incentive to gain states' cooperation.

In any case, even if the historical record were silent, that silence is unhelpful to the government. For the court to depart from the ACA's plain meaning, which favors

appellants, "there must be *evidence* that Congress meant something other than what it literally said," from which the court can conclude that applying the statute literally would be " '*demonstrably* at odds with the intentions of [the ACA's] drafters.' " …

The government, together with the dissent, also leans heavily on a more abstract form of legislative history Congress's broad purpose in passing the ACA-urging the court to view section 36B through the lens of the ACA's economic theory and ultimate aims. They emphasize that to achieve the goals of "near universal coverage" and "lower[ing] health insurance premiums," the ACA relies on three interrelated policies: insurance market reforms prohibiting insurers from denying coverage or charging higher premiums based on an individual's health status; the individual mandate; and subsidies to individuals purchasing insurance in the individual market. These policies, the government and dissent explain, are like the legs of a three-legged stool; remove any one, and the ACA will collapse. The insurance market reforms are necessary to expand the availability of insurance. The individual mandate is necessary to avoid the adverse selection that would result if people could exploit the insurance market reforms to wait to purchase insurance until they were sick. And subsidies are necessary both to make the mandated insurance affordable and, in so doing, to expand the reach of the individual mandate by reducing the cost of insurance below the threshold-eight percent of household income-at which taxpayers are exempt from the mandate's penalty. Given this structure, the government and dissent argue that it is "inconceivable" to think Congress would have risked the ACA's stability by making subsidies conditional on states establishing Exchanges.

Yet the supposedly unthinkable scenario the government and dissent describe—one in which insurers in states with federal Exchanges remain subject to the community rating and guaranteed issue requirements but lack a broad base of healthy customers to stabilize prices and avoid adverse selection—is exactly what the ACA enacts in such federal territories as the Northern Mariana Islands, where the Act imposes guaranteed issue and community rating requirements without an individual mandate. This combination, predictably, has thrown individual insurance markets in the territories into turmoil. But HHS has nevertheless refused to exempt the territories from the guaranteed issue and community rating requirements, recognizing that, "[h]owever meritorious" the reasons for doing so might be, "HHS is not authorized to choose which provisions of the [ACA] might apply to the territories."

…

More generally, the ACA's ultimate aims shed little light on the "precise question at issue," namely, whether subsidies are available on federal Exchanges because such Exchanges are "established by the State." As the Supreme Court has repeatedly warned, "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law" because "no legislation pursues its purposes at all costs." Thus, if legislative intent is to be our lodestar, we cannot assume, as the

government does, that section 36B single-mindedly pursues the ACA's lofty goals.

The fact is that the legislative record provides little indication one way or the other of congressional intent, but the statutory text does. Section 36B plainly makes subsidies available only on Exchanges established by states. And in the absence of any contrary indications, that text is conclusive evidence of Congress's intent. To hold otherwise would be to say that enacted legislation, on its own, does not command our respect—an utterly untenable proposition. Accordingly, applying the statute's plain meaning, we find that section 36B unambiguously forecloses the interpretation embodied in the IRS Rule and instead limits the availability of premium tax credits to state-established Exchanges.

IV

We reach this conclusion, frankly, with reluctance. At least until states that wish to can set up Exchanges, our ruling will likely have significant consequences both for the millions of individuals receiving tax credits through federal Exchanges and for health insurance markets more broadly. But, high as those stakes are, the principle of legislative supremacy that guides us is higher still. Within constitutional limits, Congress is supreme in matters of policy, and the consequence of that supremacy is that our duty when interpreting a statute is to ascertain the meaning of the words of the statute duly enacted through the formal legislative process. This limited role serves democratic interests by ensuring that policy is made by elected, politically accountable representatives, not by appointed, life-tenured judges.

Thus, although our decision has major consequences, our role is quite limited: deciding whether the IRS Rule is a permissible reading of the ACA. Having concluded it is not, we reverse the district court and remand with instructions to grant summary judgment to appellants and vacate the IRS Rule.

EDWARDS, Senior Circuit Judge, dissenting:

This case is about Appellants' not-so-veiled attempt to gut the Patient Protection and Affordable Care Act ("ACA"). The ACA requires every State to establish a health insurance "Exchange," which "shall be a governmental agency or nonprofit entity that is established by a State." The Department of Health and Human Services ("HHS") is required to establish "such Exchange" when the State elects not to create one. Taxpayers who purchase insurance from an Exchange and whose income is between 100% and 400% of the poverty line are eligible for premium subsidies. Appellants challenge regulations issued by the Internal Revenue Service ("IRS") and HHS making these subsidies available in all States, including States in which HHS has established an Exchange on behalf of the State. In support of their challenge, Appellants rely on a specious argument that there is no "Exchange established by the State" in States with HHS-created Exchanges and, therefore, that taxpayers who purchase insurance in these States cannot receive subsidies.

As explained below, there are three critical components to the ACA: nondiscrimination requirements applying to insurers; the "individual mandate" requiring individuals who are not covered by an employer to purchase minimum insurance coverage or to pay a tax penalty; and premium subsidies which ensure that the individual mandate will have a broad enough sweep to attract enough healthy individuals into the individual insurance markets to create stability. These components work *in tandem.* At the time of the ACA's enactment, it was well understood that without the subsidies, the individual mandate was not viable as a mechanism for creating a stable insurance market.

Appellants' proffered construction of the statute would permit States to exempt many people from the individual mandate and thereby thwart a central element of the ACA. As Appellants' *amici* candidly acknowledge, if subsidies are unavailable to taxpayers in States with HHS-created Exchanges, "the structure of the ACA will crumble." It is inconceivable that Congress intended to give States the power to cause the ACA to "crumble."

Appellants contend that the phrase "Exchange established by the State" in § 36B unambiguously bars subsidies to individuals who purchase insurance in States in which HHS created the Exchange on the State's behalf." This argument fails because "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." When the language of § 36B is viewed in context - *i.e.,* in conjunction with other provisions of the ACA-it is quite clear that the statute does not reveal the plain meaning that Appellants would like to find.

The majority opinion ignores the obvious ambiguity in the statute and claims to rest on plain meaning where there is none to be found. In so doing, the majority misapplies the applicable standard of review, refuses to give deference to the IRS's and HHS's permissible constructions of the ACA, and issues a judgment that portends disastrous consequences. I therefore dissent.

I. STANDARD OF REVIEW

The first question a reviewing court must ask in a case of this sort is whether the disputed provisions of the statute are clear beyond dispute. "If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." In determining whether a statutory provision is ambiguous, however, a court must evaluate it within the context of the statute as a whole:

> [A] reviewing court should not confine itself to examining a particular statutory provision in isolation. Rather, the meaning-or ambiguity-of certain words or phrases may only become evident when placed in context.... It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.

When a "court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its

own construction on the statute." Rather, "the question for the court is whether the agency's answer is based on a permissible construction of the statute," that is, whether the agency's interpretation is "manifestly contrary to the statute."

Appellants argue that *Chevron* deference is unwarranted because some of the provisions at issue "are codified in a chapter of Title 42 ... the domain of *HHS,* not the IRS," and the "IRS has no power to enforce or administer those provisions." Appellants' position is mistaken. *Chevron* applies because IRS and HHS are tasked with administering the provisions of the ACA in coordination. Here, there is no issue of one agency interpreting the statute in a way that conflicts with the other agency's interpretation. The IRS's rule defines "Exchange" by reference to the HHS's definition, which provides that subsidies are available to low-income taxpayers purchasing insurance on an Exchange "regardless of whether the Exchange is established and operated by a State ... or by HHS."

Appellants also argue that *Chevron* deference is precluded by the canon that "tax credits 'must be expressed in clear and unambiguous terms.' " Again, Appellants' position is mistaken. The Supreme Court has made clear that "[t]he principles underlying [the] decision in *Chevron* apply with full force in the tax context."

II. ANALYSIS

Appellants' argument focuses almost entirely on 26 U.S.C. § 36B, considered in isolation from the other provisions of the ACA. Repeating the phrase "Exchange established by the State" as a mantra throughout their brief, Appellants contend that this language unambiguously indicates that § 36B(b) conditions refundable tax credits on a *State*—and not *HHS*—establishing an Exchange.

Appellants' argument unravels, however, when the phrase "established by the State" is subject to close scrutiny in view of the surrounding provisions in the ACA. In particular, § 36B has no plain meaning when read in conjunction with § 18031(d)(1) and § 18041(c). And, more fundamentally, the purported plain meaning of § 36B(b) would subvert the careful policy scheme crafted by Congress, which understood when it enacted the ACA that subsidies were critically necessary to ensure that the goals of the ACA could be achieved.

Perhaps because they appreciate that no legitimate method of statutory interpretation ascribes to Congress the aim of tearing down the very thing it attempted to construct, Appellants in this litigation have invented a narrative to explain why Congress would want health insurance markets to fail in States that did not elect to create their own Exchanges. Congress, they assert, made the subsidies conditional in order to *incentivize* the States to create their own exchanges. This argument is disingenuous, and it is wrong. Not only is there no evidence that anyone in *Congress* thought § 36B operated as a condition, there is also no evidence that *any State* thought of it as such. The statutory provision presumes the existence of

subsidies and was drafted to establish a formula for the payment of tax credits, not to impose a significant and substantial condition on the States.

In the end, the question for this court is whether § 36B *unambiguously* operates as a condition limiting the tax subsidies that Congress understood were a necessary part of a functioning insurance market to *only* those States that created their own exchange. The phrase "Exchange established by the State," standing alone, suggests the affirmative. But there is powerful evidence to the contrary—both in § 36B and the provisions it references, and in the Act as a whole-that shows Appellants' argument to be fatally flawed.

It is not the prerogative of this court to interpret the ambiguities uncovered in the ACA. Congress has delegated this authority to the IRS and HHS. And the interpretation given by these agencies is not only *permissible* but also the *better* construction of the statute because § 36B is not clearly drafted as a condition, because the Act empowers HHS to establish exchanges *on behalf of* the States, because parallel provisions indicate that Congress thought that federal subsidies would be provided on HHS-created exchanges, and, most importantly, because Congress established a careful legislative scheme by which individual subsidies were *essential* to the basic viability of individual insurance markets.

