Questions for the Record from Senator Coons
June 4, 2104 Hearing of the Senate Judiciary Subcommittee on Oversight, Agency Action, Federal Rights and Federal Courts

Question for. Mr. Weiner

- During the hearing, multiple members and witnesses claimed that the premium tax credit eligibility requirements in §36B illegally impose taxes on millions of Americans. Can you evaluate that assertion?

RESPONSE:

The claim is untrue, for at least four reasons.

First, the Treasury Department's rule on premium tax credits is not merely a reasonable interpretation of the ACA. It is the right interpretation. There is no illegal imposition of any sort.

Second, the Treasury Department rule provide tax credits. It does not tax anyone.

Third, if the claim is that making credits available to individuals subjects millions of employers to a tax penalty for not providing minimum coverage, it is still wrong. The employer mandate applies only to businesses employing 50 or more people. In 2010, there were 211,000 such businesses. Let's assume, conservatively, that half of those businesses were in States that established their own Exchanges. On that assumption, 105,000 businesses are subject to the employer mandate in States with Federal Exchanges. Of those businesses, 96 percent offer insurance. Thus, some 4200 do not offer minimum coverage and are potentially subject to a penalty if an employee qualifies for a subsidy on an federal exchange. That falls far short of millions. Most importantly, those employers *should* be making insurance available to their employees.

Fourth, if the claim is that the subsidies, by bringing the cost of insurance below the statutory exemption from the individual mandate, subjects them to the a tax penalty, the answer is that they only pay a tax if they do not obtain insurance. The ACA is fulfilling its goal to make insurance affordable to such individuals and families, and the vast majority of them will jump at the opportunity to become insured.

Senate Committee on the Judiciary
Subcommittee on Oversight, Agency Action, Federal Rights and Federal Courts
"Rewriting the Law: Examining the Process That Led to the ObamaCare Subsidy Rule"

Questions for the Record: Senator Amy Klobuchar

1) **Question for Mr. Weiner and Ms. Wydra:**

A main goal of the Affordable Care Act is to expand coverage to all Americans.

- How would only allowing subsidies in state-based exchanges and not in the federal exchange affect coverage?

RESPONSE OF ROBERT N. WEINER:

Allowing subsidies in only state-based exchanges and not federal exchanges would contract, rather than expand health insurance coverage. A study by the Urban Institute showed that 6.3 million people in States with Federal Exchanges would lose the ACA subsidies they receive sto enable them to afford health insurance. Without the subsidy, the cost of insurance for most of these people would then exceed 8% of their income, exempting them from the individual mandate. No longer able to afford insurance, millions of people would give it up. The individual market for insurance in those States would decline by 70 percent.[1]

But that is merely the initial impact. The youngest, healthiest people would be the most likely to drop their insurance. The sickest people would be most likely to keep it. The ACA bars insurers from terminating the coverage of sick patients or denying coverage to anyone based on their pre-existing illness. Those reforms were among the most important and popular adopted in the ACA, and it is unlikely to be repealed. Thus, extinguishing subsidies in States with Federal Exchanges would leave insurers locked into covering a less healthy population that incurs greater medical costs and is consequently more expensive to insure. According to the Urban Institute, these changes in the insurance risk pool would increase the price of insurance by 55% in the individual market, putting coverage beyond the reach even of those who were previously received no subsidies because their incomes were too high. They, too, would have to rop their coverage. All in all, more than 8.3 million people would lose their insurance, leaving them sicker, less secure financially, and more burdened by health care costs.[2]

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[1] Linda Blumberg, Matthew Bueltgens, and John Holahan, "Overview of the Potential Effects of a Supreme Court Finding for the Plaintiffs in the Pending *King v. Burwell* Case," Urban Institute (June 2015) available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000261-Overview-of-the-Potential-Effects-of-a-Supreme-Court-Finding-for%20the%20Plaintiffs-in-the-Pending-King-v.-Burwell-Case.pdf

[2] S*ee* U.S. Department of Health and Human Services, *HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT* (May 5, 2015) available at http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

- Would such a change run counter to the stated goal of the Affordable Care Act?

Yes. Congress manifestly did not intend the mean-spirited, self-destructive result that the ACA opponents advocate. The goals that Congress articulated for the ACA.

