No. 14-5018

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

JACQUELINE HALBIG, ET AL.,

Appellants,

v.

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

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA (NO. 13-623 (PLF))

APPELLANTS' MOTION TO EXPEDITE THE APPEAL

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTRODUCTION 1

BACKGROUND 4

ARGUMENT 10

I. THE PUBLIC HAS A COMPELLING INTEREST IN PROMPT ADJUDICATION OF THE VALIDITY OF THE CHALLENGED IRS RULE, UNDER WHICH *BILLIONS* OF TAXPAYER DOLLARS ARE BEING SPENT EVERY MONTH 10

II. APPELLANTS WILL ALSO SUFFER IRREPARABLE INJURY IF THE AVAILABILITY OF SUBSIDIES IS NOT RESOLVED BY MARCH 31, 2014, WHEN ACA "OPEN ENROLLMENT" CLOSES 13

III. THERE ARE SUBSTANTIAL GROUNDS FOR CHALLENGING THE DISTRICT COURT'S ATEXTUAL CONSTRUCTION OF THE RELEVANT STATUTORY LANGUAGE 15

IV. EXPEDITION WOULD NOT PREJUDICE THE GOVERNMENT 20

CONCLUSION 20

CERTIFICATE OF SERVICE

TABLE OF AUTHORITIES

Page(s)

CASES

Abbott Labs. v. Gardner,
387 U.S. 136 (1967).....14

Brock v. Pierce Cnty.,
476 U.S. 253 (1986).....12

Custis v. United States,
511 U.S. 485 (1994).....16

DeNaples v. Office of Comptroller of Currency,
706 F.3d 481 (D.C. Cir. 2013).....20

Duncan v. Walker,
533 U.S. 167 (2001).....16

Engine Mfrs. Ass'n v. EPA,
88 F.3d 1075 (D.C. Cir. 1996).....19, 20

Ex parte Young,
209 U.S. 123 (1908).....14

James River Flood Control Ass'n v. Watt,
680 F.2d 543 (8th Cir. 1982) (per curiam) 12

Lamie v. United States Tr.,
540 U.S. 526 (2004).....17

Rodriguez v. United States,
480 U.S. 522 (1987) (per curiam).....19

Russello v. United States,
464 U.S. 16 (1983).....15

Sottera, Inc. v. FDA,
627 F.3d 891 (D.C. Cir. 2010).....14

* Authorities upon which we chiefly rely are marked with asterisks.

Stichting Pensioenfonds Voor De Gezondheid v. United States, 129 F.3d 195 (D.C. Cir. 1997) 16

Yazoo & Miss. Valley R.R. Co. v. Thomas, 132 U.S. 174 (1889) 16

STATUTORY AND REGULATORY PROVISIONS

26 U.S.C. § 35 ..... 6, 19

*26 U.S.C. § 36B (ACA, § 1401) 5, 6, 12, 15, 17, 18

26 U.S.C. § 4980H (ACA, § 1513) 8

26 U.S.C. § 5000A (ACA, § 1501) 8

42 U.S.C. § 1396a (ACA, § 2001) 5, 18, 19

42 U.S.C. § 18024 (ACA, § 1304) 15

*42 U.S.C. § 18031 (ACA, § 1311) 1, 4, 5, 6, 7, 15

42 U.S.C. § 18032 (ACA, § 1312) 15, 18

*42 U.S.C. § 18041 (ACA, § 1321) 1, 4, 5, 16, 17

42 U.S.C. § 18043 (ACA, § 1323) 16

42 U.S. C. § 18082 (ACA, § 1412) 5, 11

26 C.F.R. § 1.36B-2 7

45 C.F.R. § 155.20 7

45 C.F.R. § 155.605 8

OTHER AUTHORITIES

CBO, *Effects of Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline* (May 14, 2013), *available at* http://www.cbo.gov/publication/44190 11

CMS, *Shared Responsibility Provision Question and Answer* (Oct. 28, 2013), *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf 14