A. ***Appellants' "Plain Meaning" Argument Viewed in Context***

We cannot read § 36B in isolation; we must also consider the specific context of the provision and the "broader context of the statute as a whole." And viewing the matter through this wider lens, as we must, the provision which initially might appear plain is far from unambiguous. To begin with, as the Government points out, § 36B refers to premiums for health plans enrolled in through "an Exchange established by the State *under 1311* [*i.e.*, 42 U.S.C. § 18031]." The cross-referenced provision—42 U.S.C. § 18031—contains language indicating that *all* States are required to establish an exchange under the section. In other words, if our statutory universe consisted only of these two provisions, it would be clear that § 36B intended that residents in *all* States would receive subsidies because *all* States were required to create such exchanges by the section of the Act referenced in § 36B.

Of course, the ACA is broader than just § 36B and § 18031, and in 42 U.S.C. § 18041 it permits a State to elect to allow HHS to establish the Exchange on behalf of the State. In such circumstances, however, the Act *requires* HHS to establish and operate "*such* Exchange." The use of "such" can reasonably be interpreted to deem the HHS-created Exchange to be the equivalent of an Exchange created in the first instance by the State.

Indeed, the Act says as much when it defines the term "Exchange" as "a governmental agency or nonprofit entity that is established by a State." It is clear that § 18031 is the source of the definition of the term "Exchange" under the Act. It is also clear that § 18031 defines *every* "Exchange"

under the Act as "a governmental agency or nonprofit entity that is *established by a State*." Because § 18041(c) authorizes the federal government to establish "Exchanges," the phrase "established by the State" in § 18031 must be broad enough to accommodate Exchanges created by the HHS on a State's behalf. Section 36B expressly incorporates this broad definition of "Exchange" when it uses the phrase an "Exchange established by the State *under* [§ 18031]." Therefore, the phrase "established by the State" in § 36B is reasonably understood to take its meaning from the cognate language in the incorporated definition in § 18031, which embraces Exchanges created by HHS on the State's behalf. These provisions belie the "plain meaning" that Appellants attempt to attribute to § 36B.

What is more, Appellants' interpretation of the operative language in § 36B sits awkwardly with the section's structure. Subsection (a) provides tax credits to any "applicable taxpayer," defined in reference to the poverty line and without regard to what the taxpayer's State has or has not done. Subsection (b) then establishes a numerical formula for calculating the amount of the subsidy. It is only in the context of this numerical formula and its definition of "coverage month" that the purported condition is found. If Congress intended to create a significant condition on taxpayer eligibility for subsidies of the sort advocated by Appellants, one would expect that it would say so plainly and clearly. There is no "if/then" or other such conditional language in § 36B.

B. *The Statute Read as a Whole*

1. The "Three–Legged Stool" and the Indispensable Role of the Tax Subsidies

Appellants' interpretation is implausible because it would destroy the fundamental policy structure and goals of the ACA that are apparent when the statute is read as a whole. A key component to achieving the Act's goal of "near-universal coverage" for all Americans is a series of measures to reform the individual insurance market. These measures—nondiscrimination requirements applying to insurers, the individual mandate, and premium subsidies—work *in tandem,* each one a necessary component to ensure the basic viability of each State's insurance market. Because premium subsidies are so critical to an insurance market's sustainability, Appellants' interpretation of § 36B would, in the words of Appellants' *amici,* cause "the structure of the ACA [to] crumble."

This point is essential and worth explaining in detail. The ACA has been described as a "three-legged stool" in view of its three interrelated and interdependent reforms. The first "leg" of the ACA is the "guaranteed issue" and "community rating" provisions, which prohibit insurers from denying coverage based on health status or history, and require insurers to offer coverage to all individuals at community-wide rates. But such nondiscrimination provisions cannot function alone because of the problem of "adverse selection." When insurers cannot deny coverage or charge sick or high-risk individuals higher premiums, healthy people delay purchasing insurance (knowing they will not be denied coverage if and when they

become sick), and insurers' risk pools thus become skewed toward high-risk individuals (as they are the only ones willing to pay the premiums). The result is that insurers wind up paying more per average on each policy, which leads them to increase the community-wide rate, which, in turn, serves only to exacerbate the "adverse selection" process (as now only those who are *really* sick will find insurance worthwhile). This is the so-called "death-spiral," which Congress understood would doom each State's individual insurance market in the absence of a multifaceted reform program.

This is where the individual mandate, the second "leg" of the ACA, comes in. Congress recognized:

> By significantly increasing health insurance coverage, the [individual coverage] requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.

Accordingly, the Act requires each individual who is not covered by an employer to purchase minimum coverage or to pay a tax penalty. But recognizing that individuals cannot be made to purchase what they cannot afford, Congress provided that the mandate would not apply if the cost of insurance exceeds eight percent of the taxpayer's income after subsidies.

The third "leg" of the ACA is the subsidies. The subsidies ensure that the individual mandate will have a broad enough sweep to attract enough healthy individuals into the individual insurance markets to create stability, *i.e.*, to prevent an adverse-selection death spiral. Without the subsidies, the individual mandate is simply not viable as a mechanism for creating a stable insurance market: the lowest level of coverage for typical subsidy-eligible participants will cost 23% of income, meaning that these individuals will be exempt from the mandate. Congress was informed of the importance of the subsidies to the overall legislative scheme. It is thus no surprise that Congress provided generous subsidies in the ACA and, importantly, expressly linked the operation of the individual mandate to the cost of insurance *after* taking account of the subsidies.

If nothing else, it is clear that premium subsidies are an essential component of the regulatory framework established by the ACA. If, as Appellants contend, a State could block subsidies by electing not to establish an Exchange, this would exempt a large number of taxpayers from the individual mandate, cause the risk pool to skew toward higher risk people, and effectively cut the heart out of the ACA. This is one of the points that was made in the joint opinion by Justice Scalia, Justice Kennedy, Justice Thomas, and Justice Alito in *National Federation of Independent Business v. Sebelius*.

This "adverse selection" is precisely what Congress sought to avoid when it enacted the individual mandate.

Section 36B cannot be interpreted divorced from the ACA's unmistakable regulatory scheme in which premium subsidies are an indispensable component of creating viable

and stable individual insurance markets. Due regard for the carefully crafted legislative scheme casts § 36B in a clearer light. "Congress ... does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." If Congress meant to deny subsidies to taxpayers in States with HHS-created Exchanges—thereby initiating an adverse-selection death-spiral that would effectively gut the statute in those States—one would expect to find this limit set forth in terms as clear as day. But the subsection defining which taxpayers are eligible for subsidies make no mention of State-established Exchanges. Subsidies are available to an "applicable taxpayer," and "applicable taxpayer" is defined as any individual whose household income for the taxable year is between 100% and 400% of the poverty line.

2. The Advance Payment Reporting Requirements of § 36B(f)(3)

One of the subsections in § 36B—which is the section upon which Appellants stake their case—makes it clear that Congress intended that taxpayers on HHS-created Exchanges would be eligible for subsidies. Subsection (f), entitled "Reconciliation of credit and advance credit," tasks the IRS with reducing the amount of a taxpayer's end-of-year premium tax credit under § 36B by the sum of any advance payments of the credit. Crucially, subsection (f) establishes reporting requirements that *expressly apply to HHS-created Exchanges.* These reporting requirements mandate that Exchanges provide certain information to the IRS, including the "aggregate amount of any advance payment of such credit"; information needed to determine the taxpayer's "eligibility for, and the amount of, such credit"; and "[i]nformation necessary to determine whether a taxpayer has received excess advance payments." The self-evident primary purpose of these requirements—reconciling end-of-year premium tax credits with advance payments of such credits—could not be met with respect to Exchanges created by HHS on behalf of a State if these Exchanges were not authorized to deliver tax credits. It is thus plain from subsection (f) that Congress intended credits under § 36B to be available to taxpayers in States with HHS-created Exchanges.

In a letter submitted to the court before oral argument, Appellants cited an IRS regulation, 26 C.F.R. § 1.6055–1(d)(1), that addresses information reporting requirements. "In order to reduce the compliance burden on" insurers, the IRS decided not to require insurers "to report under section 6055 for coverage under individual market qualified health plans purchased through an Exchange because Exchanges must report on this coverage under section 36B(f)(3)." Appellants seem to think that this regulation somehow vindicates their view of § 36B(f)(3), but their argument makes no sense. That the IRS determined that additional reporting by insurers in specified circumstances was unnecessary does not imply that Congress drafted § 36B(f)(3) solely to enforce the individual mandate, as Appellants would have it. What is clear here is that § 36B(f)(3)establishes reporting requirements

for the *principal* purpose of requiring disclosure of information concerning advanced payments of tax credits, a purpose which cannot be squared with Appellants' interpretation under which no credits are available on federally-created Exchanges.

3. Other Provisions

There are two other provisions of the ACA that strongly support the Government's claim that the statute, read as a whole, permits taxpayers who purchase insurance in non-electing States to receive subsidies. First, the statute defines a "qualified individual" as a person who "resides in the State that established the Exchange." There is no separate definition of "qualified individual" for States with HHS-created Exchanges. If an HHS-created Exchange does not count as established by the State it is in, there would be no individuals "qualified" to purchase coverage in the 34 States with HHS-created Exchanges. This would make little sense.

Second, in a subparagraph entitled "Assurance of exchange coverage for targeted low-income children unable to be provided child health assistance as a result of funding shortfalls," the ACA requires States to "ensure" that low-income children who are not covered under the State's child health plan are enrolled in a health plan that is offered through "an Exchange established by the State under [§ 18031]." Here again, the statute simply presumes that the existence of such State-established exchanges. The statute's objective of "*assur[ing] exchange coverage for targeted low-income children* " would be largely lost if States with HHS-created Exchanges are excluded. There is nothing in the statute to indicate that Congress meant to exclude benefits for low-income children in the 34 States in which HHS has established an Exchange on behalf of the State.

C. *Appellants' Extraordinary Subsidies–As–Incentive Argument*

The record indicates that, when the ACA was enacted, no State even considered the possibility that its taxpayers would be denied subsidies if the State opted to allow HHS to establish an Exchange on its behalf. Not one. Indeed no State even suggested that a lack of subsidies factored into its decision whether to create its own Exchange. "States were motivated by a mix of policy considerations, such as flexibility and control, and 'strategic' calculations by ACA opponents, not the availability of tax credits." The fact that all States recognized and protested the Medicaid expansion condition, while no State raised any concern over the purported subsidy-condition shows that Appellants' argument is at best fanciful.

