No. 14-1158

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

DAVID KING, et al.,

Plaintiffs-Appellants,

v.

KATHLEEN SEBELIUS, Secretary of Health and Human Services, et al.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA (No. 3:13-cv-630) (Hon. James R. Spencer)

AMICUS BRIEF FOR THE COMMONWEALTH OF VIRGINIA ON BEHALF OF DEFENDANTS-APPELLEES

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INTEREST OF *AMICUS CURIAE*

Two sovereign interests compel the Commonwealth of Virginia to file this brief. First, the Commonwealth represents the interests of the hundreds of thousands of Virginians who depend on federal premium tax-credit assistance to afford the health insurance that is now available under the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or "ACA").[1] Their interests are not represented by the Appellants here, four individual Virginians who do not want health insurance. Second, the Appellants' legal theory contradicts the fundamental assumption on which the Commonwealth elected to forgo building its own health insurance exchange in favor of a federally-facilitated exchange: that doing so would not harm the interests of Virginians. The Appellants' theory must be rejected under the *Pennhurst* doctrine, which prevents Spending Clause statutes like the ACA from being used to impose unusual conditions about which States were not provided "clear notice." What is more, if Congress had actually done what Appellants claim — made State citizens financial hostages in a scheme to force State governments to adopt State-based exchanges — it would have violated the Tenth Amendment's prohibition on coercing States to carry out federal policies. Accordingly, this Court should reject Appellants' arguments and affirm the ruling of the District Court.

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010).

ARGUMENT

I. Nearly a half million Virginians are eligible for significant premium tax-credit assistance to enable them to purchase quality health insurance.

Congress enacted the Affordable Care Act in order "to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) [*NFIB*]. In *NFIB*, the Supreme Court upheld the centerpiece of the ACA, the "individual mandate, which requires individuals to purchase a health insurance policy providing a minimum level of coverage . . . ." *Id*. at 2577.

In order to help individual Americans *afford* the health insurance that the ACA requires them to purchase, Congress provided tax credits to offset the cost of the insurance premium. 26 U.S.C. § 36B(a). The premium tax credits are provided to "an applicable taxpayer," *id.*, who is defined as a taxpayer whose income is between 100% and 400% of the federal poverty level for the size of the family involved, *id.* § 36B(c)(1)(A). Additional "cost-sharing reductions" are also available to low- and moderate-income families. *See* 42 U.S.C. § 18071(c).

An estimated 495,000 Virginians[2] are eligible for premium tax-credit assistance to purchase private qualified health plans on the Health Insurance

[2] This estimate is more conservative than the November 2013 Kaiser Foundation estimate of 518,000. *See* Table 1, Estimated Number of Tax-Credit-Eligible Individuals and Potential Market for Marketplace Coverage, By State, available at

Marketplace. As of March 1 of this year, 82,634 Virginians had already enrolled in qualified health plans with tax-credit eligibility totaling $170 million. If *all* eligible Virginians were to enroll this year, they would enjoy tax credits totaling $1.02 billion. Over the next 10 years, the total premium tax-credit benefit to Virginians is projected to be $19.4 billion.

It is difficult to exaggerate the meaning of premium tax credits to low- and moderate-income Virginians who, unlike the four Appellants, want to buy quality health insurance for themselves and their families.[3] "The Exchanges provide advance payments of premium tax credits directly to an eligible individual's insurer, thus lowering the net cost of insurance to the individual." *King v. Sebelius*, No. 3:13-CV-630, 2014 U.S. Dist. LEXIS 20019, at *5-6 (E.D. Va. Feb. 18, 2014) (citing 42 U.S.C. §§ 18081-18082) (J.A. 293). The Henry J. Kaiser Family Foundation has built a widely utilized Health Reform Subsidy Calculator to estimate the cost of insurance and the corresponding premium tax credit.[4] For

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http://kff.org/report-section/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act-table-1/.

[3] The Commonwealth agrees with the United States that a ruling for Appellants would have to be limited to the four named Plaintiffs and should not preclude other Virginians, whom Plaintiffs do not represent, from claiming federal premium tax credits. (*See* Gov't Br. 52.)