D.C. Cir. Handbk. of Prac. & Internal Procs. 4, 10

Kaiser Family Foundation, *States Decisions for Creating Health Insurance Exchanges*, http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17.....6, 7

Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, Aug. 4, 2012, at A17.....6

INTRODUCTION

This case presents a facial challenge to the most consequential regulation promulgated under the Patient Protection and Affordable Care Act ("ACA"). As of January 1, 2014, that regulation has begun to trigger *billions* of dollars of federal expenditures, and will continue to do so *each month*. Yet the regulation is squarely foreclosed by the ACA's unambiguous text; Congress never authorized that spending. Unless this regulation is expeditiously invalidated, those billions of taxpayer dollars will be lost—or, even worse, clawed back from unsuspecting Americans who *right now* are buying health coverage based on a false premise.

Under 42 U.S.C. § 18031, each state is directed to establish a new, centralized "Exchange" for the sale and purchase of health insurance. If a state refuses, § 18041 directs HHS to create an Exchange in that state instead. To ensure states' assent to undertake the costly, complex, controversial job of establishing these novel Exchanges, Congress in the ACA also authorized federal subsidies—refundable tax credits sent directly by the Treasury to insurers to subsidize premiums for low- and middle-income Americans—for health coverage obtained through an Exchange "established by the State under section [18031]." A state must therefore establish its own Exchange to entitle residents to federal dollars; under the ACA, failure to do so deprives those residents of *billions* in gratuitous federal support.

Ultimately, however, 36 states chose not to establish Exchanges in 2014, and the federal government instead established Exchanges in those states. Under the text of the ACA, federal subsidies are *unambiguously unavailable* for coverage purchased on those federal Exchanges (*i.e.*, through HealthCare.Gov). Yet the IRS has promulgated a regulation (the "IRS Rule") that purports to extend subsidies to the federal Exchanges nonetheless. That is the regulation at issue in this case. It is manifestly contrary to the ACA and therefore legally invalid.

The urgent need for expedition of this case was obvious to the District Court (which dramatically expedited proceedings) and should be obvious to this Court as well. Starting this month, the federal government has begun to send to insurers literally billions of subsidy dollars each month, to help pay premiums for coverage purchased on federal Exchanges. Those payments are illegal. If the IRS Rule is invalidated, the ACA requires the government to claw back some of those funds from low- and middle-income Americans who *right now* are purchasing coverage on the premise of heavy subsidies. That is profoundly unfair—and, as the months pass and the sums mount, the unfairness will grow. Moreover, insofar as the funds cannot be recouped, these billions of taxpayer dollars will be squandered, giving the public an unusual and compelling interest in prompt resolution of this case.

Delay beyond March 31, 2014, would also irreparably injure individuals like Appellant David Klemencic, who would be exempt from the individual mandate

but for the IRS Rule, which renders him eligible for a subsidy and thus reduces his overall out-of-pocket cost for comprehensive insurance to a sum that is (under the Act) deemed "affordable." The "open enrollment" deadline to sign up for comprehensive coverage is March 31, 2014, which means that if the validity of the IRS Rule has not been resolved by then, Klemencic—and thousands like him—will be forced either to purchase a product they do not want or incur a penalty.

The District Judge admitted that, "[o]n its face," the law's "plain language … appears to support plaintiffs' interpretation." (Dkt. 67 ("Op.") at 26.) Yet he nonetheless held—based on one-sided policy rationales, the *absence* of legislative history, and a bizarre theory found nowhere in the ACA's text under which the *federal* government acts as a *state* when establishing an Exchange—that Congress' intent was clearly contrary to the Act's plain text. That was plainly improper statutory interpretation. Every canon of construction—including a venerable rule, ignored by the Court, that protects Congress's power of the purse by requiring tax credits to be provided unambiguously—squarely refutes the IRS Rule, as does the obvious purpose of the relevant language. Nor, although the District Court did not reach it, could *Chevron* deference save this Rule, because the statutory text is clear and because deference does not apply here *at all*.