The single piece of evidence that Appellants cite to support their claim that Congress intended to restrict subsidies to State-run Exchanges is an article by a law professor. There is no evidence, however, that anyone in Congress read, cited, or relied on this article.

III. CONCLUSION

The Supreme Court has made it clear that "[t]he plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole." We

cannot review a "particular statutory provision in isolation.... It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." Following these precepts and reading the ACA as a whole, it is clear that the statute does not unambiguously provide that individuals who purchase insurance from an Exchange created by HHS on behalf of a State are ineligible to receive a tax credit. The majority opinion evinces a painstaking effort—covering many pages—attempting to show that there is no ambiguity in the ACA. The result, I think, is to prove just the opposite.

The IRS's and HHS's constructions of the statute are perfectly consistent with the statute's text, structure, and purpose, while Appellants' interpretation would "crumble" the Act's structure. Therefore, we certainly cannot hold that that the agencies' regulations are "manifestly contrary to the statute." This court owes deference to the agencies' interpretations of the ACA. Unfortunately, by imposing the Appellants' myopic construction on the administering agencies without any regard for the overall statutory scheme, the majority opinion effectively ignores the basic tenets of statutory construction, as well as the principles of *Chevron* deference. Because the proposed judgment of the majority defies the will of Congress and the permissible interpretations of the agencies to whom Congress has delegated the authority to interpret and enforce the terms of the ACA, I dissent.

King v. Burwell

Ruling Below: King v. Sebelius, 2014 WL 637365 (E.D. Va. 2014).

Virginia residents, not wanting to purchase comprehensive health insurance, brought action challenging Internal Revenue Service (IRS) final rule, which implemented premium tax credit provision of Patient Protection and Affordable Care Act (ACA) by authorizing tax credits to individuals who purchased health insurance on both state-run and federally-facilitated insurance "Exchanges". The United States District Court for the Eastern District of Virginia government's motion to dismiss. Residents appealed.

Question Presented: Whether the IRS's interpretation of the premium tax credit provision of the Patient Protection and Affordable Care Act is contrary to the language of the statute, which Plaintiffs assert authorizes tax credits only for individuals who purchase insurance on state-run Exchanges.

David KING; Douglas Hurst; Brenda Levy; Rose Luck, Plaintiff-Appellants,

v.

Sylvia Matthews BURWELL, in her official capacity as U.S. Secretary of Health and Human Services; United States Department of Health & Human Services; Jacob Lew, in his official capacity as U.S. Secretary of the Treasury; United States Department of the Treasury; Internal Revenue Service; John Koskinen, in his official capacity as Commissioner of Internal Revenue, Defendants–Appellees.

United States Court of Appeals, Fourth Circuit

Decided on July 22, 2014

[Excerpt; some footnotes and citations omitted.]

GREGORY, Circuit Judge:

The plaintiffs-appellants bring this suit challenging the validity of an Internal Revenue Service ("IRS") final rule implementing the premium tax credit provision of the Patient Protection and Affordable Care Act (the "ACA" or "Act"). The final rule interprets the ACA as authorizing the IRS to grant tax credits to individuals who purchase health insurance on both state-run insurance "Exchanges" and federally-facilitated "Exchanges" created and operated by the Department of Health and Human Services ("HHS"). The plaintiffs contend that the IRS's interpretation is contrary to the language of the statute, which, they assert, authorizes tax credits only for individuals who purchase insurance on state-run Exchanges. For reasons explained below, we find that the applicable statutory language is ambiguous and subject to multiple interpretations. Applying deference to the IRS's determination, however, we uphold the rule as a permissible exercise of the agency's discretion. We thus affirm the judgment of the district court.

I.

In March of 2010, Congress passed the ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB*). To increase the availability of affordable insurance plans, the Act provides for the establishment of "Exchanges," through which individuals can purchase competitively-priced health care coverage. Critically, the Act provides a federal tax credit to millions of low- and middle-income Americans to offset the cost of insurance policies purchased on the Exchanges. The Exchanges facilitate this process by advancing an individual's eligible tax credit dollars directly to health insurance providers as a means of reducing the upfront cost of plans to consumers.

Section 1311 of the Act provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange." However, § 1321 of the Act clarifies that a state may "elect" to establish an Exchange. Section 1321(c) further provides that if a state does not "elect" to establish an Exchange by January 1, 2014, or fails to meet certain federal requirements for the Exchanges, "the Secretary [of HHS] shall ... establish and operate such exchange within the State...." Only sixteen states plus the District of Columbia have elected to set up their own Exchanges; the remaining thirty-four states rely on federally-facilitated Exchanges.

Eligibility for the premium tax credits is calculated according to 26 U.S.C. § 36B. This section defines the annual "premium assistance credit amount" as the sum of the monthly premium assistance amounts for "all coverage months of the taxpayer occurring during the taxable year." A "coverage month" is one in which the taxpayer is enrolled in a health plan "through an Exchange established by the State under section 1311."

In addition to the tax credits, the Act requires most Americans to obtain "minimum essential" coverage or pay a tax penalty imposed by the IRS. However, the Act includes an unaffordability exemption that excuses low-income individuals for whom the annual cost of health coverage exceeds eight percent of their projected household income. The cost of coverage is calculated as the annual premium for the least expensive insurance plan available on an Exchange offered in a consumer's state, minus the tax credit described above. The tax credits thereby reduce the number of individuals exempt from the minimum coverage requirement, and in turn increase the number of individuals who must either purchase health insurance coverage, albeit at a discounted rate, or pay a penalty.

The IRS has promulgated regulations making the premium tax credits available to qualifying individuals who purchase health insurance on both state-run and federally-facilitated Exchanges. (collectively the "IRS Rule"). The IRS Rule provides that the credits shall be available to anyone "enrolled in one or more qualified health plans through an Exchange," and then adopts by cross-reference an HHS definition of "Exchange" that includes any Exchange, "regardless of whether the Exchange is established and operated by a State ... or by

HHS." Individuals who purchase insurance through federally-facilitated Exchanges are thus eligible for the premium tax credits under the IRS Rule. In response to commentary that this interpretation might conflict with the text of the statute, the IRS issued the following explanation:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

The plaintiffs in this case are Virginia residents who do not want to purchase comprehensive health insurance. Virginia has declined to establish a state-run Exchange and is therefore served by the prominent federally-facilitated Exchange known as HealthCare.gov. Without the premium tax credits, the plaintiffs would be exempt from the individual mandate under the unaffordability exemption. With the credits, however, the reduced costs of the policies available to the plaintiffs subject them to the minimum coverage penalty. According to the plaintiffs, then, as a result of the IRS Rule, they will incur some financial cost because they will be forced either to purchase insurance or pay the individual mandate penalty.

The plaintiffs' complaint alleges that the IRS Rule exceeds the agency's statutory authority, is arbitrary and capricious, and is contrary to law in violation of the Administrative Procedure Act ("APA"). The plaintiffs contend that the statutory language calculating the amount of premium tax credits according to the cost of the insurance policy that the taxpayer "enrolled in through an *Exchange established by the State under [§ 1311]* " precludes the IRS's interpretation that the credits are also available on national Exchanges. The district court disagreed, finding that the statute as a whole clearly evinced Congress's intent to make the tax credits available nationwide. The district court granted the defendants' motion to dismiss, and the plaintiffs timely appealed.

II.

We must first address whether the plaintiffs' claims are justiciable. The defendants make two arguments on this point: (1) that the plaintiffs lack standing; and (2) that the availability of a tax-refund action acts as an independent bar to the plaintiffs' claims under the APA.

A.

We review de novo the legal question of whether plaintiffs have standing to sue. Article III standing requires a litigant to demonstrate "an invasion of a legally protected interest" that is "concrete and particularized" and " 'actual or imminent.' " The plaintiffs premise their standing on the claim that, if they were not eligible for the premium tax credits, they would qualify for

the unaffordability exemption in 26 U.S.C. § 5000A and would therefore not be subject to the tax penalty for failing to maintain minimum essential coverage. Thus, because of the credits, the plaintiffs argue that they face a direct financial burden because they are forced either to purchase insurance or pay the penalty.

We agree that this represents a concrete economic injury that is directly traceable to the IRS Rule. The IRS Rule forces the plaintiffs to purchase a product they otherwise would not, at an expense to them, or to pay the tax penalty for failing to comply with the individual mandate, also subjecting them to some financial cost…

The defendants' argument against standing is premised on the claim that the plaintiffs want to purchase "catastrophic" insurance coverage, which in some cases is more expensive than subsidized comprehensive coverage required by the Act. The defendants thus claim that the plaintiffs have acknowledged they would actually expend *more* money on a separate policy even if they were eligible for the credits. Regardless of the viability of this argument, it rests on an incorrect premise. The defendants misread the plaintiffs' complaint, which, while mentioning the possibility that several of the plaintiffs wish to purchase catastrophic coverage, also clearly alleges that each plaintiff does not want to buy comprehensive, ACA-compliant coverage and is harmed by having to do so or pay a penalty. The harm in this case is having to choose between ACA-compliant coverage and the penalty, both of which represent a financial cost to the plaintiffs. That harm is actual or imminent, and is directly traceable to the IRS Rule. The plaintiffs thus have standing to present their claims.

B.

The defendants also argue that the availability of a tax-refund action bars the plaintiffs' claims under the APA. The defendants assert that the proper course of action for the plaintiffs is to pay the tax penalty and then present their legal arguments against the IRS Rule as part of a tax-refund action brought under either 26 U.S.C. § 7422(a) or the Little Tucker Act. The defendants do not, nor could they, assert this as a jurisdictional bar, but instead point to "general equitable principles disfavoring the issuance of federal injunctions against taxes, absent clear proof that available remedies at law [are] inadequate." The defendants argue that a tax refund action presents an "adequate remedy" that the plaintiffs must first pursue before challenging the IRS Rule directly under the APA.

The defendants' arguments are not persuasive. First, they fail to point to a single case in which a court has refused to entertain a similar suit on the grounds that the parties were required to first pursue a tax-refund action under 26 U.S.C. § 7422(a) or 28 U.S .C. § 1346. Moreover, the plaintiffs are not seeking a tax refund; they ask for no monetary relief, alleging instead claims for declaratory and injunctive relief in an attempt to forestall the lose-lose choice (in their minds) of purchasing a product they do not want or paying the penalty. Section 7422(a) does not allow for prospective relief. Instead, it bars suit "for

the *recovery* of any internal revenue tax alleged to have been erroneously or illegally assessed or collected." Similarly, "[t]he Little Tucker Act does not authorize claims that seek primarily equitable relief."