[4] http://kff.org/interactive/subsidy-calculator/. *See Halbig v. Sebelius*, No. 13-0623, 2014 U.S. Dist. LEXIS 4853, at *9 (D.D.C. Jan. 15, 2014), *appeal pending*, No. 14-5018 (D.C. Cir.) (referencing this calculator).

example, a single 36-year-old mother of two children living in Richmond and earning $25,000 a year (128% of the federal poverty level) could purchase a silver-level health insurance plan for her family for an annual premium of $5,941, with *92% of that cost* ($5,441) advanced by the premium tax credit, meaning that she would pay only $500 per year. A single 52-year old man earning $20,000 (174% of the poverty level) would face a premium of $4,639, but 78% ($3,617) would be covered by the tax credit, costing him only $1,022.

For the 495,000 Virginians between 100% and 400% of the federal poverty level who are uninsured or who purchase individual market coverage, the average annual premium tax credit per person is $2,059; the median is $1,833; the 25th percentile is $608; and the 75th percentile is $2,954. But under Appellants' theory, these Virginians would bear the *full premium cost* and forgo those subsidies entirely. That is real money. And forcing Virginians to spend it on health care premiums because the federal subsidy is unavailable would mean less money for their retirement and for basic expenses like food, shelter, clothing, and education.

State officials could not responsibly choose to forgo building a State-based exchange if they were not told that such drastic consequences would result.

II. Appellants' legal theory must be rejected because the federal government did not give Virginia clear notice that electing to forgo a State-based exchange would cost Virginians their premium tax-credit assistance.

A. The *Pennhurst* doctrine requires that the federal government give States clear notice when their actions under Spending Clause statutes will result in unusual consequences.

When Congress seeks the States' cooperation to implement federal legislation enacted under the Spending Clause, U.S. Const. art. I, § 8, cl. 1, as it did with the Affordable Care Act, the States are entitled to clear notice about the conditions that will be imposed on them. *NFIB*, 132 S. Ct. at 2602, 2605-06. In *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), the Court described that clear-statement rule as follows:

> Legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract." There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation. *Id.* at 17 (citations and footnote omitted).

In 2006, the Supreme Court applied *Pennhurst* to hold that expert witness fees were not recoverable under the Individuals with Disabilities Education Act (IDEA), because the statute did not provide "clear notice" that the recovery of "reasonable attorneys' fees as part of the costs" would include the recovery of expert witness fees. *Arlington Cent. Sch. Dist. Bd. of Ed. v. Murphy*, 548 U.S. 291, 293-94, 298 (2006). The Court explained that, in applying the *Pennhurst* doctrine, the statute must be interpreted from *the State's* perspective:

> [W]e must view the IDEA *from the perspective of a state official* who is engaged in the process of deciding whether the State should accept IDEA funds and the obligations that go with those funds. We must ask *whether such a state official would clearly understand* that one of the obligations of the Act is the obligation to compensate prevailing parents for expert fees. In other words, [we must ask] whether the IDEA [furnishes *clear notice* regarding the liability at issue in this case]. *Id.* at 296 (emphasis added; alterations in original).

The Supreme Court applied *Pennhurst* again in *NFIB*. In striking down the ACA's provision that denied all Medicaid funding to States that failed to adopt Medicaid expansion, seven Justices agreed that States were not on fair notice that participating in the Medicaid program would subject them to such a draconian, later-imposed condition. 132 S. Ct. at 2602-06 (Opinion by Roberts, C.J., joined by Breyer and Kagan, JJ.); *id.* at 2666 (Opinion of Scalia, J., joined by Kennedy, Thomas and Alito, JJ.). Although "Congress' power to legislate under the

spending power is broad, it does not include surprising participating States with postacceptance or 'retroactive' conditions." *Id.* at 2606 (Opinion by Roberts, C.J.).

B. The federal government did not give Virginia clear notice that its citizens would lose their federal premium tax-credit assistance if the Commonwealth relied on a federally-facilitated exchange.

The District Court was correct to apply the *Pennhurst* doctrine, which it called the "*Arlington* rule," *King v. Sebelius*, 2014 U.S. Dist. LEXIS 20019, at *36 (J.A. 309), but the court did not take it far enough. For no one can reasonably claim that the federal government gave Virginia clear notice that its citizens would be denied premium tax-credit assistance as punishment for the Commonwealth's decision to forgo building its own health insurance exchange.

