[ORAL ARGUMENT SCHEDULED FOR MARCH 25, 2014]

No. 14-5018

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

JACQUELINE HALBIG, ET AL.,

Appellants,

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))

BRIEF *AMICI CURIAE* FOR ECONOMIC SCHOLARS IN SUPPORT OF APPELLEES

MATTHEW S. HELLMAN
Lead Counsel
MATTHEW E. PRICE
JULIE STRAUS HARRIS*
PREVIN WARREN*
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
Tel: 202-639-6000
Email: mhellman@jenner.com

Counsel for Amici Curiae

** Not admitted in D.C.; supervised by principals of the Firm*

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the Economic Scholars certify that:

(A) Parties and *Amici*

In addition to the parties and *amici* listed in the Appellants' Opening Brief, the Economic Scholars submitting this brief may have an interest in the outcome of this case. That group consists of the following 48 individuals:

- **Henry J. Aaron, Ph.D.**,[†] [§] Senior Fellow, Brookings Institution; Assistant Secretary for Planning and Evaluation, Department of Health, Education & Welfare (1977-78);
- **Stuart Altman, Ph.D.**,[§] Sol C. Chaikin Professor of National Health Policy, Brandeis University; Deputy Assistant Secretary for Planning and Evaluation, Department of Health, Education & Welfare (1971-76);
- **Susan Athey, Ph.D.**,[†] [‡] Professor of Economics, Stanford Graduate School of Business; recipient of John Bates Clark Medal;
- **Linda Blumberg, Ph.D.**, Senior Fellow, The Urban Institute; Health Policy Advisor, Office of Management & Budget, The White House (1993-94);
- **Barry Bosworth, Ph.D.**, Senior Fellow, Brookings Institution; Director, Council on Wage & Price Stability, The White House (1977-79); Staff Economist, Council of Economic Advisors, The White House (1968-69);

[†] signifies Fellow, American Academy of Arts and Sciences

[‡] signifies Member, National Academy of Sciences

[§] signifies Member, Institute of Medicine

- **Gary Burtless, Ph.D.**, Senior Fellow & Whitehead Chair in Economic Studies, Brookings Institution; Economist, Office of the U.S. Secretary of Labor (1979-81); Economist, Office of the U.S. Secretary of Health, Education, and Welfare (1977-79);

- **Amitabh Chandra, Ph.D.**, Professor & Director of Health Policy Research, Kennedy School of Government, Harvard University; recipient of Medal for Best Economist under 40, American Society of Health Economists; Member, Congressional Budget Office Panel of Health Advisors (2012-present); recipient of the Arrow Award, for best paper in health economics;

- **Philip J. Cook, Ph.D.**,[‡] [§] ITT/Terry Sanford Professor of Public Policy Studies and Professor of Economics & Sociology, Sanford School of Public Policy, Duke University; recipient of the Arrow Award, for best paper in health economics;

- **Janet Currie, Ph.D.**,[‡] [§] Henry Putnam Professor of Economics & Public Affairs and Director, Center for Health & Well Being, Princeton University; President-Elect, Society of Labor Economists;

- **David Cutler, Ph.D.**,[†] [§] Otto Eckstein Professor of Applied Economics, Department of Economics and Kennedy School of Government, Harvard University; Senior Economist, Council of Economic Advisors (1993); Director, National Economic Council (1993); recipient of the Arrow Award, for best paper in health economics;

- **Karen Davis, Ph.D.**,[§] Eugene and Mildred Lipitz Professor, Department of Health Policy and Management, John Hopkins University; Deputy Assistant Secretary for Health Policy, U.S. Department of Health and Human Services (1977-1980);

- **J. Bradford DeLong**, **Ph.D.**, Professor of Economics, University of California Berkeley; Deputy Assistant Secretary for Economic Policy, U.S. Department of Treasury (1993-95);

- **Peter Diamond**, **Ph.D.**,[† ‡] Professor Emeritus, Massachusetts Institute of Technology; recipient of Nobel Prize in Economic Sciences; former President, American Economic Association;

- **Ezekiel Emanuel, M.D., Ph.D.**,[§] Chair, Department of Medical Ethics & Health Policy, Vice Provost for Global Initiatives, Diane v.S. Levy & Robert M. Levy University Professor, Perelman School of Medicine and The Wharton School, University of Pennsylvania; Special Advisor for Health Policy to the Director of the Office of Management & Budget, The White House (2009-11); Member, National Bioethics Advisory Committee (1996-98); Member, Health Care Task Force, The White House (1993);

- **Austin Frakt, Ph.D.**, Health Economist and Associate Professor, Boston University;

- **Sherry Glied, Ph.D.**,[‡] Dean and Professor of Public Service, Robert F. Wagner Graduate School of Public Service, New York University; Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2010-12); Senior Economist, Council of Economic Advisors (1992-93);

- **Paul B. Ginsburg**, **Ph.D.**, President, Center for Studying Health System Change; Executive Director, Physician Payment Review Commission (1986-1995), Deputy Assistant Director, Congressional Budget Office (1978-1984);

- **Claudia Goldin, Ph.D.**,[† ‡] Henry Lee Professor of Economics, Harvard University; President-elect, American Economic Association;

- **Jonathan Gruber, Ph.D.**,[† §] Ford Professor of Economics, Massachusetts Institute of Technology; Deputy Assistant Secretary for Economic Policy, U.S. Department of Treasury (1997-98); recipient of the Arrow Award, for best paper in health economics;

- **Genevieve M. Kenney, Ph.D.**, Senior Fellow and Co-Director, Health Policy Center, The Urban Institute;

- **Vivian Ho, Ph.D.**, James A. Baker III Institute Chair in Health Economics and Professor of Economics, Rice University; Professor, Department of Medicine, Baylor College of Medicine;

- **John Holahan, Ph.D.**, Institute Fellow, Health Policy Center, The Urban Institute;

- **Jill Horwitz, Ph.D.**, Professor of Law, UCLA School of Law;

- **Lawrence Katz, Ph.D.**,† Elisabeth Allison Professor of Economics, Harvard University; Chief Economist, U.S. Department of Labor (1993-94); President, Society of Labor Economists (2013-14)

- **Frank Levy, Ph.D.**, Daniel Rose Professor of Urban Economics, Emeritus, Massachusetts Institute of Technology;

- **Peter H. Lindert, Ph.D.**, Distinguished Research Professor of Economics, University of California Davis;