It is clear, then, that the alternative forms of relief suggested by the defendants would not afford the plaintiffs the complete relief they seek. This is simply not a typical tax refund action in which an individual taxpayer complains of the manner in which a tax was assessed or collected and seeks reimbursement for wrongly paid sums. The plaintiffs here challenge the legality of a final agency action, which is consistent with the APA's underlying purpose of "remov[ing] obstacles to judicial review of agency action." Requiring the plaintiffs to choose between purchasing insurance and thereby waiving their claims or paying the tax and challenging the IRS Rule after the fact creates just such an obstacle. We therefore find that the plaintiffs' suit is not barred under the APA.

III.

Turning to the merits, "we review questions of statutory construction de novo." Because this case concerns a challenge to an agency's construction of a statute, we apply the familiar two-step analytic framework set forth in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.* At *Chevron's* first step, a court looks to the "plain meaning" of the statute to determine if the regulation responds to it. If it does, that is the end of the inquiry and the regulation stands. However, if the statute is susceptible to multiple interpretations, the court then moves to *Chevron's* second step and defers to the agency's interpretation so long as it is based on a permissible construction of the statute.

A.

At step one, "[i]f the statute is clear and unambiguous 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.' " A statute is ambiguous only if the disputed language is "reasonably susceptible of different interpretations." … Courts should employ all the traditional tools of statutory construction in determining whether Congress has clearly expressed its intent regarding the issue in question.

1.

In construing a statute's meaning, the court "begin[s], as always, with the language of the statute." As described above, 26 U.S.C. § 36B provides that the premium assistance amount is the sum of the monthly premium assistance amounts for all "coverage months" for which the taxpayer is covered during a year. A "coverage month" is one in which "the taxpayer ... is covered by a qualified health plan ... enrolled in through an Exchange established by the State under [§] 1311 of the [Act]." Similarly, the statute calculates an individual's tax credit by totaling the "premium assistance amounts" for all "coverage months" in a given year. The "premium assistance amount" is based in part on the cost of the monthly premium for the health plan that the taxpayer purchased "through an Exchange established by the State under [§] 1311."

The plaintiffs assert that the plain language of both relevant subsections in § 36B is determinative. They contend that in defining the terms "coverage months" and "premium assistance amount" by reference to Exchanges that are "established by the State under [§] 1311," Congress limited the availability of tax credits to individuals purchasing insurance on state Exchanges. Under the plaintiffs' construction, the premium credit amount for individuals purchasing insurance through a federal Exchange would always be zero.

The plaintiffs' primary rationale for their interpretation is that the language says what it says, and that it clearly mentions state-run Exchanges under § 1311. If Congress meant to include federally-run Exchanges, it would not have specifically chosen the word "state" or referenced § 1311. The federal government is not a "State," and so the phrase "Exchange established by the State under [§] 1311," standing alone, supports the notion that credits are unavailable to consumers on federal Exchanges. Further, the plaintiffs assert that because state and federal Exchanges are referred to separately in § 1311 and § 1321, the omission in 26 U.S.C. § 36B of any reference to federal Exchanges established under § 1321 represents an intentional choice on behalf of Congress to exclude federal Exchanges and include only state Exchanges established under § 1311.

There can be no question that there is a certain sense to the plaintiffs' position. If Congress did in fact intend to make the tax credits available to consumers on both state and federal Exchanges, it would have been easy to write in broader language, as it did in other places in the statute.

However, when conducting statutory analysis, "a reviewing court should not confine itself to examining a particular statutory provision in isolation. Rather, [t]he meaning—or ambiguity—of certain words or phrases may only become evident when placed in context." With this in mind, the defendants' primary counterargument points to ACA §§ 1311 and 1321, which, when read in tandem with 26 U.S.C. § 36B, provide an equally plausible understanding of the statute, and one that comports with the IRS's interpretation that credits are available nationwide.

As noted, § 1311 provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange [.]" It goes on to say that "[a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State," apparently narrowing the definition of "Exchange" to encompass only state-created Exchanges. ACA § 1311(d)(1). Similarly, the definitions section of the Act, § 1563(b), provides that "[t]he term 'Exchange' means an American Health Benefit Exchange established under [§] 1311," further supporting the notion that all Exchanges should be considered as if they were established by a State.

Of course, § 1311's directive that each State establish an Exchange cannot be understood literally in light of § 1321, which provides that a state may "elect" to do so. Section 1321(c) provides that if a state fails to establish an Exchange by January 1, 2014, 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." The defendants' position is that the term "such Exchange" refers to a state Exchange that is set up and operated by HHS. In other words, the statute mandates the existence of state Exchanges, but directs HHS to establish such Exchanges when the states fail to do so themselves. In the absence of state action, the federal government is required to step in and create, by definition, "an American Health Benefit Exchange established under [§] 1311" on behalf of the state.

Having thus explained the parties' competing primary arguments, the court is of the opinion that the defendants have the stronger position, although only slightly. Given that Congress defined "Exchange" as an Exchange established by the state, it makes sense to read § 1321(c)'s directive that HHS establish "such Exchange" to mean that the federal government acts on behalf of the state when it establishes its own Exchange. However, the court cannot ignore the common-sense appeal of the plaintiffs' argument; a literal reading of the statute undoubtedly accords more closely with their position. As such, based solely on the language and context of the most relevant statutory provisions, the court cannot say that Congress's intent is so clear and unambiguous that it "foreclose[s] any other interpretation."

2.

We next examine two other, less directly relevant provisions of the Act to see if they shed any more light on Congress's intent. First, the defendants argue that reporting provisions in § 36B(f) conflict with the plaintiffs' interpretation and confirm that the premium tax credits must be available on federally-run Exchanges. Section 36B(f)—titled "Reconciliation of credit and advance credit"—requires the IRS to reduce the amount of a taxpayer's end-of-year premium tax credit by the amount of any advance payment of such credit. To enable the IRS to track these advance payments, the statute requires "*[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 [Act])" to provide certain information to the Department of the Treasury. There is no dispute that the reporting requirements apply regardless of whether an Exchange was established by a state or HHS. The Exchanges are required to report the following information:

> (A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.
>
> (B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.
>
> (C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.
>
> (D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.
>
> (E) Any information provided to the Exchange, including any change of circumstances, necessary to determine

> eligibility for, and the amount of, such credit.
>
> (F) Information necessary to determine whether a taxpayer has received excess advance payments.

The defendants argue, sensibly, that if premium tax credits were not available on federally-run Exchanges, there would be no reason to require such Exchanges to report the information found in subsections (C), (E), and (F). It is therefore possible to infer from the reporting requirements that Congress intended the tax credits to be available on both state- and federally-facilitated Exchanges. The plaintiffs acknowledge that some of the reporting requirements are extraneous for federally-run Exchanges, but note that the other categories of reportable information, i.e., subsections (A), (B), and (D), remain relevant even in the absence of credits. The plaintiffs suggest that Congress was simply saving itself the trouble of writing two separate subsections, one for each type of Exchange, by including a single comprehensive list.

The second source of potentially irreconcilable language offered by the defendants concerns the "qualified individuals" provision under ACA § 1312. That section sets forth provisions regarding which individuals may purchase insurance from the Exchanges. It provides that only "qualified individuals" may purchase health plans in the individual markets offered through the Exchanges, and explains that a "qualified individual" is a person who "resides in the State that established the Exchange." The defendants argue that unless their reading of § 1321 is adopted and understood to mean that the federal government stands in the shoes of the state for purposes of establishing an Exchange, there would be no "qualified individuals" existing in the thirty-four states with federally-facilitated Exchanges because none of those states is a "State that established the Exchange." This would leave the federal Exchanges with no eligible customers, a result Congress could not possibly have intended.

The plaintiffs acknowledge that this would be untenable, and suggest that the residency requirement is only applicable to state-created Exchanges. They note that § 1312 states that a "qualified individual"—"*with respect to an Exchange*"—is one who "resides in the State that established the Exchange." Accordingly, because "Exchange" is defined as an Exchange established under § 1311,i.e., the provision directing *states* to establish Exchanges, the residency requirement only limits enrollment on state Exchanges.

Having considered the parties' competing arguments on both of the above-referenced sections, we remain unpersuaded by either side. Again, while we think the defendants make the better of the two cases, we are not convinced that either of the purported statutory conflicts render Congress's intent clear. Both parties offer reasonable arguments and counterarguments that make discerning Congress's intent difficult. Additionally, we note that the Supreme Court has recently reiterated the admonition that courts avoid revising ambiguously drafted legislation out of an effort to avoid "apparent anomal [ies]" within a statute. It is

not especially surprising that in a bill of this size—"10 titles stretch[ing] over 900 pages and contain [ing] hundreds of provisions,"—there would be one or more conflicting provisions. Wary of granting excessive analytical weight to relatively minor conflicts within a statute of this size, we decline to accept the defendants' arguments as dispositive of Congress's intent.

3.

The Act's legislative history is also not particularly illuminating on the issue of tax credits. As both parties concede, the legislative history of the Act is somewhat lacking, particularly for a bill of this size. Several floor statements from Senators support the notion that it was well understood that tax credits would be available for low- and middle-income Americans nationwide. For example, Senator Baucus stated that the "tax credits will help to ensure *all* Americans can afford quality health insurance." He later estimated that "60 percent of those who are getting insurance in the individual market on the exchange will get tax credits...." … These figures only make sense if all financially eligible Americans are understood to have access to the credits.

However, it is possible that such statements were made under the assumption that every state would in fact establish its own Exchange. As the district court stated, "Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges." The statements therefore do not necessarily address the question of whether the credits would remain available in the absence of state-created Exchanges. The plaintiffs argue extensively that Congress could not have anticipated that so few states would establish their own Exchanges. Indeed, they argue that Congress attempted to "coerce" the states into establishing Exchanges by conditioning the availability of the credits on the presence of state Exchanges. The plaintiffs contend that Congress struck an internal bargain in which it decided to favor state-run Exchanges by incentivizing their creation with billions of dollars of tax credits. According to the plaintiffs, however, Congress's plan backfired when a majority of states refused to establish their own Exchanges, in spite of the incentives. The plaintiffs thus acknowledge that the lack of widely available tax credits is counter to Congress's original intentions, but consider this the product of a Congressional miscalculation that the courts have no business correcting.