For these reasons, this case exemplifies *both* of the situations in which this Court will expedite an appeal. The "public" at large has "an unusual interest in

prompt disposition" that is "strongly compelling," given the significance of this regulation to the public fisc and the chaos that would result from delaying its invalidation. D.C. Cir. Handbk. of Prac. & Internal Procs. 33. And "delay will cause irreparable injury" to Appellants too, in a case where "the decision under review is subject to substantial challenge." *Id.* Appellants thus move for this Court to expedite their appeal, with: (1) their opening brief due 10 days after this Court grants this motion; (2) Appellees' response briefs due 18 days thereafter; (3) Appellants' reply brief due 7 days thereafter; and (4) oral argument scheduled as soon as practicable, before March 31, 2014.

BACKGROUND

1. The ACA regulates the individual health insurance market through "Exchanges" set up along state lines. Congress specifically wanted the Exchanges to be run by states. The ACA thus calls on states to establish and operate these Exchanges. In particular, § 1311 of the ACA, 42 U.S.C. § 18031, provides: "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange … for the State that facilitates the purchase of qualified health plans." ACA § 1311(b)(1). But the federal government may not *compel* sovereign states to create Exchanges. Section 1321 of the ACA, 42 U.S.C. § 18041, accordingly recognizes that some states may choose not to establish Exchanges; in such cases, it authorizes the HHS Secretary to "establish and operate such Exchange within the

State." ACA § 1321(c). In other words, if a state declines to establish an Exchange, that responsibility falls upon HHS instead.

2. Because Congress could not compel states to establish Exchanges, the Act uses a variety of tools to encourage them to voluntarily play that role. For example, it uses the "carrot" of federal grants to states for "activities … related to establishing an [Exchange]." ACA § 1311(a); 42 U.S.C. § 18031(a). The Act also uses "sticks" to penalize states that do not create their own Exchanges, such as its prohibition on states' tightening their Medicaid eligibility standards until they do so. ACA § 2001(b)(2); 42 U.S.C. § 1396a(gg) (requiring states to maintain their Medicaid eligibility standards until "the Secretary determines that an Exchange established by the State under section [18031] is fully operational").

Most importantly, the Act's scheme authorizes premium assistance subsidies for low- and moderate-income Americans who purchase coverage through *state-established* Exchanges. These subsidies take the form of refundable tax credits, paid directly by the Treasury to the taxpayer's insurer, as an offset against premiums owed. *See* ACA §§ 1401, 1412. Critically, subsidies are available only for individuals who purchase coverage on an Exchange *established by a state*. The Act provides that a tax credit "shall be allowed" in a particular "amount," 26 U.S.C. § 36B(a), with that amount calculated based on the number of "coverage months of the taxpayer," *id.* § 36B(b)(1). The Act then defines a "coverage

month" as a month during which "the taxpayer … is covered by a qualified health plan … that was enrolled in through an Exchange *established by the State under section [18031]*." *Id.* § 36B(c)(2)(A)(i) (emphasis added). Unless the citizen buys insurance through a state-established Exchange, there are no "coverage months" and no subsidy. Confirming that fact, the value of the subsidy for any particular "coverage month" is based on the monthly premium for a "qualified health pla[n] … which cover[s] the taxpayer … *and which w[as] enrolled in through an Exchange established by the State under [§18031]*," *id.* § 36B(b)(2)(A) (emphasis added). Unless the individual enrolls through a state-created Exchange established under § 18031, he gets no subsidy. Inducing state cooperation by making it a condition on benefits to state residents is an old congressional tactic, forming the basis for Medicaid and other tax credits. *E.g.*, 26 U.S.C. § 35(e)(2).

Believing its offer so irresistible that every state would comply, Congress did not appropriate funds for federal Exchanges, even as it appropriated unlimited funds to help states create theirs, ACA § 1311(a). "[L]awmakers assumed that every state would set up its own exchange." Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, Aug. 4, 2012, at A17.