- **Eric S. Maskin, Ph.D.**,† Adams University Professor, Harvard University; recipient of Nobel Prize in Economic Sciences;

- **Marilyn Moon, Ph.D.**, Institute Fellow, American Institutes for Research;

- **Alan C. Monheit, Ph.D.**, Professor of Health Economics and Associate Dean, School of Public Health, Rutgers University;

- **Joseph Newhouse, Ph.D.**,† ‡ John D. MacArthur Professor of Health Policy and Management, Harvard University; recipient of the Arrow Award, for best paper in health economics;

- **Mark V. Pauly, Ph.D.**, Bendheim Professor, Professor of Health Care Management, and Professor of Business Economics and Public Policy, Wharton School, University of Pennsylvania;

- **Harold Pollack, Ph.D.**, Helen Ross Professor of Social Service Administration and Faculty Chair, Center for Health Administration Studies, University of Chicago;

- **Daniel Polsky, Ph.D.**, Executive Director, Leonard Davis Institute of Health Economics; Robert D. Eilers Professor of Health Care Management and Professor of Medicine, University of Pennsylvania; Senior Economist on health issues for Council of Economic Advisers (2007-2008);

- **James B. Rebitzer, Ph.D.**, Professor of Management, Economics & Public Policy, School of Management, and Professor of Economics, College of Arts and Sciences, Boston University; recipient of the Arrow Award, for best paper in health economics;

- **Michael Reich, Ph.D.**, Professor of Economics and Director of Institute for Research on Labor and Employment, University of California Berkeley;

- **Robert D. Reischauer, Ph.D.**, Distinguished Institute Fellow and President Emeritus, The Urban Institute; Director, Congressional Budget Office (1989-95); Public Trustee, Social Security & Medicare Trust Fund;

- **Alice Rivlin, Ph.D.**,[†] Senior Fellow, Leonard D. Schaeffer Chair in Health Policy Studies, Director, Engelberg Center for Health Care Reform, Brookings Institution; Vice-Chair, Federal Reserve Board (1996-99); Director, Office of Management & Budget, The White House (1994-96); Director, Congressional Budget Office (1975-83); Assistant Secretary for Planning & Evaluation, U.S. Department of Health, Education & Welfare (1968-69); recipient of MacArthur Foundation Prize Fellowship (1983);

- **Meredith Rosenthal, Ph.D.**, Professor of Health Economics and Policy and Associate Dean, Harvard School of Public Health;

- **Isabel Sawhill, Ph.D.**, Senior Fellow, Brookings Institution; Associate Director, Office of Management and Budget, The White House (1993-95);

- **John B. Shoven, Ph.D.**,[†] Trione Director of the Stanford Institute for Economic Policy Research and Charles R. Schwab Professor of Economics at Stanford University; Senior Fellow, Hoover Institution;

- **Jonathan Skinner, Ph.D.**,[§] James O. Freedman Presidential Professor of Economics, Dartmouth College; Professor, Geisel School of Medicine;

- **Lawrence Summers, Ph.D.**,[‡] Charles Eliot University Professor, Harvard University; Secretary of the Treasury (1999-2001); Director of the National Economic Council (2009-2010); recipient of John Bates Clark Medal; recipient of Alan T. Waterman Award;

- **Katherine Swartz, Ph.D.**,[§] Professor of Health Economics and Policy, Harvard School of Public Health;

- **Kenneth Thorpe, Ph.D.**, Robert W. Woodruff Professor and Chair of Department of Health Policy and Management, Rollins School of Public Health, Emory University; Executive Director and Director of Center for Entitlement Reform, Institute of Advanced Policy Solutions;

- **Laura Tyson, Ph.D.**, Professor of Economics and Business and Director of the Institute for Business and Social Impact, Haas School of Business, University of California at Berkeley; Chair of the Council of Economic Advisers (1993-1995); Chair of the National Economic Council and National Economic Adviser (1995-1996);

- **Paul N. Van de Water, Ph.D.**, Senior Fellow, Center on Budget and Policy Priorities; Assistant Director, Congressional Budget Office (1994-1999); Assistant Deputy Commissioner for Policy, Social Security Administration (2001-2005);

- **Justin Wolfers, Ph.D.**, Senior Fellow, Brookings Institution; Professor of Economics and Professor of Public Policy, University of Michigan (currently on leave); and

- **Stephen Zuckerman, Ph.D.**, Senior Fellow and Co-Director, Health Policy Center, The Urban Institute.

(B) Rulings Under Review

References to the rulings at issue appear in the Appellants' Opening Brief.

(C) Related Cases

References to the related cases appear in the Appellants' Opening Brief.

/s/ Matthew S. Hellman
MATTHEW S. HELLMAN
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
Tel: 202-639-6000
Email: mhellman@jenner.com

Counsel for Amici Curiae

STATEMENT REGARDING CONSENT TO FILE AND SEPARATE BRIEFING

All parties have consented to the filing of this brief.* The Economic Scholars filed notice of their intent to participate as *amici curiae* on February 14, 2014.

Pursuant to D.C. Circuit Rule 29(d), *amici curiae* certify that a separate brief is necessary because no other *amicus* brief of which we are aware will address the issue raised in this brief: namely, whether Congress intended the negative economic consequences that would flow from Appellants' proffered interpretation of the statute. To our knowledge, *amici* are the only group of economic scholars submitting a brief in support of Appellees. In light of *amici*'s activities, discussed more fully herein, *amici* are particularly well-suited to discuss the economic underpinnings of the Affordable Care Act as evidenced by the statute's text, structure, and purpose, as well as the economic consequences of Appellants' position.

* Pursuant to Fed. R. App. P. 29(c), *amici curiae* state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or their counsel made a monetary contribution to its preparation or submission.

TABLE OF CONTENTS

Page(s)

TABLE OF AUTHORITIES*

CASES

STATUTES

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

LEGISLATIVE MATERIALS

OTHER AUTHORITIES

GLOSSARY

ACA:	Patient Protection and Affordable Care Act, 111 Pub. L. No. 148, 124 Stat. 119, 111th Cong., 2d Sess., Mar. 23, 2010
CBO:	Congressional Budget Office
GMSIM:	Gruber Microsimulation Model
USVI:	U.S. Virgin Islands

INTEREST OF *AMICI CURIAE*

Amici curiae are a group of 48 distinguished professors and internationally recognized scholars of economics who have taught and researched the economic forces operating in the health care and health insurance markets. The Economic Scholars include economists who have served in high-ranking positions in the Johnson, Ford, Carter, George H.W. Bush, Clinton, George W. Bush, and Obama administrations; two Nobel Laureates in Economics; two recipients of the John Bates Clark medal, which is awarded biennially to the American economist under 40 who has made the most significant contribution to economic thought and knowledge; one of only two social scientists awarded the Alan T. Waterman Award, usually reserved for physical and chemical scientists; six recipients of the Arrow award for best paper in health economics; and two recipients of the American Society of Health Economists Medal for the best American health economist aged 40 and under. A complete list of the Economic Scholars is provided in the Certificate as to Parties, Rulings, and Related Cases at the front of this brief.