Although the plaintiffs offer no compelling support in the legislative record for their argument, it is at least plausible that Congress would have wanted to ensure state involvement in the creation and operation of the Exchanges. Such an approach would certainly comport with a literal reading of 26 U.S.C. § 36B's text. In any event, it is certainly possible that the Senators quoted above were speaking under the assumption that each state would establish its own Exchange, and that they could not have envisioned the issue currently being litigated. Although Congress included a fallback provision in the event the states failed to act, it is not clear from the legislative record how large a role Congress expected the federal Exchanges to play in

administering the Act. We are thus of the opinion that nothing in the legislative history of the Act provides compelling support for either side's position.

Having examined the plain language and context of the most relevant statutory sections, the context and structure of related provisions, and the legislative history of the Act, we are unable to say definitively that Congress limited the premium tax credits to individuals living in states with state-run Exchanges. We note again that, on the whole, the defendants have the better of the statutory construction arguments, but that they fail to carry the day. Simply put, the statute is ambiguous and subject to at least two different interpretations. As a result, we are unable to resolve the case in either party's favor at the first step of the *Chevron* analysis.

B.

Finding that Congress has not "directly spoken to the precise question at issue," we move to *Chevron's* second step. At step two, we ask whether the "agency's [action] is based on a permissible construction of the statute." We "will not usurp an agency's interpretive authority by supplanting its construction with our own, so long as the interpretation is not 'arbitrary, capricious, or manifestly contrary to the statute.' A construction meets this standard if it 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute.' " We have been clear that "[r]eview under this standard is highly deferential, with a presumption in favor of finding the agency action valid."

…

What we must decide is whether the statute permits the IRS to decide whether the tax credits would be available on federal Exchanges. In answering this question in the affirmative we are primarily persuaded by the IRS Rule's advancement of the broad policy goals of the Act. There is no question that the Act was intended as a major overhaul of the nation's entire health insurance market. The Supreme Court has recognized the broad policy goals of the Act: "to increase the number of Americans covered by health insurance and decrease the cost of health care." Similarly, Title I of the ACA is titled "Quality, Affordable Health Care for *All* Americans"

Several provisions of the Act are necessary to achieving these goals. To begin with, the individual mandate requires nearly all Americans to have health insurance or pay a fine. Increasing the pool of insured individuals has the intended side-effect of increasing revenue for insurance providers. The increased revenue, in turn, supports several more specific policy goals contained in the Act. The most prominent of these are the guaranteed-issue and community-rating provisions. In short, these provisions bar insurers from denying coverage or charging higher premiums because of an individual's health status. However, these requirements, standing alone, would result in an "adverse selection" scenario whereby individuals disproportionately likely to utilize health care would drive up the costs of policies available on the Exchanges.

Congress understood that one way to avoid such price increases was to require near-

universal participation in the insurance marketplace via the individual mandate. In combination with the individual mandate, Congress authorized broad incentives—totaling hundreds of billions of dollars—to further increase market participation among low- and middle-income individuals. A Congressional Budget Office report issued while the Act was under consideration informed Congress that there would be an "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed." The report further advised Congress that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people"; and that the structure of the premium tax credits, under which federal subsidies increase if premiums rise, "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." As the defendants further explain, denying tax credits to individuals shopping on federal Exchanges would throw a debilitating wrench into the Act's internal economic machinery:

> Insurers in States with federally-run Exchanges would still be required to comply with guaranteed-issue and community-rating rules, but, without premium tax subsidies to encourage broad participation, insurers would be deprived of the broad policy-holder base required to make those reforms viable. Adverse selection would cause premiums to rise, further discouraging market participation, and the ultimate result would be an adverse-selection "death spiral" in the individual insurance markets in States with federally-run Exchanges.

It is therefore clear that widely available tax credits are essential to fulfilling the Act's primary goals and that Congress was aware of their importance when drafting the bill. The IRS Rule advances this understanding by ensuring that this essential component exists on a sufficiently large scale. The IRS Rule became all the more important once a significant number of states indicated their intent to forgo establishing Exchanges. With only sixteen state-run Exchanges currently in place, the economic framework supporting the Act would crumble if the credits were unavailable on federal Exchanges. Furthermore, without an exception to the individual mandate, millions more Americans unable to purchase insurance without the credits would be forced to pay a penalty that Congress never envisioned imposing on them. The IRS Rule avoids both these unforeseen and undesirable consequences and thereby advances the true purpose and means of the Act.

It is thus entirely sensible that the IRS would enact the regulations it did, making *Chevron* deference appropriate. Confronted with the Act's ambiguity, the IRS crafted a rule ensuring the credits' broad availability and furthering the goals of the law. In the face of this permissible construction, we must defer to the IRS Rule.

Tellingly, the plaintiffs do not dispute that the premium tax credits are an essential component of the Act's viability. Instead, as explained above, they concede that Congress probably wanted to make subsidies available

throughout the country, but argue that Congress was equally concerned with ensuring that the states play a leading role in administering the Act, and thus conditioned the availability of the credits on the creation of state Exchanges. The plaintiffs argue that the IRS Rule exceeds the agency's authority because it irreconcilably conflicts with Congress's goal of ensuring state leadership. For the reasons explained above, however, we are not persuaded by the plaintiffs' "coercion" argument and do not consider it a valid basis for circumscribing the agency's authority to implement the Act in an efficacious manner.

The plaintiffs also attempt to avert *Chevron* deference by arguing that ACA §§ 1311 and 1321 are administered by HHS and not the IRS, and that as a result the IRS had no authority to enact its final rule. However, the relevant statutory language is found in 26 U.S.C. § 36B, which is part of the Internal Revenue Code and subject to interpretation by the IRS. Although the IRS Rule adopts by cross-reference an HHS definition of "Exchange," the Act clearly gives to the IRS authority to resolve ambiguities in 26 U.S.C. § 38B. This clear delegation of authority to the IRS relieves us of any possible doubt regarding the propriety of relying on one agency's interpretation of a single piece of a jointly-administered statute.

Finally, the plaintiffs contend that a rule of statutory construction that requires tax exemptions and credits to be construed narrowly displaces *Chevron* deference in this case. However, while the Supreme Court has stated that tax credits "must be expressed in clear and unambiguous terms," the Supreme Court has never suggested that this principle displaces *Chevron* deference, and in fact has made it quite clear that it does not.

Rejecting all of the plaintiffs' arguments as to why *Chevron* deference is inappropriate in this case, for the reasons explained above we are satisfied that the IRS Rule is a permissible construction of the statutory language. We must therefore apply *Chevron* deference and uphold the IRS Rule.

Accordingly, the judgment of the district court is affirmed.

AFFIRMED

DAVIS, Senior Circuit Judge, concurring:

I am pleased to join in full the majority's holding that the Patient Protection and Affordable Care Act (the Act) "permits" the Internal Revenue Service to decide whether premium tax credits should be available to consumers who purchase health insurance coverage on federally-run Exchanges. But I am also persuaded that, even if one takes the view that the Act is not ambiguous in the manner and for the reasons described, the necessary outcome of this case is precisely the same. That is, I would hold that Congress has mandated in the Act that the IRS provide tax credits to all consumers regardless of whether the Exchange on which they purchased their health insurance coverage is a creature of the state or the federal bureaucracy. Accordingly, at *Chevron* Step One, the IRS Rule making the tax credits available to all consumers of Exchange-purchased health insurance

coverage is the correct interpretation of the Act and is required as a matter of law.

Although the Act expressly contemplates state-run Exchanges, Congress created a contingency provision that permits the federal government, via the Secretary of Health and Human Services, to "establish and operate such Exchange within the State and ... take such actions as are necessary to implement such other requirements." This contingency provision is triggered when a state elects not to set up an Exchange, when a state is delayed in setting up an Exchange, or when a state Exchange fails to meet certain statutory and regulatory requirements.

Enter the premium tax credits, essentially a tax subsidy for the purchase of health insurance. The amended tax code sets forth the formula for calculating the amount of a consumer's premium tax credit. In general, the credit is equal to the lesser of two amounts: the monthly premium for a qualified health plan "enrolled in through an Exchange established by the State," or the excess of the adjusted monthly premium for a certain type of health plan over a percentage of the taxpayer's household income.

Appellants contend that the language "enrolled in through an Exchange *established by the State*" precludes the IRS from providing premium tax credits to consumers who purchase health insurance coverage on federal Exchanges. To them, "established by the State" in the premium tax credits calculation subprovision is the *sine qua non* of this case. An Exchange established by the State is not an Exchange established by the federal government, they argue; thus, the equation for calculating the amount of the premium tax credit is wholly inapplicable to all consumers who purchase health insurance coverage on federally-run Exchanges.

I am not persuaded and for a simple reason: "[E]stablished by the State" indeed means established by the state-except when it does not, i.e., except when a state has failed to establish an Exchange and when the Secretary, charged with acting pursuant to a contingency for which Congress planned, establishes and operates the Exchange in place of the state. When a state elects not to establish an Exchange, the contingency provision authorizes federal officials to establish and operate "such Exchange" and to take any action adjunct to doing so.

That disposes of the Appellants' contention. This is not a case that calls up the decades-long clashes between textualists, purposivists, and other schools of statutory interpretation. The case can be resolved through a contextual reading of a few different subsections of the statute. If there were any remaining doubt over this construction, the bill's structure dispels it: The contingency provision at § 1321(c)(1) is set forth in "Part III" of the bill, titled "State Flexibility Relating to Exchanges," a section that appears *after* the section that creates the Exchanges and mandates that they be operated by state governments. What's more, the contingency provision does not create two-tiers of Exchanges; there is no indication that Congress intended the federally-operated Exchanges to be lesser Exchanges and for consumers who utilize

them to be less entitled to important benefits. Thus, I conclude that a holistic reading of the Act's text and proper attention to its structure lead to only one sensible conclusion: The premium tax credits must be available to consumers who purchase health insurance coverage through their designated Exchange regardless of whether the Exchange is state- or federally-operated.