3. Exercising the option granted by the Act, however, 34 states decided not to establish their own Exchanges. *See* Kaiser Family Foundation, *State Decisions For Creating Health Insurance Exchanges*, http://www.statehealthfacts.

org/comparemaptable.jsp?ind=962&cat=17. Two states also could not establish Exchanges in time, meaning 36 states are on HealthCare.Gov this year. *Id.* nn.1, 4.

4. As explained above, premium assistance subsidies are not available under the text of the ACA in the 36 states with federally established Exchanges in 2014, because individuals in those states cannot enroll in coverage "through an Exchange established by the State under section [18031]," which is a prerequisite to subsidy eligibility. But the IRS has promulgated a regulation ("the IRS Rule") requiring the federal Treasury to disburse subsidies in those states regardless.

Specifically, the Rule states that subsidies shall be available to anyone "enrolled in one or more qualified health plans through an Exchange," and then adopts an HHS definition of "Exchange" that includes *any* Exchange, "regardless of whether the Exchange is established and operated by a State … or by HHS." 26 C.F.R. § 1.36B-2; 45 C.F.R. § 155.20. In effect, the Rule eliminates the statutory language restricting subsidies to Exchanges "established by the State under section 1311." Under the IRS Rule, federal subsidies are thus available in all states, even those states that failed to establish their own Exchanges.

5. By expanding the availability of subsidies to individuals who buy coverage even on federally established Exchanges, the IRS Rule also triggers other mandates and penalties under the Act for millions of individuals and thousands of

employers in these 36 states—including Appellants. In other words, this "free" federal money actually has harmful consequences for many.

For individuals, the availability of the subsidy triggers the Act's individual mandate penalty for many who would otherwise be exempt. While that mandate requires most individuals to obtain "minimum essential coverage" or else pay a fine, 26 U.S.C. § 5000A, there is an exemption for those "who cannot afford coverage" or would suffer "hardship" if forced to buy it. *Id.* § 5000A(e)(1), (5). In particular, an individual is exempt from the mandate penalty if the annual cost of coverage exceeds 8% of his projected income. 45 C.F.R. § 155.605(g)(5). By making subsidies available in states without their own Exchanges, the IRS Rule reduces the cost of coverage and thus vastly increases the number of people in those states who are disqualified from this exemption.

For employers, the availability of the subsidy triggers exposure to the Act's so-called employer mandate, which penalizes large employers who fail to offer full-time employees the opportunity to enroll in affordable health coverage. But the penalty is only triggered if at least one employee enrolls through an Exchange in a plan for which "an applicable premium tax credit … is allowed or paid." 26 U.S.C. § 4980H. Thus, if no federal subsidies are available in a state because that state has not established its own Exchange, then employers in that state would not be threatened with liability for any penalties under the employer mandate.

6. Appellants are individuals and employers residing in states served by federal Exchanges, who are injured by the IRS Rule. Proceedings in the District Court focused on David Klemencic, who would be exempt from the individual mandate if he were not eligible for a subsidy under the IRS Rule, but because of that Rule is now required to pay out-of-pocket for a product he does not want.[1]

7. District Judge Paul Friedman expedited the proceedings below after this case was assigned to him on September 13, 2013. On October 21, he held oral argument on the Government's motion to dismiss and on Plaintiffs' motion for a preliminary injunction—and then issued an oral ruling on both motions *the next day*, in view of the time-sensitive nature of the case. (Dkt. 42, 43.) He rejected the Government's jurisdictional arguments, and denied preliminary relief after finding that he would be able to issue a merits decision in time to avoid irreparable injury. (Tr., Dkt. 46, at 40, 46.) Judge Friedman then ordered expedited briefing on cross-motions for summary judgment, and held oral argument on December 3.