1. The language and structure of the ACA did not provide clear notice to Virginia.

Virginia agrees that "the best evidence of Congress's intent is the statutory text." *NFIB*, 132 S. Ct. at 2583. But as the district court found below and in *Halbig*, the plain language of the ACA does not show that States relying on federally-facilitated exchanges would deprive their citizens of tax-credit assistance.

a. Appellants' interpretation of § 36B(b)(2)(A) cannot be squared with the rest of the Affordable Care Act.

Appellants' plain-language argument immediately runs off the rails by focusing too narrowly on one phrase — "and which were enrolled in through an Exchange established by the State under [42 U.S.C. § 18031]" — in 26 U.S.C. §

36B(b)(2)(A). Their narrow focus ignores the rule that the "plainness or ambiguity of statutory language" is determined not only "by reference to the language itself," but also by "the specific context in which that language is used, and the broader context of the statute as a whole." *Healthkeepers, Inc. v. Richmond Ambulance Auth.*, 642 F.3d 466, 471 (4th Cir. 2011) (quoting *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340 (1997)). Courts must use their "common sense as a guide," *United States v. Thompson-Riviere*, 561 F.3d 345, 354 (4th Cir. 2009), and "[s]tatutory construction is a 'holistic endeavor,'" *Koons Buick Pontiac GMC, Inc. v. Nigh*, 543 U.S. 50, 60 (2004) (quoting *United Sav. Ass'n v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988)).

Thus, by focusing on one phrase out of "10 titles stretch[ing] over 900 pages and contain[ing] hundreds of provisions," *NFIB*, 132 S. Ct. at 2580, Appellants commit a basic error of statutory construction. As the Supreme Court emphasized in *United States National Bank v. Independent Insurance Agents of America*, 508 U.S. 439 (1993) ("*U.S. Nat'l Bank*"): "Over and over we have stressed that 'in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.'" *Id.* at 455 (quoting *United States v. Heirs of Boisdore*, 49 U.S. 113, 122 (1849)). Or, as the Court has sometimes put it, "literalness may strangle meaning." *Adoptive Couple v. Baby Girl*, 133 S. Ct. 2552, 2577 (2013)

(Sotomayor, J., dissenting) (quoting *Utah Junk Co. v. Porter*, 328 U.S. 39, 44 (1946)). While that one phrase in § 36B(b)(2)(A) may "point[] in one direction, *all* of the other evidence from the statute points the other way." *U.S. Nat'l Bank*, 508 U.S. at 455 (emphasis added). "It points so certainly . . . as to allow only [one] conclusion . . . ." *Id.*

The Commonwealth agrees with the statutory analysis by the United States in this case (Gov't Br. 14-30), and by the district court in *Halbig*, 2014 U.S. Dist. LEXIS 4853, at *42-55, and the one below, *King*, 2014 U.S. Dist. LEXIS 20019, at *28-37 (J.A. 305-10). We will not repeat that analysis, but it is compelling.[5]

[5] In particular, Appellants' argument would result in the absurd conclusion that *no one* would be entitled to enroll in a federally-facilitated exchange because the definition of "qualified individual," in § 18032(f)(1)(A)(ii), uses the *same* formulation as § 36B(b)(2)(A): a person who "resides in the State *that established the Exchange*." 42 U.S.C. § 18032(f)(1)(A)(ii) (emphasis added). That unintelligible result is "a telltale sign that [Appellants'] reading of section 36B is wrong." *King*, 2014 U.S. Dist. LEXIS 20019, at *33 (J.A. 307-08). It would be an "absurd construction" indeed if no one could enroll "in the thirty-four states with federally-facilitated Exchanges." *Halbig*, 2014 U.S. Dist. LEXIS 4853, at *53.