The majority opinion understandably engages with the Appellants and respectfully posits they could be perceived to advance a plausible construction of the Act, i.e., that Congress may have sought to restrict the scope of the contingency provision when it used the phrase "established by the State" in the premium tax credits calculation subprovision. But as the majority opinion deftly illustrates, a straightforward reading of the Act strips away any and all possible explanations for why Congress would have intended to exclude consumers who purchase health insurance coverage on federally-run Exchanges from qualifying for premium tax credits. Such a reading, the majority opinion persuasively explains, is not supported by the legislative history or by the overall structure of the Act. Moreover, the majority carefully and cogently explains how "widely available tax credits are essential to fulfilling the Act's primary goals and [how] Congress was aware of their importance when drafting the bill." Thus, the majority correctly holds that Congress did not intend a reading that has no legislative history to support it and runs contrary to the Act's text, structure, and goals. Appellants' "literal reading" of the premium tax credits calculation subprovision renders the entire Congressional scheme nonsensical.

In fact, Appellants' reading is not literal; it's cramped. No case stands for the proposition that literal readings should take place in a vacuum, acontextually, and untethered from other parts of the operative text; indeed, the case law indicates the opposite. So does common sense: If I ask for pizza from Pizza Hut for lunch but clarify that I would be fine with a pizza from Domino's, and I then specify that I want ham and pepperoni on my pizza from Pizza Hut, my friend who returns from Domino's with a ham and pepperoni pizza has still complied with a literal construction of my lunch order. That is this case: Congress specified that Exchanges should be established and run by the states, but the contingency provision permits federal officials to act in place of the state when it fails to establish an Exchange. The premium tax credit calculation subprovision later specifies certain conditions regarding state-run Exchanges, but that does not mean that a literal reading of that provision somehow precludes its applicability to substitute federally-run Exchanges or erases the contingency provision out of the statute.

That Congress sometimes specified state *and* federal Exchanges in the bill is as unremarkable as it is unrevealing. This was, after all, a 900–page bill that purported to restructure the means of providing health care in this country. Neither the canons of construction nor any empirical analysis suggests that congressional drafting is a perfectly harmonious, symmetrical, and elegant endeavor. Sausage-makers are

indeed offended when their craft is linked to legislating. At worst, the drafters' perceived inconsistencies (if that is what they are at all) are far less probative of Congress' intent than the unqualified and broad contingency provision.

Appellants insist that the use of "established by the State" in the premium tax credits calculation subprovision is evidence of Congress' intent to limit the availability of tax credits to consumers of state Exchange-purchased health insurance coverage. Their reading bespeaks a deeply flawed effort to squeeze the proverbial elephant into the proverbial mousehole. If Congress wanted to create a two-tiered Exchange system, it would have done so expressly in the section of the Act that authorizes the creation of contingent, federally-run Exchanges. If Congress wanted to limit the availability of premium tax credits to consumers who purchase health coverage on state-run Exchanges, it would have said so rather than tinkering with the formula in a subprovision governing how to calculate the amount of the credit.

The real danger in the Appellants' proposed interpretation of the Act is that it misses the forest for the trees by eliding Congress' central purpose in enacting the Act: to radically restructure the American health care market with "the most expansive social legislation enacted in decades." The widespread availability of premium tax credits was intended as a critical part of the bill, a point the President highlighted at the bill signing. Appellants' approach would effectively destroy the statute by promulgating a new rule that makes premium tax credits unavailable to consumers who purchased health coverage on federal Exchanges. But of course, as their counsel largely conceded at oral argument, that is their not so transparent purpose.

Appellants, citizens of the Commonwealth of Virginia, do not wish to buy health insurance. Most assuredly, they have the right, but not the unfettered right, to decline to do so. They have a clear choice, one afforded by the admittedly less-than-perfect representative process ordained by our constitutional structure: they can either pay the relatively minimal amounts needed to obtain health care insurance as provided by the Act, or they can refuse to pay and run the risk of incurring a tiny tax penalty. What they may not do is rely on our help to deny to millions of Americans desperately-needed health insurance through a tortured, nonsensical construction of a federal statute whose manifest purpose, as revealed by the wholeness and coherence of its text and structure, could not be more clear.

As elaborated in this separate opinion, I am pleased to concur in full in Judge Gregory's carefully reasoned opinion for the panel.

“Lawyers Challenging Health Subsidies Seek Quick Supreme Court Ruling”

The LA Times
David G. Savage
July 31, 2014

Lawyers challenging President Obama's healthcare law filed a quick appeal with the Supreme Court on Thursday, urging justices to take up the issue this fall and throw out insurance subsidies for nearly 5 million Americans.

"The monumental significance of this legal issue requires the court's immediate, urgent attention," they said in a filing. "The longer the lawless IRS rule is in effect, the greater the upheaval when it is ultimately vacated."

Last week, two federal appeals courts handed down conflicting rulings on whether the Obama administration may pay subsidies to low-and middle-income Americans who buy insurance on the federal "exchange" created under the Affordable Care Act.

In one ruling from the District of Columbia, an appeals court panel said these subsidies are illegal in the 36 states that rely on an exchange established by federal authorities. The judges pointed to a part of the law that says tax subsidies may be paid for insurance purchased on an exchange "established by the state."

But in a second ruling, an appeals court in Virginia rejected this challenge and decided Congress intended to offer subsidies nationwide regardless of whether consumers use a state or federal exchange.

Under the court's rules, lawyers who lose in an appeals court have 90 days to seek a review in the Supreme Court. And normally, lawyers take the full time. But in this instance, the opponents of the Affordable Care Act want the court's conservative justices to have a chance to take up the new healthcare case in a few months so they can rule by next spring.

The Obama administration has the opposite strategy on timing. The Justice Department said it planned to ask the full appeals court in the District of Columbia to reconsider last week's ruling by a three-judge panel. If so, that could delay a final ruling from the appeals court until next year and push off a Supreme Court decision to 2016.

By then, millions of Americans will have relied for several years on having health insurance they could afford thanks to the subsidies. A single adult with an income up to $45,960 and a family of four with an income up $94,200 may obtain insurance on an exchange at a reduced cost.

The appeal filed Thursday is funded by the libertarian Competitive Enterprise Institute. Late last week, the group publicized a video from 2012 in which a leading academic advocate of the healthcare law says states must establish insurance exchanges or lose subsidies for its citizens.

Jonathan Gruber, an MIT economist who advised Democrats on the healthcare law, was asked at a conference whether the federal government could run an exchange if the states refused. Yes, Gruber said. "If the

states don't provide them, the federal backstop will. The federal government has been sort of slow in putting out its backstop, I think partly because they want to sort of squeeze the states to do it. I think what's important to remember politically about this is, if you are a state and you don't set up an exchange, that means your citizens don't get their tax credits."

In appealing to the Supreme Court, the lawyers quote Gruber's statement as evidence that the sponsors of the law intended to limit subsidies to those states which established an exchange.

Defenders of the law have insisted that view is absurd. They say the Democrats who wrote the law intended that subsidies would be offered to everyone who qualified and that the federal exchanges were intended to play the same role as the state exchanges.

"Halbig, King Decisions Overturning Subsidies May Hinder ACA Implementation"

Wolters Kluwer
August 4, 2014

The ultimate outcomes of *Halbig v Burwell* and *King v Burwell*, remain to be seen. However, the overturn of 26 USC Sec. 36B that may result is predicted to "broadly undermine the implementation" of the Patient Protection and Affordable Care Act (ACA), according to a report by the Urban Institute and the Robert Wood Johnson Foundation. Consequences of the possible overturn of Sec. 36B, which provides premium subsidies for plans on the federally facilitated Marketplaces (FFMs), are likely to include increases in premiums and uninsured rates.

Recent decisions. In *Halbig*, the Court of Appeals for the D.C. Circuit vacated the IRS regulation that provides for federal funding for subsidies to aid in the purchase of health insurance through the FFMs, stating, "[W]e conclude that the ACA unambiguously restricts the section 36B subsidy to insurance purchased on Exchanges 'established by the State.'" Previous oral arguments turned on whether the legislative history showed intent to use premium tax subsidies as an incentive for states to create their own Exchanges. The D.C. Circuit had been dubious of the government's arguments against such an interpretation of the legislative intent—especially considering that the words "established by the state" appeared in the statute's language eight or nine times.

In contrast, the Fourth Circuit in *King* found the ACA's language—which the D.C. Circuit purported to limit such tax credits to state-run Exchanges—"ambiguous and subject to multiple interpretations," and gave the IRS deference its application of tax credits to FFMs.

Implications in coverage and subsidies. According to the report, which was written before the release of the *King* and *Halbig* decisions, nearly 12 million enrollments are expected in the 34 FFMs in 2016. Of those enrollments, an estimated 7.3 million individuals will receive federal subsidies to aid in the purchase of health insurance through the Marketplaces, and many are expected to pay lower copayments, deductibles, and coinsurance through cost-sharing subsidies. If Sec. 36B is ultimately overturned, it would "[translate] into a loss of $36.1 billion in 2016 of funds that would otherwise go to individuals and families with incomes below 400 percent of the federal poverty level."

The effects of the overturn of Sec. 36B also are predicted to cause spillover effects to state economies, which will likely experience a loss of federal funding, according to the report. The study estimated losses as high as $4.8 billion in Florida and $5.6 billion in Texas. Twenty-four of the 34 states are already foregoing federal funding in choosing not to expand Medicaid under the ACA. The report suggests that the 34

FFM states consider creating their own state-based Marketplaces to avoid the consequences of an overturn of Sec. 36B.

Effects on other ACA components. According to the report, the elimination of the premium tax subsidies "would have a domino effect on other components of the ACA, as well." Among the effects predicted in the report is an increase in the number of uninsured as a result of unaffordable premium costs in the absence of subsidies, resulting in an increase of individual mandate penalties. The report also suggests that the shrinking of the insurance pool is likely to result in insurers advocating for the repeal of anti-discrimination regulations.

"After Health Law Rulings, Here are Possible Next Steps"

The New York Times (The Upshot)
Margot Sanger-Katz
July 22, 2014

We now have two federal appeals courts that have issued conflicting rulings on a major provision of the Affordable Care Act. Those decisions are not the final word on whether residents of some states will be able to continue receiving financial assistance to buy health insurance. Here are some possible next steps:

All the judges on the D.C. Circuit could decide the *Halbig v. Burwell* case. There is a process called "en banc" review in which the case would be reargued before all of the 11 judges on the D.C. Circuit Court, and the Obama administration has said it will ask the court for such a review. A majority of the judges would have to agree to rehear the case for it to be reconsidered in this way. Appellate courts rarely accept cases for en banc review, but this is a big one. Many legal experts think that the full court would view the government's position more favorably than the two judges who ruled against them in the original decision on Tuesday; legal questions don't necessarily break down along political lines, but Democratic appointees outnumber Republican appointees on the court and include four new judges recently appointed by President Obama.