8. On January 15, 2014, Judge Friedman upheld the Rule, concluding that while the subsidy provision's "plain language … appears to support plaintiffs' interpretation," Congress clearly intended just the contrary. (Op. 26.) The Court

[1] Disagreeing with the Fourth and Seventh Circuits, the District Court held that the employer mandate is a "tax" and so the *employers'* claims were barred by the Anti-Injunction Act. (Op. 19-21.) But, because Klemencic had standing and faced no such hurdles, the court still had to reach the merits. (Op. 22.)

deduced that counter-textual intent from (i) Congress' policy goal "to provide affordable health care" (Op. 33); (ii) the *absence* of legislative history confirming the plain text (Op. 34, 37); (iii) supposed "anomalies" in operation of some of the Act's *other* provisions if the subsidy provision were given its plain meaning (Op. 30); and (iv) a contorted reading of statutory cross-references to create an implied legal fiction that HHS acts *as a state* when it establishes an Exchange, even though the Act says no such thing (yet does *expressly* direct that U.S. territories should be treated as states when they create Exchanges).

ARGUMENT

At least two circumstances give this Court good cause to expedite here: *first*, when "the public" at large has "an unusual interest in prompt disposition" that is "strongly compelling"; or *second*, when "delay will cause irreparable injury" to the appellant and "the decision under review is subject to substantial challenge." D.C. Cir. Handbk. of Prac. & Internal Procs. 33. This unique case easily satisfies both standards, and substantial expedition would not prejudice the Government.

I. THE PUBLIC HAS A COMPELLING INTEREST IN PROMPT ADJUDICATION OF THE VALIDITY OF THE CHALLENGED IRS RULE, UNDER WHICH *BILLIONS* OF TAXPAYER DOLLARS ARE BEING SPENT EVERY MONTH.

The principal ground for expediting this appeal is the critical importance of prompt resolution to the public as a whole. The IRS Rule is a foundation of the implementation of the ACA, and the Nation desperately needs certainty about the

legal viability of this regime. If the IRS Rule is indeed invalid, the public deserves to know as soon as possible; every month of delay will cost taxpayers *billions* of dollars in unauthorized spending and/or put hundreds of thousands of low-income Americans on the hook for premiums deceptively presented as heavily subsidized. The longer this Rule applies, the worse the chaos when eventually invalidated. As even the District Court recognized, definitive resolution of this issue is thus urgently required.

A. Many of the ACA's major reforms, including operation of the new Exchanges and provision of the new premium subsidies, took effect on January 1, 2014. That means that, while this case remains pending, the IRS Rule will dictate that the Treasury send federal funds to insurers in 36 states to help pay premiums for individuals who enroll in coverage through HealthCare.Gov—in violation of the ACA's express text, which restricts subsidies to state-established Exchanges. Those payments are made on a monthly basis, *see* ACA § 1412(c)(2)(A), and so *every month of delay* will result in more payments that are contrary to law.

These are *massive* sums. Just months ago, the Congressional Budget Office estimated that, in 2014, there will be 6 million enrollees entitled to subsidies, with those subsidies averaging $5,290 per recipient.[2] That amounts to over $2.6 *billion*

[2] *See* CBO, *Effects of Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline* tbl. 1 (May 14, 2013), *available at* http://www.cbo.gov/publication/44190.

in subsidies *every month*. Since 36 states are not running Exchanges this year, a large majority of those funds will represent subsidies authorized only by virtue of the IRS Rule. Unhurried consideration of this appeal thus implicates billions of taxpayer dollars on a monthly basis, which alone is sufficient reason to expedite. As the Supreme Court has recognized, "the protection of the public fisc is a matter that is of interest to every citizen." *Brock v. Pierce Cnty.*, 476 U.S. 253, 262 (1986); *see also James River Flood Control Ass'n v. Watt*, 680 F.2d 543, 544-45 (8th Cir. 1982) (per curiam) (concluding that avoiding potentially unnecessary "expenditures from the public treasury" "serves the public interest").