The United States is also correct that the language in § 36B(b)(2)(A) must be understood in light of the "such Exchange" language in 42 U.S.C. § 18041(c)(i). (Gov't Br. 16-19.) Section 18041(c)(i) makes clear that if a State fails to establish the required Exchange, the Secretary will establish "such Exchange" on its behalf. *King*, 2014 U.S. Dist. LEXIS 20019, at *31 (J.A. 307); *Halbig*, 2014 U.S. Dist. LEXIS 4853, at *48 ("In other words, even where a state does not actually establish an Exchange, the federal government can create 'an Exchange established by the State' . . . *on behalf of* that state.").

b. The Court does not need to reach the *Sunterra* exceptions, but they would be satisfied in any event.

The Appellants' narrow focus on § 36B(b)(2)(A) also leads them to reach prematurely the "two narrow exceptions to application of a statute's plain language." *In re Sunterra Corp.*, 361 F.3d 257, 265 (4th Cir. 2004). *Sunterra* described the two exceptions this way:

> The first such exception, premised on absurdity, exists when literal application of the statutory language at issue results in an outcome that can truly be characterized as absurd, i.e., that is so gross as to shock the general moral or common sense . . . . The second exception is premised on legislative intent, and it exists only when literal application of the statutory language at issue produces an outcome that is demonstrably at odds with clearly expressed congressional intent . . . . *Id.* (citations and quotations omitted).

Those exceptions do not apply unless and until the Court determines that the plain meaning of the statute is "unambiguous." *Id.* at 263.

This Court does not need to reach the *Sunterra* exceptions where, as here, standard tools of statutory construction resolve any ambiguity. The Court should rule that § 36B(b)(2)(A), in context, is *not* ambiguous. That was the approach, for instance, in *AT&T Mobility LLC v. Concepcion*, where the Supreme Court said that "[a] provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme . . . because only one of the permissible

meanings produces a substantive effect that is compatible with the rest of the law." 131 S. Ct. 1740, 1754 (2011); *accord Koons Buick Pontiac*, 543 U.S. at 60 (same).

Alternatively, the Court could rule that § 36B(b)(2)(A) *is* ambiguous but that the ambiguity is resolved by the *other* provisions in the ACA. *See, e.g.*, *Robinson*, 519 U.S. at 341 (finding one provision's use of the term "employee" ambiguous as to whether it covered former employees, but resolving that question by reference to other sections); *Maharaj v. Stubbs & Perdue, P.A.*, 681 F.3d 558, 568-70 (4th Cir. 2012) (finding language ambiguous but resolving it by reference to "the broader context of the statute as a whole"). And even if it ruled that the entire statute were ambiguous on the question, the Court would have to give *Chevron* deference to the agencies' determination that premium tax credits are available in States with both State- and federally-facilitated exchanges. (Gov't Br. 43-48.) *See King*, 2014 U.S. Dist. LEXIS 20019, at *41-44 (J.A. 311-13); *Halbig*, 2014 U.S. Dist. LEXIS 4853, at *64 n.14; *Othi v. Holder*, 734 F.3d 259, 268 (4th Cir. 2013) (stating that court "would reach the same result even if [it] did not find the statute's text to be plain, as principles of administrative deference under *Chevron* would compel [it] to do so"; such a situation "presents a straightforward question of statutory interpretation . . . and the [agencies'] interpretations . . . are entitled to deference and must be accepted if reasonable.") (citation and quotation omitted).

Although any of these approaches would resolve this case without reaching the *Sunterra* exceptions, those exceptions would be satisfied even if the Court needed to address them. The reading advanced by Appellants is "demonstrably at odds with clearly expressed congressional intent." 361 F.3d at 265 (quoting *Sigmon Coal Co. v. Apfel*, 226 F.3d 291, 304 (4th Cir. 2000), *aff'd sub nom. Barnhart v. Sigmon Coal Co.*, 534 U.S. 438 (2002)). Besides the statutory arguments that persuaded the district judges in *Halbig* and this case, the very title in which § 36B(b)(2)(A) appears reads "Quality, Affordable Health Care for *All* Americans." 124 Stat. 130 (emphasis added). The subtitle, similarly, is "Affordable Coverage Choices for *All* Americans." 124 Stat. 213 (emphasis added). Congress's choice of the word *all* shows that § 36B(b)(2)(A) was not meant to deny *most* or even *some* Americans affordable health care simply because they live in States that rely on federally-facilitated exchanges.