The law's challengers could ask the Fourth Circuit to reconsider *King v. Burwell*. Same rules apply, and the Fourth Circuit also has more judges appointed by Democrats than Republicans.

Decisions will be issued by other courts. The plaintiffs in the Virginia and D.C. cases are not the only ones challenging tax subsidies in the Affordable Care Act. Two trial court cases raise similar issues, one in Oklahoma and one in Indiana. Those cases could also go to appellate courts. Oklahoma is in the 10th Circuit; Indiana is in the 7th. Depending on the outcomes of the various rulings, all courts could end up agreeing, or there could remain a disagreement between different circuits.

Either side—or both—could appeal the rulings to the Supreme Court. The Supreme Court can pick which case it wants to hear; four judges must vote to take a case for it to be added to the court's schedule. The Supreme Court generally rejects most petitions for a hearing but tends to intervene when circuit courts disagree about a substantive issue of law. The current disagreement between the D.C. and Fourth Circuits is a good example of the type of split that usually gets its attention.

The Supreme Court could decide the case. In addition to deciding whether tax subsidies can be used in states without their own exchanges, the court would face another question if it ruled in favor of the challengers: What happens to the tax credits that have already been handed out?

Congress could act. The legal question came up because of ambiguities in the drafting of the Affordable Care Act that

made it unclear when tax subsidies should apply. If it was so inclined—a big if, in this polarized climate—Congress could fix the language and clarify who is eligible for the federal money.

States could act. Right now, 36 states are relying on the federal government to run at least parts of their insurance marketplaces, meaning that their residents could lose access to tax credits if the D.C. Circuit case is upheld. But any of those states could choose to switch to a state exchange, where the law is clear that the tax credits do apply. A few states are already working on switching from federal to state exchanges. Others might consider a similar shift, though the change would be difficult and potentially expensive.

“Supreme Court Could Hear Obamacare Subsidy Feud”

CNBC Business
July 31, 2014

Let's get ready to rumble.

The U.S. Supreme Court on Thursday was asked to hear a case that is considered perhaps the single biggest current threat to Obamacare.

The case hinges on the question of whether the federal government can give billions of dollars in financial aid to people who buy Obamacare insurance on HealthCare.gov.

The request to fast-track a final decision on that issue comes a week after judicial panels in separate federal appeals circuits issued conflicting rulings on the legality of such subsidies for enrollees on that federally run Obamacare exchange. Financial aid given customers of state-run marketplaces is not being challenged.

If the Supreme Court takes the case, and ultimately rules for the plaintiffs, it would render illegal tax credits that helped nearly 5 million people buy insurance on HealthCare.gov, which sells health plans insurance in 36 states.

For now, those subsidies, which go to 86 percent of federal exchange customers, remain legal.

If the high court said the HealthCare.gov subsidies were illegal, it also would destroy or cripple in those affected states two major Obamacare mandates, which impose fines if certain employers don't offer health insurance to workers, and if individuals don't obtain health coverage.

The Competitive Enterprise Institute, the group that has backed several court challenges to the Obamacare subsidies, announced the petition had been filed.

For the Supreme Court to take the case, it would require at least four justices to agree to hear it. If the court takes the case, it could be heard after it opens its next term in October, and decided by next May.

"From the time these case were first filed, we've tried to get this issue resolved as quickly as possible for the plaintiffs and the millions of individual like them," said CEI general counsel Sam Kazman.

"A fast resolution is also vitally important to the states that chose not to set up exchanges, to the employers in those states who face either major compliance costs or huge penalties, and to employees who face possible layoffs or reductions in their work hours as a result of this illegal IRS rule," Kazman said

"Our petition today to the Supreme Court represents the next step in that process."

Kazman noted that two days after last week's split rulings, a 2012 video surfaced of MIT economist Jonathan Gruber, one of the architects of Obamacare, saying that residents of states that did not establish their own Obamacare exchanges would not be eligible for subsidies.

"If you're a state and you don't set up an exchange, that means your citizens don't get

their tax credits. … I hope that's a blatant enough political reality that states will get their act together and realize there are billions of dollars at stake here in setting up these exchanges, and that they'll do it," Gruber told his audience on the video.

CEI, in a press release, said Gruber's comment :contradicts the current claim by the government: that Congress never intended to withhold subsidies." The petition asking the Supreme Court to take up the case cites Gruber's remarks.

Timothy Jost, a law professor who argues that the subsidies are legal regardless of what kind of government exchange they're issued through, said, "This is an act of desperation to keep a case alive which was always an act of desperation by advocates who have been unable in succeed in Congress."

But Michael Cannon, director of health studies at the Cato Institute and one of the intellectual godfathers of the challenge to the subsidies, said it was "the right decision" to ask the Supreme Court to settle the issue once and for all.

"There are tens of millions of individuals and a quarter-million businesses, dozens of insurance companies and three dozen states that need to have this issue resolved and resolved quickly," Cannon said. "It's not a small issue."

"Even if all those people's economic decisions were" not at issue, he said. "There's a question of whether the president of the United State is borrowing, and spending and taxing tens of billions of dollars without Congressional authorization," Cannon said. He said there are "probably" enough votes on the court to grant the petition to be heard.

The Supreme Court is being asked to reverse 3-0 ruling by a panel of judges in the Fourth Circuit federal appeals court last week that upheld the legality of financial aid given to enrollees on a federally-run Obamacare exchange. That case is known as *King v. Burwell.*

Another federal appeals court panel sitting in Washington, D.C., in a bombshell, 2-1, decision, ruled those subsidies are illegal because they were issued to enrollees on the federal exchange HealthCare.gov. In that case, known as *Halbig v. Burwell,* the Obama administration intends to seek a reversal of the decision by a so-called en banc panel made up f all judges in the D.C. appeals circuit.

A senior Obama administration official, speaking on the condition of anonymity, said, "We think that the Fourth Circuit's unanimous panel made the right decision, agreeing with Congress and common sense."

"As we have previously said, the government is following the normal process and seeking a full review of 2-1 decision in the *Halbig* case. If the en banc D.C. Circuit rules in favor of the government, there will be no split in the courts of appeals and no need for Supreme Court review."

"This litigation should be seen for what it is – another partisan attempt to undermine the Affordable Care Act," the senior official said.

The Obama administration survived a challenge to Obamacare at the Supreme Court, when a majority that surprisingly included conservative Chief Justice John Roberts upheld most elements of the Affordable Care Act, including the mandate that most Americans obtain health insurance or pay a tax penalty.

But neither the administration nor supporters of Obamacare relish having the high court take up the question of subsidies, particularly after a recent Supreme Court ruling that went against the administration in an Obamacare case.

In that case, known as *Hobby Lobby*, the high court said that certain companies could claim a religious exemption to the mandate that their health plans covers contraception without requiring employees to pay out-of-pocket costs.

Plaintiffs in both subsidy-related cases claim the Affordable Care Act as written only allows financial aid to be given to customers of state-run Obamacare marketplaces. The ACA, in fact, explicitly only mentions such aid in the context of it being given to state-run exchange enrollees.

The Obama administration, and Obamacare advocates, in turn argue that is a too-narrow reading of the statute, and that it ignores what they say was Congress' obvious intention to make financial aid available to all qualified individuals, regardless of where they purchased insurance.

Subsidies issued to people who buy Obamacare plans on one of 15 exchanges run by individual states and the District of Columbia are not threatened by the cases. About 2 million people receiving such financial aid this year.

There is no right to have a case heard by the Supreme Court. It will be up to the justices on the court whether to take the case.

It is possible they will let the issue be sorted out first by the lower federal appeals courts.

The administration is considered to have the edge in such a so-called "en banc" review by the full appeals court because judges appointed by Democratic presidents hold a 7-4 edge over Republican appointees in that circuit.

Last fall, US Senate Majority Harry Reid, D-Nev., changed Senate rules to remove the ability of senators to use a filibuster to prevent judicial nominations below the Supreme Court. Reid's move set in motion the seating of three judges appointed by President Obama to the D.C. appeals circuit — who are part of that three-vote margin in the administration's favor on the court now.

If the administration won an en banc review in the D.C. circuit, then there would be no split with the Fourth Circuit in their view of the subsidies' legality. That, in turn, would make it less likely for the Supreme Court to consider an appeal by the plaintiffs.

Jost, the Washington and Lee University School of Law professor who has been a key player in the debate over the subsidies, said, "The Justice Department has already said that it will file for en banc review with the full D.C.circuit."

Once that happens, it is likely that [D.C. Circuit judge Thomas]Griffith's obviously political decision will be set aside. In the

absence of a division between the D.C. Circuit and Fourth Circuit, it is very unlikely the Supreme Court will take the case, unless it is willing to make an overtly politically partisan move," Jost said.

There are two other similar cases pending in federal courts in Indiana and Oklahoma, but neither has reached the appellate level.

The Wall Street Journal editorial page last week urged Michael Carvin, the lawyer who has been representing the plaintiffs in both pending appeals, to skip asking the Fourth Circuit for an en banc review of its decision, and instead to petition the Supreme Court to hear the case, and resolve the issue once and for all.

Carvin's chances with an en banc review at the Fourth Circuit are not rated very high by people on both sides of the argument.

Obamacare supporters have long scoffed at the claims of the plaintiffs, but they have readily conceded the fact that if the plaintiffs prevailed it would be a dire threat to the goals of the Affordable Care Act.

If the Supreme Court ruled for the plaintiffs, it would prevent billions of dollars worth of taxpayer funded subsidies from being given to help people buy insurance on a federally-run exchange.

Such a ruling also would destroy in those HealthCare.gov-served states a looming Obamacare rule that will require most mid- and large-sized employers to offer affordable health coverage to workers or pay a fine.

That's because those fines only take effect if a worker at such a company buys a plan from an Obamacare exchange with financial aid from the government.

And, such a ruling also would effectively cripple, again in those states, another Obamacare rule that compels individuals to have some form of health coverage or pay a tax penalty. Without subsidies, insurance sold on HealthCare.gov would be considered unaffordable for many people under the rules of Obamacare, and they would be exempt from the penalty for not having insurance.