B. Even worse, if Treasury makes these payments but this Court later concludes that subsidies are not available on federal Exchanges, the ACA leaves *low- and middle-income Americans* on the hook to repay the improper payments. 26 U.S.C. § 36B(f)(2). An American who buys coverage on HealthCare.Gov after being advised that his premiums will be subsidized would, if the IRS Rule is invalidated later in 2014, thus find himself owing the promised subsidies back to the IRS in taxes. If invalidation occurs early in 2014, he would at least be able to minimize the losses by cancelling his coverage or switching to a cheaper plan. But a delayed ruling would cause his taxes to accumulate on a monthly basis, all after being falsely promised that his premiums would be paid in large part by the Government. That is grossly unfair. Expedition would minimize that unfairness to

millions of non-parties, and the Court should grant this motion for that reason too.

Of course, to the extent that the improperly paid subsidy funds cannot or will not be recouped from the supposed beneficiaries, that simply shifts the burden of these huge losses back to the public at large. Either way, therefore, the public has a uniquely compelling interest in the prompt resolution of this appeal. As do the affected subsidy recipients, who would obviously prefer to know sooner rather than later if they need to make other arrangements for insurance in 2014.

C. Judge Friedman was persuaded by the foregoing arguments for speed. He expedited resolution of this case, ruling orally on a complex motion to dismiss just *one day* after that motion was argued, in light of the "urgency to both sides." (Tr., Dkt. 46, at 3.) That urgency remains, and this Court should follow suit.

II. APPELLANTS WILL ALSO SUFFER IRREPARABLE INJURY IF THE AVAILABILITY OF SUBSIDIES IS NOT RESOLVED BY MARCH 31, 2014, WHEN ACA "OPEN ENROLLMENT" CLOSES.

Of course, it is not just the public at large, and millions of affected persons, who will suffer irreparable injury from delayed adjudication of the IRS Rule's validity. Appellants, too, will be forced to a Hobson's Choice if their eligibility for subsidies remains uncertain when the ACA's "open enrollment" period closes on March 31, 2014. By that date, individuals like Mr. Klemencic must either comply with the individual mandate—and buy comprehensive health coverage they do not

want—or else violate the mandate and potentially incur a penalty.[3] (Op. 13-14.) That penalty, however, applies *only* if the IRS Rule is valid; otherwise, Klemencic is exempt from the penalty and therefore would never be put to this choice.

Forcing people like Klemencic to either buy a product they do not want or risk a penalty is a classic form of irreparable harm. *See Ex parte Young*, 209 U.S. 123, 148 (1908) ("[T]o impose upon a party … the burden of obtaining a judicial decision … only upon the condition that if unsuccessful he must … pay fines …, is, in effect, to close up all approaches to the courts … and therefore invalid."); *Abbott Labs. v. Gardner*, 387 U.S. 136, 152 (1967) (citing "dilemma" of either "comply[ing] … and incur[ring] the costs" of doing so or violating the law "and risk[ing]" penalties if legal challenge fails). And if, under threat of liability, they choose to comply with the mandate, those costs would never be recoverable from the Government. *Sottera, Inc. v. FDA*, 627 F.3d 891, 898 (D.C. Cir. 2010).

In short, not only is prompt adjudication necessary to avoid harm and chaos for the nation at large, but it is also needed to forestall tangible irreparable injury to the individual Appellants here and all those similarly situated, who, absent prompt

[3] *See* CMS, *Shared Responsibility Provision Question and Answer* 2 (Oct. 28, 2013), *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf ("[I]ndividuals have until the end of the initial open enrollment period to enroll in coverage through the new Marketplaces while avoiding liability for the [individual mandate] payment.").

adjudication, will be coerced into spending unreimbursable funds on products that they do not want and, absent the IRS Rule, would not be required to buy.

III. THERE ARE SUBSTANTIAL GROUNDS FOR CHALLENGING THE DISTRICT COURT'S ATEXTUAL CONSTRUCTION OF THE RELEVANT STATUTORY LANGUAGE.

Expedition is particularly required because it is highly likely that this Court will disagree with the District Court's construction of the ACA's text.

A. The District Court admitted that "the plain language of 26 U.S.C. § 36B, viewed in isolation, appears to support plaintiffs' interpretation." (Op. 26.) That is undoubtedly true because § 36B authorizes subsidies only for policies provided by "an Exchange established by the *State* under section 1311" of the Act. HHS is obviously not a "State," under either common usage or the ACA's own definitions, ACA § 1304(d), and therefore an Exchange established by HHS is therefore obviously not "an Exchange established by the State."