Amici believe that reform of the health care system is essential to constraining the growth of health care spending and to extending health insurance coverage, and that such reforms cannot succeed without premium subsidies for people with low or moderate incomes.

Amici submit this brief to explain the economic reasons why premium subsidies are essential to achieving the reforms of the health care system that Congress seeks through the Affordable Care Act ("ACA"), and to urge that the ACA cannot conceivably achieve those reforms if it is interpreted in the manner proposed by the Appellants. Congress – correctly – structured the ACA as a series of interlocking reforms, of which premium subsidies are essential components. If those subsidies are unavailable to the many who will buy insurance on the federal Exchange, the other components of the ACA will not work, and the legislation will fail to achieve its goal of expanding coverage. The best available economic modeling demonstrates that, without these subsidies, average premiums would double and an estimated 6.5 million fewer Americans would have health insurance. These increased premiums would burden not just those who would otherwise have been eligible for the subsidies, but the remaining enrollees as well. The reason is that those with high expected health care needs will be the most likely to buy coverage, making the insurance pool more expensive to insure and causing much higher premiums for all those buying coverage. Failure to apply the ACA in its intended manner to avoid these consequences would thwart Congress's goal of bringing affordable health care to all Americans.

SUMMARY OF ARGUMENT

A central aim of the ACA is to "achieve near-universal coverage" by making health insurance available and affordable to as many Americans as possible – a goal that can be achieved only by subsidizing the premiums of low- and middle-income Americans who do not qualify for Medicaid, and who otherwise would be unable to afford health insurance. 42 U.S.C. § 18091(2)(D). Appellants do not and cannot deny that expanding coverage was Congress's goal. They nevertheless contend that Congress intended to deny subsidies to those individuals purchasing insurance in States where the federal government, rather than the State, operates the marketplace, known as the health insurance Exchange, where individuals and families can compare and shop for non-group health insurance.

Appellants' interpretation of the ACA cannot be squared with the basic economic framework undergirding that statute. That framework has been analogized to a stool with three legs. All three are necessary to fostering stable, functioning insurance markets consistent with Congress's goal of broad, affordable coverage. The first leg is a series of *non-discrimination rules* that prevent insurers from charging higher premiums or denying coverage to people with pre-existing conditions or other characteristics that raise the likelihood that they will need health care services. The second leg is the *individual mandate*, which requires everyone, sick or healthy, to buy insurance, and avoids a situation in which only

the sickest individuals sign up for insurance, and premiums consequently rise to cover these costly customers. *Premium subsidies* comprise the third leg. These ensure that all people subject to the mandate can afford insurance. After all, a mandate to purchase insurance would be a cruel hoax if people were required to buy insurance that they cannot afford. Indeed, Congress included affordability protection as part of the mandate, exempting those for whom insurance would be too expensive without subsidies.

Appellants' interpretation would chop out the third leg from this three-legged stool in all States where the federal government operates the Exchange, destabilizing the ACA framework in those states and contravening Congress's clearly stated goal of broadening coverage. Without premium subsidies, millions of people will be exempt from the mandate altogether or will choose to pay the tax penalty rather than purchase unaffordable insurance. Yet the sickest people will continue to sign up for insurance and insurers will have to cover them. The resulting higher premiums will threaten an adverse selection "death spiral": as premiums increase, more and more healthy people will be exempt from the mandate or will choose to pay the tax penalty rather than buy insurance, leaving sicker people an ever greater portion of the risk pool, leading to escalating premiums, and even fewer enrollees. That result is incompatible with the structure of the ACA's provisions, as well as the wealth of legislative history showing that

Congress understood premium subsidies to be an indispensible part of the ACA's reforms.

Economic modeling confirms what Congress understood: without premium subsidies for every eligible person who buys insurance on an Exchange, the ACA cannot achieve its goals. The well-known Gruber Microsimulation Model ("Gruber Model" or "GMSIM") predicts that if subsidies are unavailable to low- and middle-income individuals on the federally-run Exchange, premiums would increase. The Gruber Model further demonstrates that those increases would be dramatic. For the typical subsidy-eligible participant, premiums under the lowest level ("bronze") plan in the federally-run Exchanges would increase from 3 percent to 23 percent of income. Premiums for the mid-level ("silver") plan would *double* for all in the market, and would increase from 6 percent to 28 percent of income for the average participant currently eligible for subsidies. Because of these increased premium costs, 6.5 *million* fewer people would end up with health insurance. It is likely that the federally-run Exchanges could not function in the face of those higher premiums and reduced number of covered individuals.

The predictions of the Gruber Model are corroborated by real world experiences. Massachusetts, New York, and New Jersey tried to implement insurance reforms barring discrimination without simultaneously ensuring wide participation through subsidies and mandates. In these states, the obligation to

cover a large population of mostly sick and previously uninsurable individuals caused insurers' costs to skyrocket. Faced with a costlier and riskier pool, some insurers simply stopped selling insurance in these states. Those who remained raised premiums to broadly unaffordable levels. Congress, aware of these well-publicized experiments, could not have intended a similar outcome for the nation.

Appellants lack a plausible counter-narrative to support their position. According to Appellants, Congress wanted to allow premium subsidies only for individuals who purchased policies in State-implemented Exchanges to motivate States to set up those Exchanges. This construct entirely misunderstands the role of premium tax credits in the ACA reforms. The ability to offer subsidies is not a gratuitous "carrot" dangled in front of States to lure them to set up their own Exchanges. Rather, subsidies are a crucial component of the ACA legislative scheme, without which *no* Exchange can operate successfully, and without which Congress's goal of broad, affordable coverage cannot be achieved.