Sunterra's other exception, the one for "absurd" results, would also be satisfied. It makes no sense to deny premium tax credits to low-income citizens, *making* them purchase insurance that then becomes *unaffordable* simply because their State elected to rely on a federally-facilitated exchange, rather than building its own. The creation of a health care exchange is not an end in itself, but a means to an end — making health insurance affordable for all Americans. Moreover, the supposed "incentive" to create a State-based exchange operates by *punishing*

citizens for their State's decision to rely on a federally-facilitated exchange. If there is any logic whatsoever to that approach, it is not apparent.

In sum, the *Pennhurst* doctrine requires the Court to construe the statute "from the perspective of a state official"; that is, the Court "must ask whether such a state official would clearly understand," *Arlington*, 548 U.S. at 296, that forgoing a State-based exchange would result in its citizens losing their entitlement to premium tax credits. Appellants cannot meet that burden here.

2. There was no suggestion when the ACA was adopted that premium tax credits would be unavailable in States with federally-facilitated exchanges.

The legislative history of the Affordable Care Act reinforces that the federal government failed to provide clear notice that States electing to rely on federally-facilitated exchanges would jeopardize their citizens' eligibility for premium tax-credit assistance. Indeed, no member of Congress expressed that view when the ACA was debated or enacted. Even the two conservative scholars who later published the roadmap for the Appellants' legal challenge admitted they were "were both surprised to discover this feature of the law and initially characterized it as a 'glitch.'" Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule To Expand Tax Credits Under the PPACA*, 23 Health Matrix 119, 123 (2013) (cited in Appellants' Br. at 45).

In enacting the ACA, Congress recognized that "[t]hese credits are key to ensuring people affordable health coverage." H.R. Rep. No. 111-443, at 250 (2010). The contemporaneous statements by members of Congress all pointed to the shared assumption that federal premium tax credits would be available to *all* eligible Americans *regardless* of whether States built their own exchanges.

For example, when Sen. Baucus addressed the question on the Senate floor, he never once suggested that premium tax credits would be denied to low-income Americans if their States elected to rely on federally-facilitated exchanges. He said, instead, that "tax credits will help to ensure *all* Americans can afford quality health insurance." 155 Cong. Rec. S11,964 (Nov. 21, 2009) (emphasis added). And his other statements:

- that "60 percent of those who are getting insurance in the individual market on the exchange will get tax credits," and
- "that people with low incomes would receive premium tax credits that will reduce the price they pay for health insurance by as much as $2,500 to $7,500,"[6]

cannot be squared with the notion that such credits would be unavailable in States with federally-facilitated exchanges.

Sen. Baucus also assured his colleagues that the ACA "fundamentally gives States the choice to participate in the exchanges themselves or, if they do not

[6] 155 Cong. Rec. S12,764 (Dec. 9, 2009) (J.A. 242).

choose to do so, to allow the Federal Government to set up the exchanges." 155 Cong. Rec. S13,832 (Dec. 23, 2009). If Appellants were correct, it was a misrepresentation for him to omit that Congress would actually *punish* States not building their own exchanges by withholding federal subsidies from their low- and moderate-income citizens, thereby making their health insurance *unaffordable*.

Numerous other members of Congress shared Sen. Baucus's understanding that premium tax credits would be available in every State. Sen. Johnson said the ACA "will also form health insurance exchanges in *every* State through which those limited to the individual market will have access to affordable and meaningful coverage." 155 Cong. Rec. S13,375 (Dec. 17, 2009) (J.A. 248) (emphasis added). Sen. Bingaman likewise said that the ACA "includes creation of a new health insurance exchange *in each State* which will provide Americans . . . meaningful private insurance as well as refundable tax credits to ensure that coverage is affordable. 155 Cong. Rec. S12,358 (Dec. 4, 2009) (J.A. 250) (emphasis added).

As Sen. Durbin put it:

> This bill says, if you are making less than $80,000 a year, we will help you pay your health insurance premiums, give you tax breaks to pay those premiums. That means a lot of people who today cannot afford to pay for health insurance premiums will be able to. 155 Cong. Rec. S12,779 (Dec. 9, 2009).