Moreover, every conceivable canon of construction confirms the plain text. When Congress wanted to refer to *both* state- and HHS-established Exchanges, it did so *expressly*, by specifying both, *e.g.*, 26 U.S.C. § 36B(f)(3), or by using the broad phrase "Exchange established under this Act," *e.g.*, ACA § 1312(d)(3)(D)(i). *Russello v. United States*, 464 U.S. 16, 23 (1983) ("differing language" in "two subsections" cannot have "same meaning"). When Congress wanted entities other than states *deemed* to be states, it said *that* expressly—such as by providing that a

U.S. territory that establishes an Exchange "shall be treated as a State," ACA § 1323(a)(1)—proving that Congress "knew how to do so," *Custis v. United States*, 511 U.S. 485, 492 (1994). And if Congress meant to subsidize coverage procured on *any* Exchange, the language "established by the State" is surplusage. *Duncan v. Walker*, 533 U.S. 167, 174 (2001). On top of all this, courts protect Congress' power of the purse by recognizing tax credits only if they are "unquestionably and conclusively" established, *Stichting Pensioenfonds Voor De Gezondheid v. United States*, 129 F.3d 195, 198 (D.C. Cir. 1997), expressed in "clear and unambiguous terms," *Yazoo & Miss. Valley R.R. Co. v. Thomas*, 132 U.S. 174, 186 (1889). The District Court simply disregarded all of these venerable canons of construction.

B. The District Court nonetheless contended that, when the ACA subsidy provision refers to an "Exchange established *by the State*," it includes an Exchange established *by HHS*, because § 18041 of the Act allows HHS to establish Exchanges in states that fail to establish their own. (Op. 28.) That is a non-sequitur. It is precisely *because* two distinct entities may establish Exchanges that "Exchange established by the State" cannot be read to include one established by HHS. That is, Congress clearly knew that it was authorizing both state- and HHS-established Exchanges; its reference to *one* of those cannot be construed as a reference to *both* simply because both are authorized to exist.

The District Court seems to have concluded that, when HHS establishes an Exchange under § 18041 because a state fails to do so, HHS acts "*on behalf of*" the state and thus, by some bizarre transitive property, an HHS-established Exchange is "established by the State." (Op. 28-29.) That makes no sense. An Exchange is established either by a state or by HHS; it cannot be both at once. A "federally established state-established Exchange" is an oxymoron. Moreover, an Exchange established by HHS "on behalf of" the state that declined to establish one is plainly not "established by the *State*," it is established by HHS in the refusing state. Finally, the ACA does not even state that HHS shall establish an Exchange "on behalf of" the state; rather, it says that HHS shall establish an Exchange "*within*" the state. 42 U.S.C. § 18041(c)(1). That language cannot *sub silentio* allow HHS to be or act as the state.

C. The District Court found that giving the subsidy provision its plain meaning would create "anomalies" in some other ACA provisions. (Op. 30.) But the alleged anomalies do not exist, and certainly do not pose absurdity sufficient to overcome plain text. *See Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004).

First, the Court claimed that a reporting rule, which calls for *both* state- and HHS-run Exchanges to report information about who has signed up for coverage, the cost of their premiums, and the amount of any subsidies they obtain, 26 U.S.C. § 36B(f), would "serve no purpose" if federal Exchanges do not offer subsidies.

(Op. 31.) That is plainly false. Treasury has good reason to want this data for people not entitled to subsidies—which is why the reporting rule applies (on state Exchanges) to those people who do not receive any subsidies. Most obviously, this information is necessary for enforcement of the individual mandate to buy insurance and to conduct the "study on affordable coverage" that the same ACA section calls for. ACA § 1401(b). Indeed, the reporting rule *confirms* the plain reading of § 36B, because it expressly clarifies that it applies to *both* State-established and HHS-established Exchanges, confirming that Congress knew they were distinct. 26 U.S.C. § 36B(f)(3).