In sum, Appellants ask this Court to believe that Congress adopted a framework for backstop federally-run Exchanges that would doom them to failure from the outset and thereby frustrate the fundamental goals of the ACA. That is, to say the least, an unreasonable construction of ACA's "text, structure, purpose, and history." *Hearth, Patio & Barbecue Ass'n v. U.S. Dep't of Energy*, 706 F.3d 499,

503 (D.C. Cir. 2013) (quotation marks omitted). *Amici* therefore ask this Court to affirm the judgment of the district court.

ARGUMENT

I. The Framework Adopted by Congress Is Premised On Three Necessary And Interrelated Reforms, Which Include Premium Subsidies On All Exchanges.

A. The ACA Rests On Three Interrelated Reforms.

Congress carefully structured the ACA to expand health insurance coverage while at the same time containing costs.[1] The coverage increases under the ACA depend on three closely related reforms. Each, correctly understood, is necessary and integral to the economic viability of the overall effort. In economic literature and the popular press, the interrelation among the ACA reforms is often described as a "three-legged stool." *See, e.g.*, Jonathan Gruber, *The Impacts of the Affordable Care Act: How Reasonable Are the Projections*? 4 (Nat'l Bureau of Econ. Research, Working Paper No. 17168, 2011), *available at* http://economics.mit.edu/files/6829.

[1] *See* 42 U.S.C. § 18091(2)(D) (articulating legislative goal of "achiev[ing] near-universal coverage"); *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("NFIB"), 132 S. Ct. 2566, 2670 (2012) ("[ACA] attempts to achieve near-universal health insurance coverage by spreading its costs to individuals, insurers, governments, hospitals, and employers – while, at the same time, offsetting significant portions of those costs with new benefits to each group.").

1. *Non-discrimination.* The first reform brings sweeping changes to the insurance markets by prohibiting various forms of discrimination by health insurers. Under the ACA's "guaranteed issue" requirements, insurers may no longer refuse to sell insurance or charge higher premiums to enrollees based on pre-existing conditions or other personal characteristics, such as health status, medical condition, medical history, or claims experience. 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4. Taken together, the reforms comprising this first leg of the stool aim to make health insurance available to all Americans, regardless of factors that previously might have excluded or priced out many individuals. *See Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 132 S. Ct. 2566, 2585 (2012). These reforms prevent insurers from "cherry-pick[ing] healthy people and . . . weed[ing] out those who are not healthy." H.R. Rep. No. 111-443, pt. II, at 990 (2010), reprinted in 2010 U.S.C.C.A.N. 474, 512.

2. *Individual Mandate.* Congress recognized, however, that barring discrimination could not, on its own, solve all problems in the health insurance marketplace – and could generate new problems. Absent further reforms, insurers would have faced rising costs driven by a less healthy pool of insured persons. If costs rise and insurers must charge everyone (or, as under the ACA, everyone of a given age) the same premium, they must "significantly increase premiums on everyone." *NFIB*, 132 S. Ct. at 2585. Increased premiums, in turn, cause some

healthier individuals to delay buying coverage, or to not buy coverage at all, a phenomenon known as "adverse selection." Over time, adverse selection leads to an increasingly sick and costly pool of insured persons – a chain reaction that economists refer to as a "death spiral."[2] *See* Brief Of Amici Curiae Economic Scholars In Support of Petitioners Urging Reversal On the Minimum Coverage Issue at 16-17, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (No. 11-398), 2012 WL 135048 ("NFIB Amici Brief"); *see also NFIB*, 132 S. Ct. at 2626 ("[Congress understood that simply prohibiting insurer discrimination] would trigger an adverse-selection death-spiral in the health-insurance market: Insurance premiums would skyrocket, the number of uninsured would increase, and insurance companies would exit the market." (Ginsburg, J., concurring in part)); s*ee* 42 U.S.C. § 18091(2)(I), (J).

Therefore, Congress included a second major reform in the ACA: the requirement that every American either purchase health insurance if it is affordable, or pay a penalty. *See* 26 U.S.C. § 5000A. This "individual mandate" was designed to ensure near universal participation in health insurance pools, whether as part of employer-sponsored group insurance, or through the purchase of individual insurance on the State and Federal Exchanges authorized by ACA. By

[2] *See* David M. Cutler & Sarah Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q. J. of Econ. 433 (1998).

bringing millions of new Americans into these pools, the mandate would spread the risks and costs of coverage across the broad spectrum of the population, both healthy and sick. Congress specifically expected the mandate to "primarily affect[] healthy, often young adults who are less likely to need significant health care." *NFIB*, 132 S. Ct. at 2590. By "broaden[ing] the health insurance risk pool to include healthy individuals," 42 U.S.C. § 18091(2)(I), Congress sought to "lower health insurance premiums," *id.*, and "help[] counter the effect of forcing insurance companies to cover others who impose greater costs than their premiums are allowed to reflect," *NFIB*, 132 S. Ct. at 2590.

3. *Premium subsidies.* The mandate posed a critical question: Would currently uninsured individuals be able to *afford* health insurance, even when *required* by law to do so? If not, the mandate would fail to draw in a vast portion of the uninsured, who would "lose the main incentive to purchase insurance inside of exchanges." *NFIB*, 132 S. Ct. at 2674 (Scalia, J., dissenting). "With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all." *Id.* Meanwhile, insurers' costs would rapidly escalate, driving up premiums and ultimately imperiling the health insurance system.

Recognizing this problem, Congress enacted a third reform in the ACA – a premium subsidy for low- and middle-income individuals who otherwise could not

afford health insurance. The ACA implements this subsidy through a tax credit, which is paid in advance directly to an individual's insurer. *See* 42 U.S.C. §§ 18081-18082; 26 U.S.C. § 36B. By subsidizing premiums, Congress ensured that the vast majority of uninsured individuals would be able to buy health insurance on one of the authorized exchanges without undue financial burden. The CBO has predicted, for example, that 20 million of the 24 million individuals purchasing insurance on the exchanges (both State and Federal) will be availing themselves of tax credits.[3] And because the subsidies make insurance affordable to nearly all, the individual mandate can apply broadly. The ACA therefore requires every individual not covered in other specified ways to buy insurance, with only limited exemptions.

In particular, the ACA exempts those for whom the cost of that insurance – *after* the premium subsidy – exceeds eight percent of his or her annual household income. 26 U.S.C. § 5000A(e)(1)(A), (B)(ii). That eight percent figure shows that Congress intended that most individuals would have the means (via subsidies) and therefore the obligation to purchase insurance. As discussed below, the best estimate is that if subsidies were not available, *99%* of otherwise subsidy-eligible

[3] *See* Cong. Budget Office, Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline, at Table 2 (Feb. 2014), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf.

persons in the federally-run Exchanges would be exempt from the mandate, because insurance costs would exceed 8% of their income. The affordability protection makes no sense if Congress intended to make insurance unaffordable in every state using the federally-run Exchange.