If the Supreme Court invalidated the HealthCare.gov subsidies, states currently served by that exchange would be free — as they are now — to set up their own exchanges that would sell subsidized coverage to their residents.

While some states might do so, many others, led by Republican governors and Republican-controlled legislatures, would be unlikely to set up an exchange because it would be seen as endorsing Obamacare.

"By Any Means Necessary"

New York Times
Linda Greenhouse
August 20, 2014

The Affordable Care Act — Obamacare — has endured so many near-death experiences that digging into the details of still another effort to demolish it is admittedly not an inviting prospect. (My own reaction, I confess, to hearing some months back about the latest legal challenge — this one aimed at the supposed effect of a single word in the 900-page statute — was something along the lines of "wake me when it's over.")

But stay with me, because this latest round, catapulted onto the Supreme Court's docket earlier this month by the same forces that brought us the failed Commerce Clause attack two years ago, opens a window on raw judicial politics so extreme that the saga so far would be funny if the potential consequences weren't so serious.

To be clear, I'm not suggesting that there is anything wrong with turning to the courts to achieve what politics won't deliver; we all know that litigation is politics by other means. (Think school desegregation. Think reproductive rights. Think, perhaps, same-sex marriage.) Nor is the creativity and determination of the Affordable Care Act's opponents any great revelation — not after they came within a hairsbreadth of getting the law's individual mandate thrown out on a constitutional theory that would have been laughed out of court not too many years ago.

Boy, are they ever determined. Flash back to December 2010, when the Commerce Clause challenges to the new law were beginning to fill the legal pipeline en route to the Supreme Court. At a conference held at the American Enterprise Institute, a conservative research organization in Washington, Michael S. Greve, an A.E.I. scholar and chairman of the Competitive Enterprise Institute, had this to say in reference to the Affordable Care Act:

> "This bastard has to be killed as a matter of political hygiene. I do not care how this is done, whether it's dismembered, whether we drive a stake through its heart, whether we tar and feather it and drive it out of town, whether we strangle it. I don't care who does it, whether it's some court some place, or the United States Congress. Any which way, any dollar spent on that goal is worth spending, any brief filed toward that end is worth filing, any speech or panel contribution toward that end is of service to the United States." Mr. Greve went on to urge a litigating strategy that looked beyond the mandate to "concentrate on bits and pieces of this law."

And that's exactly what his Competitive Enterprise Institute proceeded to do. It is financing a set of lawsuits with a seemingly modest ambition: seeking not a constitutional ruling but a mere statutory interpretation. The suits put forward an interpretation of the statutory language that would deny tax credits to people who buy insurance on the exchanges set up by the

federal government in the 36 states that have refused to establish their own exchanges. If the Supreme Court buys that statutory argument, a core goal of the Affordable Care Act — facilitating the purchase of insurance by people of modest income — would be undermined to the point of collapse. Modest indeed.

(The video from the American Enterprise Institute conference has been making its way around the internet; Mr. Greve's comments are just past the one hour, 30 minute mark. I first saw it on the website of the Constitutional Accountability Center, a progressive Washington-based think tank and legal shop.)

It was at the American Enterprise Institute conference that the statutory argument first came to light, in a Power Point presentation by a lawyer from Greenville, S.C., Thomas M. Christina, who specializes in employee benefits. He said he had essentially stumbled on the reference in Section 36B of the act that refers to the availability of tax credits to offset the cost of insurance plans "enrolled in through an exchange established by the state." His conclusion was that the tax credits — the federal subsidy that makes the system work — were not available in what he called the "non-capitulating states," those that refused to set up exchanges and, as another section of the law permitted them to do, left the job to the federal Department of Health and Human Services.

I know and like Michael Greve, who is now a law professor at George Mason University; the rhetorical excess he exhibited at that conference is part of his charm. And of course, the motivations of those who "cobbled the cases together," in Mr. Greve's description in a recent blog post, say nothing about the merits of their argument. Nonetheless, as origin stories go, this makes for a good one.

As to the merits, six federal appellate judges have evaluated the statutory argument, and four have rejected it. One judge, Harry T. Edwards of the United States Court of Appeals for the District of Columbia Circuit, called the case "specious," a "not-so-veiled attempt to gut" the law in defiance of "the will of Congress."

The problem is that Judge Edwards's totally persuasive opinion was written in dissent. The majority opinion, concluding that the Internal Revenue Service is without statutory authority to issue tax credits for insurance purchased on the federally established exchanges where more than five million people have bought their health insurance, was written by Judge Thomas B. Griffith and joined by Judge A. Raymond Randolph.

Judge Griffith is a thoughtful judge who spent five years as the Senate's legal counsel; sadly, whatever he learned in that job about the legislative process was not on display in this opinion, *Halbig v. Burwell*. (Of course there are ambiguities and inconsistencies in a 900-page bill that never went to a conference committee for a final stitching together of its many provisions.) Judge Randolph is one of the most outspoken and agenda-driven conservatives on the entire federal bench. In a speech to the far-right Heritage Foundation in 2010,

for example, he denounced the Supreme Court for having granted habeas corpus rights to the Guantánamo detainees and compared the justices to Tom and Daisy Buchanan in "The Great Gatsby," "careless people who smashed things up" and "let other people clean up the mess they made."

He then proceeded in a series of opinions on the appeals court to shrink the detainees' habeas right to the vanishing point that it eventually reached.

The decision joined by the two judges trained a laser focus on a single section, indeed on a single word, in the massive statute: the reference to "an exchange established by the state." The opinion not only ignored the broader context, in which Congress clearly intended to make insurance affordable so that as many healthy people as possible would join an economically viable pool, but also rejected the government's argument that language in other sections of the law supported the view that Congress didn't mean to treat the state and federal exchanges differently.

Section 1321(c) provides that if a state fails to establish an exchange, the secretary of Health and Human Services shall "establish and operate such Exchange within the state and the Secretary shall take such actions as are necessary to implement such other requirements." The words "such Exchange," the government argues, mean that the federal government stands in the state's shoes when it complies with this instruction; for these purposes, the federal government is the state.

That interpretation "makes sense," all three members of a three-judge panel of the United States Court of Appeals for the Fourth Circuit, in Richmond, Va., concluded in *King v. Burwell*, a decision that, by an amazing coincidence of timing, was issued the same day, July 22, as the contrary D.C. Circuit opinion. Those three judges, Roger L. Gregory, Stephanie D. Thacker and Andre M. Davis, examined the statute as a whole, in light of its purpose, and at the end of the day found the federal-state issue to be ambiguous. That's all they needed to find for the government to win the case.

To avoid the Chevron rule, the D.C. Circuit majority had to find that the statute was clear in ruling out tax credits on the federal exchanges. The majority even shed a few crocodile tears: "We reach this conclusion, frankly, with reluctance." The conclusion is simply wrong. The Supreme Court has a clear rule on what courts should do about agency regulations adopted in the face of statutory ambiguity: as long as the agency's action is based on a permissible interpretation of the statute, courts must defer to the agency. The situation is so common that the 30-year-old decision establishing the deference rule, *Chevron v. Natural Resources Defense Council* is one of the most frequently cited of all Supreme Court decisions.

In fact, one judge on the Fourth Circuit panel, Andre M. Davis, wrote a separate concurring opinion to say that the statute was completely clear in the other direction. The plaintiffs' argument, he said, was based on "a tortured, nonsensical construction of a federal statute whose manifest purpose, as

revealed by the wholeness and coherence of its text and structure, could not be more clear."

With the two contrary decisions having come down on the same day, the judicial politics surrounding the fate of the Affordable Care Act immediately got rich. The Obama administration quickly announced its intention to seek rehearing by the entire 11-member D.C. Circuit; it filed its rehearing petition on August 1. Michael A. Carvin, the lawyer for the law's opponents (he argued the two cases) might have made the same request to the Fourth Circuit. But he did the opposite: he appealed to the Supreme Court, taking only two weeks to file his petition instead of the allotted 90 days. The race was on.

What, exactly, is the race? Clearly, the law's opponents have their best chance — indeed, probably their only chance — in the Supreme Court. They not only lost in the Fourth Circuit, but they are likely to lose in the D.C. Circuit as well if that court, its membership recently bolstered by four Obama appointees, grants rehearing. And conversely, the administration has a clearer path to victory before the entire appeals court than it does in the Supreme Court. So the opponents' challenge is to persuade the justices to take the case as quickly as possible. And the best way to do that is to keep the D.C. Circuit panel's opinion on the books.

Why? Because the one reliable marker of a case the justices deem worthy of their attention is a conflict in the federal circuits on an important legal issue. But a decision by the D.C. Circuit's judges to grant rehearing automatically wipes the panel opinion off the books, even before the rehearing itself takes place. With the panel opinion vacated, there would be no conflict — only a single ruling, a government win in the Fourth Circuit, not (if neutral principles govern, as of course they may not) a particularly attractive case for Supreme Court review.

So the opponents' effort is trained on persuading the D.C. Circuit not to grant rehearing or — if that effort fails — to delegitimize a grant of rehearing in the eyes of friendly Supreme Court justices. The conservative blogosphere has been buzzing with messages to the appeals court, bank shots intended to be read by the justices, or at least their law clerks. Carrie Severino, a former clerk to Justice Clarence Thomas who blogs for National Review, wrote earlier this month that "clearly this type of case is exactly what the President had in mind when he made his court-packing blitz last year." Would the new judges be "willing to take the fall for the president in this case," she wondered: "Now those judges will have to decide whether they want their first high-profile act on the court to be one that is baldly political: overturning a meticulously reasoned decision that overturned the IRS's attempt to rewrite the Affordable Care Act. It would make the new judges look like presidential pawns who are attempting to save his bacon, lowering them to the level of the disgraced and politicized IRS itself."

The Volokh Conspiracy blog on The Washington Post carried a somewhat more politely worded imprecation to the D.C.

Circuit by Jonathan H. Adler, a law professor at Case Western Reserve University and an architect of the statutory strategy. So did the Wall Street Journal's op ed page. All these and others appeared within a day of one another. It's safe to say that never has so much (virtual) ink been spilled in public over the question of whether a federal appeals court should grant a rehearing petition. And for this politically driven crowd to claim the moral high ground in pre-emptively accusing others of playing politics borders on fantasy.

As I said at the beginning of this column, it would be funny if it wasn't so serious.