- The name of the law is the "Patient Protection and *Affordable Care* Act." The opponents' interpretation makes care less affordable.
- The heading for Title I of the Act is "Quality, Affordable Care for *All* Americans."
- Subtitle A of Title I bears the heading, "Immediate Improvements in Health Care Coverage for *All* Americans."
- Subtitle C is "Quality Health Insurance Coverage for *All* Americans.
- Subtitle D is, "Available Coverage Choices for *All* Americans."
- Subtitle E is called, "Affordable Coverage Choice for *All* Americans
- Title X of the Act is headed, "Strengthening Quality Affordable Health Care for *All* Americans."

"All Americans" does not mean "some Americans." It does not mean Americans only in States that run their own Exchanges. "All" means all, without geographic limitation.

Congress also stated its purpose clearly in the findings it adopted supporting the individual mandate. The ACA says in Section 1501(a)(1)(D) that the mandate "achieves near-universal coverage." Subsection (E) predicts that the poorer health and shorter lifespan of the uninsured causes economic losses of $207 billion a year, which the mandate will lessen "by significantly reducing the number of the insured." Likewise, Subsection (F) posits that the mandate will lower health insurance premiums, also by "reducing the number of the uninsured," while Subsection (G) forecasts that the Act will improve financial security by "significantly increasing health insurance coverage." Subsections (I) and (J) declare the objective of the Act to broaden the health insurance risk pool and lower administrative costs, again, by "significantly increasing health insurance coverage."

The school of statutory interpretation known as textualism focuses on the text of the statute as the sole indicator of Congressional intent. Whether one accepts that approach totally, partially, or not at all is irrelevant in this case, because the text of the statute leaves no doubt of Congress's intent. The ACA stated its purposes over and over again, in statutory language that both Houses enacted and that the President endorsed. No legitimate mode of statutory interpretation permits, much less dictates, the ACA opponents' willful blindness to expressly codified statutory goals

2) Question for Mr. Weiner

In your written testimony you cite previous work by Justice Scalia that argues that statutory interpretation depends on context.

- Based on your experience with statutory interpretation, would limiting subsidies to state-run exchanges make sense in the context of the full law?
- Is it reasonable that the IRS would interpret the law to allow for people in all states to have access to subsidies?

The Treasury Department's interpretation of the law is reasonable because it implements the definitions Congress adopted and thereby enables the statute to function.

Congress defined "Exchange," as an "Exchange established by the State under Section 1311." To show that "Exchange" was a defined term, Congress capitalized the word throughout the ACA.

Section 1321 of the Act states that if a State does not establish an Exchange, as Section 1311 requires, the Secretary of HHS shall "establish such Exchange." To see what this provision means, we need only substitute the definition of "Exchange" for the word itself in Section 1321. The Section would then provide that if a State does not establish an Exchange, the Secretary shall establish "such Exchange established by the State under Section 1311." The reasonable conclusion this language supports is that an Exchange established by the Secretary *qualifies* as an Exchange established by the State. The State, in other words, fulfills the requirement under 1311 to establish an Exchange by opting to have the Federal Government step into its shoes. To read the provision otherwise, as the opponents of the ACA do, would require the Secretary to perform an impossible act -- establishing an entity established by the State.

Such a reading not only makes 1321 itself nonsensical, but renders many other provisions of the ACA inoperative. For example, under Section 1312(d)(3)(C), only "qualified individuals" may purchase insurance on an Exchange. Section 1321(f)(1)(A)(ii) provides that a "qualified individual" is one who resides in the State "that established the Exchange." Unless we recognize that a State establishes an Exchange by having the Federal Government step into the State's shoes, then there can be no qualified individuals in States with Federal Exchanges. Applying logic rather than ideology, no one can seriously argue that Congress intended to create Exchanges with no customers.

The interpretation of the ACA opponents results in at least 50 similar anomalies, ably chronicled in an article by Professors Timothy Jost and James Engstrand.[3]

[3] Timothy Jost and James Engstrand, "Anomalies in the Affordable Care Act that Arise from Reading the Phrase 'Exchange Established by the State' Out of Context," 23 *U. Miami Bus. L. Rev.* 249 (2015).

- You mentioned in your testimony that there is a strong presumption for courts to read statutes to be effective, citing a book by Justice Antonin Scalia.
    - Is the book you e entitled *Reading Law: The Interpretation of Legal Texts*?

Yes

    - If so, Justice Scalia and coauthor Brian Garner discuss the Presumption Against Ineffectiveness as a Principle of Interpretation. Is this the portion of the book you are referencing?