B. The Only Reasonable Interpretation of The ACA's Provisions, Structure, and Purpose Is That Congress Intended To Make Subsidies Available To Participants On The Federally-Run Exchange.

All three legs of the stool – guaranteed issue, the individual mandate, and premium subsidies – are necessary to achieve the ACA's goals. And it is impossible to parse the statute without concluding that Congress understood and intended all three legs to work together. It is absurd to argue that Congress set up a federally-run Exchange while simultaneously denying participants the subsidies necessary to make the Exchange functional. Absent the means or obligation to pay, the rational course for an individual would be to not buy insurance until he or she becomes sick or is at high risk of becoming sick. *See* 42 U.S.C. § 18091(2)(I) (finding that, if there were no mandate, "many individuals would wait to purchase health insurance until they needed care"). Such behavior would flood the exchanges with sick individuals, raise premiums to the point that the "insurance" would effectively be prepayment, and thereby defeat the very purpose of insurance, which is to protect people from financial ruination at the time of illness. The result

would be the death spiral described above, in which continuously increasing premiums discourage healthy people from buying insurance.

Moreover, these effects would *not* be limited to just the Exchanges because the ACA explicitly requires insurers to treat as a single risk pool plans that are offered both inside and outside of an Exchange. *See* 42 U.S.C. § 18032(c)(1).[4] The result is that as premiums *inside* the Exchanges rise, premiums *outside* the Exchanges will rise as well, making insurance less affordable not just for low- and middle-income individuals who might have qualified for subsidies, but also for the sizable population that has traditionally relied on the nongroup market for insurance – e.g., the self-employed, early retirees, individuals in employment transitions, and individuals employed by small businesses that do not offer insurance coverage. Again, given that Congress tied the fortunes of these groups together, it is implausible to construe the ACA as condemning them to massive premium increases.

The legislative history confirms that Congress understood the importance of the ACA's interrelated reforms. *See, e.g., H.R. 4872, the Reconciliation Act of*

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[4] *See also* Nat'l Ass'n of Ins. Comm'rs, *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act* 2 (2011), *available at* http://www.naic.org/store/free/ASE-OP.pdf ("[P]lans offered in the Exchange must receive the same pricing if sold outside the Exchange"); Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* 2 (Jan. 22, 2014).

2010: Hearing Before the H. Comm. on Rules (Mar. 20, 2010) (statement of Rep. Andrews) (explaining that ending discrimination based on pre-existing conditions "doesn't fit together if you don't take the next step and the next step," that is, ensuring broad participation in the insurance market, which cannot be accomplished without subsidies); 157 Cong. Rec. S737 (daily ed. Feb. 15, 2011) (statement of Sen. Franken) (describing the ACA as a "[t]hree-legged stool" and noting that, "[i]f you take any leg out, the stool collapses").[5]

Congress was likewise presented with analysis from regulators and economists – including some of the Economic Scholars joining this brief – explaining how all three legs of the stool were critical in achieving Congress's goal of widespread, affordable coverage for all Americans. *See Roundtable Discussion on Comprehensive Health Care Reform: Hearings Before the S. Fin. Comm.*, 111th Cong. 501-06 (May 5, 2009) (written comments of Sandy Praeger, on behalf of the National Association of Insurance Commissioners) ("As for proposals that could result in severe adverse selection, such as guaranteed issue . . . regulators can

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[5] *See also, e.g., Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform: Hearing Before the S. Comm. On Finance*, 111th Cong. 37-38 (Sept. 25, 2009) (statement of Sen. John Kerry) (recommending that Congress follow Massachusetts' approach of mandating coverage while subsidizing premiums, to "make insurance affordable" and "create a bigger pool of people covered"); *id.* at 38 (noting that health care reform in Massachusetts included guaranteed issue requirements, an individual mandate, and a "subsidy up to 300 percent of poverty to help people buy in").

support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and *appropriate income-sensitive subsidies to make coverage affordable*." (emphasis added)); *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 13 (Apr. 22, 2009) (statement of Uwe Reinhardt, Prof. of Econ., Princeton Univ.) (noting that "adequate public subsidies" are instrumental to achieving Congress's purpose of making health insurance available and affordable to all Americans).

Indeed, the notion that subsidies would be available only on the State exchanges was so obviously fatal to the ACA's goals that Congress never considered it. As the Director of the CBO explained in a letter to Representative Issa, "the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the [ACA] legislation was being considered." Letter from Douglas W. Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives at 1 (Dec. 6, 2012). Instead, the "CBO had anticipated, in its analyses, that the credits would be available in every state."[6] *Id.* *See also* Cong.

[6] *See also* Staff of J. Comm. on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," As Amended, In Combination with the "Patient Protection and Affordable Care Act"* (JCX-18-10), at 14 (March 21,

Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act 19 (Nov. 30, 2009) (reprinted at JA 139-140).

In sum, the only sensible construction of the ACA's provisions, structure, and purpose is that the subsidies would be available to all Exchange participants. Concluding otherwise means finding that Congress sought to legislate into existence a massive new social program that it understood would immediately fail. This Court should reject that irrational construction of the statute and instead construe it consistently with the economic logic that the statute rests upon.

II. Economic Analysis Confirms What Congress Understood: The ACA Cannot Function Without Premium Subsidies.

Economic analysis confirms what Congress understood: that the ACA cannot function nationally if subsidies are available only to those who purchase insurance through the State exchanges. That is the lesson of both economic modeling, as well as the natural experiments of jurisdictions that have attempted to reform health care without providing subsidies to increase access.

2010), *available at* https://www.jct.gov/publications.html ?func=startdown&id=3673 (stating that "[p]remium assistance credits may be used for any plan purchased through an exchange"); Cong. Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, at 6-7 (Nov. 30, 2009) (estimating that about 57% of nongroup enrollees would receive subsidies "via the new insurance exchanges").

