On March 4, 2015, the U.S. Supreme Court heard oral arguments concerning whether individuals who purchase qualified health plans (health plans) through Healthcare.gov, the Federally-facilitated exchange (the Federal Exchange), are entitled to receive premium subsidies from the premium tax credit in section 1401 of the Patient Protection and Affordable Care Act (ACA), codified in 36B of the Internal Revenue Code. In King v. Burwell, the Court has been asked to determine the legal significance of the following language in section 1401 of the Affordable Care Act, which provides that the credit is available to individuals who purchase a health plan “through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.” A decision is expected by the end of June 2015.

The decision has tremendous economic health consequences to people in States that opted not to establish exchanges because approximately 70% to 80% of the individuals who purchase health plans through the Federal Exchange receive some form of tax credit to subsidize their health plan premiums. If the Court decides in favor of the Department of Health and Human Services (HHS), the Court will have to address other knotty issues to reach that result like the importance of legislative intent when the language of a statute is clear on its face. Even this will be problematic because much of the deliberations concerning the ACA took place behind closed doors, there was deal-making to garner votes for the ACA, such as the so-called “Cornhusker Kickback” and there is very little traditional legislative history for the ACA. Furthermore, there will be virtually no prospect for technical corrections legislation to correct legislative glitches in the ACA for the foreseeable future. Hopefully, the Court will disregard after-the-fact explanations of so-called legislative intent offered by proponents of the ACA in amicus briefs and focus on the words, legislative language, legislative procedures and actual actions of legislators before the ACA was enacted.

I believe the legislative intent to limit premium tax credits to residents of States that established exchanges is clearer than one might think, based on how Congress approached Medicaid expansion. There, Congress explicitly told the States that they either must participate in Medicaid expansion, which is funded in the near term by the Federal government, or lose the Federal share of Medicaid support in its

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3. The “Cornhusker Kickback” was a deal struck to secure Nebraska Senator Ben Nelson’s crucial sixtieth vote to invoke cloture and render the Patient Protection and Affordable Care Act filibuster-proof. The deal gave Senator Nelson’s home state – Nebraska – $ 100 million in Medicaid funds to fund Medicaid expansion and anti-abortion language and also exempted Blue Cross and Blue Shield of Nebraska from the annual fee on health insurers found is section 9010 of the ACA. See ACA § 10905(c); Statement of Senator Mike Enzi (R-Wyo.), Cong. Rec. S13813, at S13814 (Dec. 23, 2009). Senator Carl Levin (D-Mi.) obtained similar relief for Blue Cross Blue Shield of Michigan. Id. The Cornhusker Kickback was eventually repealed by another enactment, a reconciliation bill entitled the Health Care and Education Reconciliation Act of 2010, which was introduced and passed shortly after the Patient Protection and Affordable Care Act. The legislative history and logic regarding the use of reconciliation in this matter is a tortured one, complicated by the special election of Republican Scott Brown to fill Ted Kennedy’s vacant Massachusetts Senate seat. For a fuller history regarding the use of reconciliation in the passage of the Patient Protection and Affordable Care Act, see Tonja Jacobi and Jeff VanDam, The Filibuster and Reconciliation: The Future of Majoritarian Lawmaking in the U.S. Senate, 47 U.C. Davis L. Rev. 261 (2013).
entirely. The legislative intent to coerce States to participate in Medicaid expansion was so clear that the Court found it unconstitutionally coercive in National Federation of Independent Business v. Sebelius.  

Similarly, it does not require a great leap of logic to reach the same conclusion about premium subsidies for commercial health plans purchased through State exchanges. Just as did for Medicaid expansion, it is reasonable to argue that Congress wanted to incentivize States to establish their own exchanges and that it did so with the “carrot,” tax credits under section 36B for health plans purchased through State exchanges, and the “stick,” no tax credits for health plans purchased through the Federal Exchange. Congress also offered the States generous grants totaling more than $4 billion to fund the development of State-run exchanges. Obviously the “carrot” and “stick” approach coupled with generous grant funding failed in all but 16 States and the District of Columbia, but that should not give license to the Court to ignore the clear statutory language in section 1401 of the ACA.

The ACA will not fail if the Court finds the section 36B Treasury regulations invalid; while important, availability of the tax credit subsidy is in reality only a small piece of a complex statute much of which will be difficult politically to repeal. Instead, State legislatures and governors in States that elected not to establish an exchange will face the same political challenge they faced with Medicaid expansions as originally enacted: Do they continue to oppose the ACA on political grounds at all costs to their residents? Or do they compromise on a matter of economic interest to their residents and establish a State exchange rather than rely on the Federal Exchange? More is at stake. Words of a statute, particularly words that are part of the Internal Revenue Code, have meaning and should be given their meaning by courts. That is the rule of law. And that rule of law should be followed irrespective of whether one is in support of the ACA or would like to see it repealed in its entirety.

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5 See Paul Demko and Darius Tahir, Funding Woes Imperil Future of State-Run Insurance Exchanges, Modern Healthcare 8 (Jan. 12, 2015) (“So far the CMS [Centers for Medicare and Medicaid Services] has dispensed more than $4 billion in grants to help launch state-run exchanges. In December [2014], the agency issued its final round of grants, roughly $265 million to 10 states with existing state-run marketplaces ....”