Yes

    - If so, this presumption is described in the book as, "*A textually permissible interpretation* that furthers rather than obstructs the document's purpose…." Because the plain meaning of the statute in question clearly states that only States that create their own exchanges may gain federal subsidies, which precludes any other interpretation without ambiguity, how do you reconcile your contention with Justice Scalia's description of this principle that you cited in your testimony?

RESPONSE:

As I stated in my testimony, the presumption in favor of effectiveness dictates adoption of a "*textually permissible* interpretation that furthers rather than obstructs" the statutory purpose. The qualifying phrase "textually permissible" precisely embodied my point. Under the rule articulated by Scalia and Garner, the ACA opponents must show that the Treasury Department's interpretation is *im*permissible – not undesirable, not awkward or suboptimal, but impossible. They must show that no one could rationally read the statute that way. Here, not only the Treasury Department, but also six Judges, at least four Justices, five leading experts on statutory interpretation, the Senate and House sponsors of the ACA, key Republican and Democratic staffers involved in drafting it, 22 states and the District of Columbia, the American Cancer Society, the largest association of health insurers, the American Heart Association, and many, many others read the statute the same way the Treasury Department does. How could all these individuals and institutions read the statute in a way that it cannot conceivably be read? There are only three possible answers. Either none of them can read, or all of them are dishonest, or the premise of the question is wrong. The first two options are implausible, leaving the third option as the answer -- the premise of the question is wrong. The Treasury Department's reading of the statute *is* permissible.

- You said that healthcare price inflation is at its lowest point in fifty years and the rate of increase in insurance premiums has declined under the Affordable Care Act, however, that data is cushioned by the substantial increase in newly covered individuals that receive subsidies. The Obama administration released data showing that many middle-class Americans and their families with health insurance bought under the Affordable Care Act could face substantial price increases this year (as much as 20 percent). Isn't it true that the marker for the success of this act is its effect on the middle class, the strength of which is the leading indicator for economic health?

The vast majority of middle class Americans obtain insurance through their workplace. The prices in that market are largely unaffected by the ACA's reforms, because most of that insurance was already compliant.

Claims of double-digit increases in the cost of insurance sold on the Exchanges reflect an exercise in cherry-picking. For example, one legislator claimed that BlueCross/Blue Shield in Montana was increasing its rates by 23% in 2016. In fact, the company is asking for large increases on only two plans it intends to offer in Montana. Currently, BlueCross/BlueShield sells 50 plans in the State.[1] In addition, a recent study shows that in fact, the proposed 2016 price increases for health insurance sold on the Exchanges are relatively modest.[2]

- What is your response to Mr. Carvin's contention that the model that was followed in the ACA for the subsidies was precisely the model for Medicaid expansion and that the logic was the same, meaning that subsidies were conditioned on the States setting up their own exchanges just like Medicaid expansion was conditioned on States doing certain things?

The contention is wrong. Under Medicaid, HHS has the right to cut off or not grant Medicaid funds if a State does not comply with the conditions of the grant. In other words, with regard to HHS's authority, if a State does not have a compliant Medicaid program, it has *no* Medicaid program. There is no federal backup system.

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[1]Eric Whitney, "Health Insurance Premiums Will Go Up in 2016, But by How Much?" NATIONAL PUBLIC RADIO (June 12, 2015) available at http://www.npr.org/sections/health-shots/2015/06/12/413073921/health-insurance-premiums-will-go-up-in-2016-but-by-how-much

[2] Caroline Pearson, "Lowest-Cost Exchange Premiums Remain Competitive in 2016; Consumers may be able to keep increases small by selecting a low-cost silver option," Avalere Health LLC (June 11, 2015), available at http://avalere.com/expertise/managed-care/insights/lowest-cost-exchange-premiums-remain-competitive-in-2016-consumers-may-be-a

By contrast, under the ACA, if a State does not set up its own Exchange, the Federal Government establishes one for it. The Federal Exchange is the backup absent from Medicaid. As ACA opponents have conceded, without the subsidies, the backup does not work. Supposedly, Congress anticipated that the prospect of such dysfunction would coerce States to establish their own Exchanges.

That makes no sense. If Congress wanted to set up a system like Medicaid, where funding would be cut off to States that did not set up their own Exchange, it knew how to say so clearly and directly. Congress would not have provided for a Federal backup that was doomed to fail.