A. Economic Modeling Shows That, Absent Premium Subsidies, Health Insurance Will Be Unaffordable.

Economist and MIT Professor Jonathan Gruber has developed a sophisticated economic model that allows for a robust prediction of outcomes in the health care system, depending on various policy changes. The Gruber Microsimulation Model ("GMSIM") utilizes two primary sets of data: (1) Fixed information on individuals, derived from 2011 Current Population Survey data and updated to 2013 and later years; and (2) varying information on policy parameters, which inform the changes in price and eligibility of various forms of insurance. *See* MIT Economics, Jonathan Gruber, Documentation for the Gruber Microsimulation Model at 2-3, *available at* http://economics.mit.edu/faculty/gruberj/lightread. The GMSIM has been cited as one of the leading options for modeling health insurance reforms such as the ACA.[7]

The GMSIM demonstrates that the health care reforms effectuated by the ACA will not be economically viable without premium subsidies for insurance policies purchased on all exchanges. For the typical subsidy-eligible participant, coverage under the lowest level ("bronze") plan in the federally-run exchanges

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[7] *See, e.g.*, Dahlia Remler et al., *Modeling Health Insurance Expansions: Effect of Alternate Approaches*, 23 J. of Policy Analysis & Mgmt. 291 (2004); Jean M. Abraham, State Health Reform Assistance Network, *Predicting the Effects of the Affordable Care Act: A Comparative Analysis of Policy Microsimulation Models* 5 (Mar. 2012), *available at* http://www.shadac.org/files/shadac/publications/Brief_Microsimulation_Mar2012_0.pdf.

would cost 23 percent of income. Premiums for the mid-level ("silver") plan would *double* for all market participants, subsidized or not, and would cost an average 28 percent of income for currently subsidy-eligible participants. Considering that Congress chose not to impose the individual mandate on any individual for whom the cost of insurance was more than *8 percent* of their income, *see supra*, it is clear that Congress would have viewed premiums in this amount as unaffordable. And indeed, absent subsidies, the GMSIM predicts that health insurance coverage would remain unaffordable for more than 99 percent of the families and individuals eligible for subsidies under the current IRS rule. Moreover, the GMSIM predicts that, if subsidies were unavailable in states with a federally-run Exchange, the estimated number of Americans without health insurance coverage would *increase* by 6.5 million, relative to the ACA as designed.[8] And, as explained above, there would be spillover effects to the non-

[8] It should also go without saying that the costs to society as a whole will be enormous. Millions of Americans who would have received necessary medical care will now be denied that care. *See, e.g.*, Nat'l Research Council, *Care Without Coverage: Too Little, Too Late* (2002); Stan Dorn, Urban Institute, *Uninsured and Dying Because of it: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* (Jan. 2008), *available at* http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf; Angela Fowler-Brown, et al., *Risk of Cardiovascular Events and Death – Does Insurance Matter?*, 22 J. Gen. Internal Med. 502 (2007); J. Michael McWilliams et al., *Health Insurance Coverage And Mortality Among The Near-Elderly*, 23 Health Affairs 223 (2004).

group market more generally because the ACA requires insurers to treat all non-group enrollees the same, regardless if they purchase insurance on the federally-run Exchanges. *See supra*. It is quite likely that overall prices in the individual insurance market, inside and outside of exchanges, would end up higher than they are today.

B. State-Based Reform Efforts Confirm That Premium Subsidies Are Essential To Properly Functioning Exchanges.

Congress's understanding of the three-legged stool concept and the results of the GMSIM modeling are corroborated further by evidence from state-based experiments with health insurance reform and a real-world analysis conducted by

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Millions of Americans, moreover, who were to be protected from the dire financial consequences of being uninsured will now be subjected to increased bankruptcy risk and the enormous negative mental health implications of that stress. *See* 42 U.S.C. § 18091(2)(G) (finding that "62 percent of all personal bankruptcies are caused in part by medical expenses," and that the provisions of the ACA "will improve financial security for families"); *see also* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 New Eng. J. Med. 1713 (2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa1212321. And hospitals who were to see a substantial reduction in the costs of their uncompensated care will now see those costs remain high, at the same time that the ACA is cutting back on their federal subsidies to support such care. *Cf.* John Holahan et al., The Urban Institute, *The Cost of Not Expanding Medicaid* 11-13 (July 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/ 2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf. Finally, the coverage and access-to-care disparities that would be triggered by eliminating subsidies in states with a federally-run Exchange would be further exacerbated by the decision in many of those same states to decline federal support for Medicaid expansion. *Id.* at 17.

the U.S. Virgin Islands. These jurisdictions provide evidence that health care reform is entirely impracticable without premium subsidies.

Massachusetts. The tumultuous experience in Massachusetts documents why all three legs are necessary to make broad coverage affordable and stable. The state first tried to reform the health insurance market in 1996. The legislature passed guaranteed issue and community rating laws that prohibited insurers from discriminating in the issuance of insurance on the basis of health status or other factors, prohibited insurers from varying premium rates based on health status, and restricted the amount by which insurers might vary rates based on characteristics such as age or sex. Following these reforms, average premiums for individual coverage reached $8,537 per year, the most expensive in the nation by a wide margin.[9] Those premiums fell only after Massachusetts implemented a second wave of reforms that included *both* an individual mandate *and* premium subsidies for low-income individuals. With the combination of those reforms, premiums for individual coverage in Massachusetts dropped by 35% compared to the national average between 2006 and 2009.[10]

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[9] *See* America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits*, at 8 (Dec. 2007), *available at* http://www.ahip.org/Individual-Market-Survey-2007/.

[10] *See* John A. Graves & Jonathan Gruber, *How Did Health Care Reform in Massachusetts Impact Insurance Premiums?*, 102 Am. Econ. Rev. 508, 511 (2012).

New York. In 1993, in what was "[w]idely regarded as the most far reaching package of [health insurance] reforms" of the time, New York implemented guaranteed issue and community rating reforms, but not a mandate or subsidies.[11] In the years following these reforms, premiums rose substantially in the non-group insurance market, with some insurers increasing premium rates by as much as 40% by early 2000.[12] Individuals who obtained insurance through the non-group market were older, experienced a greater incidence of high-cost health conditions, had higher hospital utilization, and were generally costlier to cover than individuals insured through group policies.[13] Despite subsequent remedial reform efforts by the legislature, premiums continued to skyrocket, and individual market enrollment continued to plummet.[14] This situation began to change only after the ACA's exchange-based subsidies and individual mandate came into effect for the 2014 plan year. Indeed, premiums set by insurers for 2014 ACA-compliant plans

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[11] *See* Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets*, at 37 (Mar. 2012), *available at* http://www.ahip.org/Issues/Documents/2012/The-Impact-of-Guaranteed-Issue-and-Community-Rating-Reforms-on-Individual-Insurance-Markets.aspx.