Second, the Court claimed that, because one is not eligible to buy coverage on an Exchange unless one "resides in the State that established the Exchange," 42 U.S.C. § 18032(f)(1)(A)(ii), federal Exchanges "would have no customers" unless the Court treats HHS-established Exchanges as established by states. (Op. 31.) False again. Among other things, the Court simply ignored that this eligibility provision *only governs state-run* Exchanges, 42 U.S.C. § 18032(f)(1)(A), and so would bar no one from buying through an HHS-run Exchange.[4]

D. The Court also invoked Congress' purpose—"to provide affordable health care" (Op. 33)—to support its countertextual reading. But "it frustrates

[4] The other cited provisions are no stronger. For example, the provision barring states from tightening Medicaid eligibility until they create an Exchange, 42 U.S.C. § 1396a(gg)(1), would induce them to do so, and thus makes good sense.

rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam). Congress wanted affordable health care, but *it also wanted states to run the Exchanges*—for political, financial, and practical reasons. Conditioning subsidies for a state's residents on establishment by the state of an Exchanges was the best way to satisfy both goals, just like the Act conditioned *all* future Medicaid funding on the state's acquiescence to the new Medicaid formula. ACA § 2001.

The District Court objected that Appellants pointed to "no evidence" of this objective "in the statute itself." (Op. 34.) Obviously, however, as with the Medicaid condition, the evidence *is the text of the subsidy provision*, which on its face imposes this regime.[5]

E. Finally, the Court relied on the *lack* of legislative history confirming the statute's plain text. "[N]o evidence" in the limited legislative history showed an intent to condition subsidies on state establishment of Exchanges. (Op. 37.)

That analysis, too, is backward. Where there is "no basis for the court to conclude that [Congress] voted for a regulatory scheme other than that provided by the words in the statute," the plain text must obviously govern. *Engine Mfrs. Ass'n*

[5] Contrary to the District Court, it is not remotely unusual for Congress to insert a condition on receipt of a tax credit in the statutory formula for calculating it. (Opp. 35 n.12.) Congress does so all the time. *E.g.*, 26 U.S.C. § 35(a), (b), (e).

v. EPA, 88 F.3d 1075, 1092 (D.C. Cir. 1996). "The haste and confusion attendant upon the passage of [a] massive bill do not license the court to rewrite it" but rather "are all the more reason for us to hew to the statutory text." *Id.* Again, there is no legislative history reconfirming the *Medicaid* condition on the statute's face.

F. Although the Court did not reach the issue, *Chevron* deference could not save the IRS Rule. Not only is the statutory language clear as day, but this Court squarely held just months ago that when agencies have "joint administrative authority" over a statute, as IRS and HHS do with respect to the subsidy scheme, there is no "deference to their interpretations." *DeNaples v. Office of Comptroller of Currency*, 706 F.3d 481, 488 (D.C. Cir. 2013).

IV. EXPEDITION WOULD NOT PREJUDICE THE GOVERNMENT.

Finally, Appellants note that even a highly abbreviated briefing schedule would not prejudice the Government. The issue presented is one of pure statutory construction, which this Court reviews *de novo*. The Government has thoroughly briefed this precise issue *repeatedly* in the District Court. (Dkts. 38, 49, 50, 62). Notably, each Government brief was largely a cut-and-paste of its previous effort, and there is no reason why its brief on appeal would or should be any different.

CONCLUSION

The Court should expedite this appeal to require briefing on the timetable set forth on page 4, with oral argument before March 31, 2014.

January 16, 2014

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 16th day of January 2014, I electronically filed the original of the foregoing document with the clerk of this Court by using the CM/ECF system, and I also filed four copies of the foregoing document, by hand delivery, with the clerk of this Court.

I further certify that, on this 16th day of January 2014, I caused the foregoing document to be served via regular and electronic mail on the lead counsel (in the court below) for Defendants-Appellees:

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January 16, 2014

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