[12] Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & Law 71 (2000).

[13] *Id.*; Wachenheim & Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, at 38.

[14] Wachenheim & Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, at 39.

in the non-group insurance market have dropped dramatically relative to the pre-ACA levels.[15] More people have already signed up for exchange-based coverage (before the completion of the open enrollment period) than had previously been insured in the non-group market prior to 2014.

New Jersey. The experience of New Jersey, which enacted guaranteed issue and community rating reforms in 1992, shows evidence of the "adverse selection death spiral" of which economists warn.[16] As the reforms took hold in the market, premiums increased dramatically; one carrier raised premiums by 415% over a two-year period. Additionally, the number of carriers in the market shrank from a high of 29 in 1995 to only 6 in 2012, and the proportion of residents with insurance fell.[17] Ultimately, New Jersey's reform experiment failed even to maintain the pre-reform rate of insurance in the state.[18]

U.S. Virgin Islands. The U.S. Virgin Islands (USVI) conducted a comprehensive analysis examining whether the ACA's market reforms without premium subsidies would lower health care premiums and increase insurance

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[15] *See* Freeman Klopott & Alex Nussbaum, *New York Health Exchanges Offer 50% Drop In Premiums*, Bloomberg (July 17, 2013, 11:29 AM), *available at* http://www.bloomberg.com/news/2013-07-17/new-york-insurance-rates-said-to-drop-about-50-for-individuals.html.

[16] Wachenheim & Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, at 31.

[17] *Id.* at 30.

[18] *Id.* at 33.

coverage. That analysis corroborates that premium subsidies are necessary for successful health care reform.[19]

Under the ACA, territories such as the USVI may choose between setting up an exchange or expanding the territory's Medicaid program. 42 U.S.C. § 18043(a). The USVI was given the option of accepting either $25 million to fund premium and cost-sharing for a new exchange, or $270 million to expand Medicaid.[20] The USVI Health Reform Implementation Task Force set out to determine how best to implement ACA reforms in the territory.[21] The Task Force calculated that it could cost the USVI over $*200 million* to "provide subsidies at a level that would enable VI residents to purchase coverage through the Exchange." The USVI allocation of approximately $25 million would fall hugely short of covering those costs.[22] USVI HRITF Report at 63.

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[19] *See generally* U.S. Virgin Islands Health Reform Implementation Task Force, *Final Report & Recommendations on the Affordable Care Act Option to Establish a Health Insurance Exchange* (May 28, 2013), *available at* http://www.governordejongh.com/healthreform/assets/documents/2013/vi-exchange-report.pdf ("USVI HRITF Report").

[20] *See* Lynn A. Blewett et al., *Health Reform and the US Virgin Islands: High-Need—Limited Impact*, 19 J. Pub. Health Mgmt. Prac. 393, 395-96 (2013).

[21] *See generally* USVI HRITF Report.

[22] The average per capita income in the USVI ($14,500) is just 53% of that in the mainland states ($27,334), and the cost of living in the USVI is relatively high. *See, e.g.*, Blewett et al., *Health Reform and the US Virgin Islands: High-Need—Limited Impact*, 19 J. Pub. Health Mgmt. Prac. at 393. Consequently, a large

Having found it "not feasible to establish a VI Exchange" absent federal premium subsidies, *id.* at 64, the Task Force recommended that the USVI opt instead to expand its Medicaid program. The Task Force rightly feared that moving forward with ACA reforms would trigger an adverse selection death spiral – and the eventual if not immediate collapse of any new exchange.[23] As the work of the Task Force demonstrated, the reformed health insurance system contemplated by the ACA cannot stand without premium subsidies. Moreover, a report from the National Association of Insurance Commissioners, analyzing evidence from the USVI experience, demonstrates that the fear that the exchanges will collapse without subsidies is not purely speculative. Prior to the ACA, only one insurer sold individual policies in the USVI; since enactment of the ACA reforms, however, this insurer ceased selling new policies, and USVI residents

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proportion of USVI's 110,000 residents are uninsured and cannot afford insurance premiums.

[23] As challenging as the funding shortfalls alone may have been, they would have been compounded by the fact that the U.S. territories are exempt from the individual mandate. Accordingly, in conducting its analysis, the Task Force examined "whether enough individuals, or 'covered lives,' will purchase health care coverage through the Exchange" to "enable[] 'pooling'" of costs to allow insurers to offset the high cost of covering less healthy (high users of services) with the low cost of insuring healthy individuals (low users of services). USVI HRITF at 35-36. This analysis revealed that because the USVI would lack funding for sufficient premium and cost-sharing assistance, "most VI residents [would] be unable to purchase health care coverage through the Exchange." USVI HRITF at 27.

have been entirely unable to purchase nongroup insurance.[24] That is, fears of the adverse death spiral dissuaded insurers from offering individual policies, the type of coverage Congress designed the exchanges to provide.

III. Appellants Offer No Plausible Explanation For Why Congress Would Have Established A Backup Federal Exchange Doomed To Failure.

It is telling that Appellants do not offer any counter-model to explain plausibly how affordability reform of the American health care system could stand without one of the three "legs" described above. Instead, Appellants posit that Congress purposely dangled the "carrot" of affordable health insurance for low-income families and individuals in front of states to encourage states to establish exchanges. In Appellants' conception, the "stick" of having to "explain to their voters that they had deprived them of billions of dollars by failing to establish an Exchange" would so frighten state officials that eventually, every state would create an Exchange and, consequently, uninsured Americans nationwide would become eligible for premium subsidies. Appellants' Br. at 5, 28. That account –

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[24] *See* Nat'l Ass'n of Ins. Comm'rs, Health Ins. & Managed Care Comm., *Implementation of the Affordable Care Act in the U.S. Territories* (Oct. 7, 2013), *available at* http://www.naic.org/documents/committees_b_us_territories_discussion_paper.

for which Appellants provide no evidentiary support – is implausible and indeed irreconcilable with the ACA's structure and purpose.[25]

According to Appellants' construct, Congress knew that § 1401 of the ACA limited availability of premium subsidies to residents of states that established their

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[25] The *amicus* brief submitted by Kansas and a handful of other states suggests that the ACA should not be construed to provide subsidies to participants on the federal Exchange because that interpretation "would deprive States of the economic benefit of their decision not to establish State Exchanges." Br. of Kansas et al. at 18. *Amici* cite a recent report from the Congressional Budget Office ("CBO") in support of these claims. *See* CBO, *The Budget and Economic Outlook: 2014 to 2024*, App. C at 117 (Feb. 2014). But *amici* overstate the relevance and the findings of that report. First, *amici* have nowhere established that Congress was cognizant of a significant potential workforce reduction at the time ACA was enacted. *See* Doug Elmendorf, Cong. Budget Office, *Frequently Asked Questions About CBO's Estimates of the Labor Market Effects of the ACA* ("FAQ") (Feb. 10, 2014), *available at* http://www.cbo.gov/publication/45096 (CBO Director explaining that "new information and new analysis [has] led to a significant change in our earlier estimate" from August 2010).

Second, *amici* have not established that Congress would have been dissuaded from pursuing widely available premium subsidies even had it known of the CBO's latest predictions. For while the new CBO report predicts a workforce reduction, it also establishes that widely available subsidies will increase labor mobility, boosting innovation and efficiency in the economy. *See* Jonathan Gruber, *Obamacare: It's a Net Gain for the Economy*, L.A. Times, Feb. 9, 2014, at A26. Moreover, the CBO has clarified that the predicted long-term workforce reduction stems not "from people 'losing' their jobs," but rather from more people deciding "to retire, to leave work to take care of their families, or to cut back on their hours to pursue other interests." Elmendorf, FAQ. Those individuals "presumably feel that they will be happier as a result of those decisions," even though "total employment … will be smaller." *Id.* As the CBO correctly observed, "whether voluntary reductions in hours worked owing to the ACA are good or bad for the country as a whole is a matter of judgment." *Id.* But Congress *has* expressed a clear judgment on this point: to expand access to health insurance through ACA's reforms. This Court should not override the ACA's structure and purpose in favor of other purported policy goals.

own exchanges. As Appellants see it, Congress was willing to exclude from the promise of affordable health insurance any low- or moderate-income family or individual who happened to be unfortunate enough to live in a state that refused to set up its own Exchange. Congress, Appellants assert, intentionally conditioned federal assistance to make health insurance affordable for these families and individuals on each state's willingness to "undertake the thankless job of establishing and operating Exchanges." *See* Appellants' Br. at 28. According to Appellants' theory, states will eventually buckle under the pressure of their uninsured citizenry and create their own exchanges.

But the tale told by Appellants is entirely at odds with what Congress knew and intended when it enacted the ACA. First, as explained above, Congress fully understood the economic need for the ACA to rest on the three interlocking reforms, of which subsidies were one primary component. Nothing in the record suggests that Congress intended the economically disastrous approach of dramatically limiting subsidies only to participants in state exchanges. Second, the Congressional Budget Office never entertained the possibility that subsidies would not be available across all Exchanges. *See supra*. Members of Congress consulted regularly with the CBO, yet not one of them indicated that the CBO's work was at odds with congressional intent. Third, initial versions of the ACA indicate that premium subsidies were understood to be available for enrollees buying insurance

on the federal Exchange. Premium tax credits were included in the House bill even though that bill provided for a single Federal exchange rather than state exchanges. Affordable Health Care for America Act, H.R. 3962, 111th Cong. tit. III, § 301 (2009) (establishing single, federal exchange); *id.* tit. III, § 343 (providing for "affordability premium credit"). In the endgame debate in which the House debated Senate language, it is inconceivable that the House would have accepted a change sure to cripple the federally-run Exchange. Appellants point to nothing in the legislative record to support their economically implausible argument that the purpose of the subsidies changed from the initial House proposal to the final Act.

If anything, the record establishes that Congress created the state Exchanges not because it intended the federally-run Exchanges to be dysfunctional, but simply to provide States the option of creating their own exchanges. The federally-run Exchanges remained available to those States that lacked the resources, expertise, or desire to build their own.[26]

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[26] *See, e.g.*, 156 Cong. Rec. H2423-H2424 (Mar. 25, 2010) (statement of Rep. Waxman) ("Under the new law, 'a State is free to establish a health insurance exchange if it so chooses. But if it declines, the Secretary will establish an exchange.' This is a strong example of what the Supreme Court has recognized as an appropriate exercise of federal power to encourage State participation in important federal programs."); 156 Cong. Rec. H2207 (Mar. 22, 2010) (statement of Rep. Burgess) ("[W]hat happens in a State that doesn't set up an exchange? . . . . [T]he [federal government] . . . is going to . . . [set] up . . . a national exchange that every State that doesn't have a State-based exchange, that their citizens can buy through this national exchange."); H. Comms. on Ways & Means, Energy & Commerce, & Educ. & Labor, 111th Cong., Affordable Health Care for Am.,

In sum, Appellants' argument simply cannot be squared with what Congress correctly understood to be the case: that the goals of the ACA could not be accomplished without providing subsidies to low and middle income individuals and families, regardless of whether they purchased insurance on a state or federal Exchange. This Court should reject an interpretation of the ACA that cannot be, and is not, what Congress intended.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge that the Court affirm the district court's judgment.

Health Ins. Reform at a Glance, Health Ins. Exchs. (March 20, 2010) (the health reform law "will create state-based health insurance Exchanges, for states that choose to operate their own exchange, and a multi-state Exchange for the others."), *available at* http://housedocs.house.gov/energycommerce/EXCHANGE.pdf.

February 17, 2014

Respectfully submitted,

/s/ Matthew S. Hellman
MATTHEW S. HELLMAN
Lead Counsel
MATTHEW E. PRICE
JULIE STRAUS HARRIS*
PREVIN WARREN*
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
Tel: 202-639-6000
Email: mhellman@jenner.com

Counsel for Amici Curiae

** Not admitted in D.C.; supervised by principals of the Firm*

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Pursuant to Fed. R. App. P. 32(a)(7)(C), I certify the following:

This brief complies with the type-volume limitations of Fed. R. App. P. 29(d) because it contains 6,948 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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/s/ Matthew S. Hellman

MATTHEW S. HELLMAN
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
Tel: 202-639-6000
Email: mhellman@jenner.com

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of February, 2014, a true and correct copy of the foregoing was filed with the Clerk of the United States Court of Appeals for the D.C. Circuit via the Court's CM/ECF system, which will send notice of such filing to all counsel who are registered CM/ECF users.

/s/ Matthew S. Hellman

MATTHEW S. HELLMAN
JENNER & BLOCK LLP
1099 New York Avenue NW
Suite 900
Washington, DC 20001
Tel: 202-639-6000
Email: mhellman@jenner.com

Counsel for Amici Curiae