He added that half of the "30 million Americans today who have no health insurance . . . will qualify for . . . tax credits to help them pay their premiums so they can have and afford health insurance." 155 Cong. Rec. S13,559 (Dec. 20, 2009) (J.A. 244). Those figures could not have been accurate if premium tax credits were not available in every State.

Even one of the ACA's staunchest opponents, Representative Paul Ryan, criticized it precisely because it made tax credits available in every State: "it's a new, open-ended entitlement that basically says that *just about everybody in this country* -- people making less than $100,000, you know what, if your health care expenses exceed anywhere from 2 to 9.8 percent of your adjusted gross income, don't worry about it, taxpayers got you covered, the government is going to subsidize the rest."[7]

None of those statements would have made sense if members of Congress had understood that premium tax credits would be unavailable in States relying on federally-facilitated exchanges.

Appellants dismiss that problem by arguing that everyone in Congress silently but mistakenly assumed that every State would create its own Exchange. (Appellants' Br. 6, 42.) That claim finds no support in the record. The ACA was

[7] Verbatim Transcript, House of Representatives, Committee on Budget Committee Hearing, 2010 WL 941012 (Mar. 15, 2010).

controversial when it was debated and adopted, and it was well known that numerous States objected to it and would not go along willingly. As Rep. Burgess said on the House floor, "you have heard that several States around the country . . . I believe it's up to 37, was the last count, are looking at either filing a constitutional challenge or somehow exempting their State from participating in this new Federal legislation." 156 Cong. Rec. H2,207 (Mar. 22, 2010).

Tellingly, the *only* legislative history cited by Appellants to support their interpretation is a cryptic statement in a Senate Finance Committee transcript in which Sen. Baucus discussed his committee's jurisdiction. (Appellants' Br. 45 (citing J.A. 285-87).)[8] But no fair reading of that excerpt tells the reader that tax credits would be unavailable to States that forgo creating their own exchanges. And such a reading would contradict Sen. Baucus's other statements, cited above, that evidenced his belief that premium tax credits would be available to eligible Americans in every State.

The district court in *Halbig* cut to the heart of the matter when it forced Appellants' counsel here to concede that their theory of what Congress did was not supported by the plain language of the ACA or its legislative history:

[8] This was likewise the only legislative history that Adler and Cannon could find to support their argument. *See* Adler & Cannon, *supra*, at 156 ("In our extensive search of the PPACA's legislative history, this comment by Sen. Baucus is the only instance we found of a member of Congress discussing whether tax credits would be available in federal Exchanges.").

> The problem that plaintiffs confront in pressing this argument is that there is simply no evidence in the statute itself or in the legislative history of any intent by Congress to ensure that states established their own Exchanges. *And when counsel for plaintiffs was asked about this at oral argument, he could point to none*. Indeed, if anything, the legislative history cuts in the *other* direction and suggests that Congress intended to provide states with flexibility as to whether or not to establish and operate Exchanges. 2014 U.S. Dist. LEXIS 4853, at *57-58 (emphasis added).

The district court here agreed. *King*, 2014 U.S. Dist. LEXIS 20019, at *40 ("What *is* clear is that there is no direct support in the legislative history of the ACA for Plaintiffs' theory that Congress intended to condition federal funds on state participation.") (J.A. 311).

In short, there was nothing in either the text or the legislative history of the ACA to make it "unambiguously" clear, *Pennhurst*, 451 U.S. at 17, that Virginia's decision to rely on a federally-facilitated exchange would deprive its low- and moderate-income citizens of premium tax-credit assistance worth upwards of a billion dollars a year. If two federal district judges could not find any mention of that consequence in the statute or legislative history, how could Virginia have been on "clear notice"? *Arlington*, 548 U.S. at 296.

3. Virginia was also entitled to rely on the Treasury Department's rulemaking.

The Department of the Treasury promulgated final regulations to implement

the premium tax credit on May 23, 2012, giving the term "Exchange" the same meaning as in the regulation promulgated by the Department of Health and Human Services (HHS), referring to either a State exchange or an exchange established by the federal government on the State's behalf. Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012) (codified at 26 C.F.R. § 1.36B-1(k)). The Department concluded that "[t]he statutory language of section 36B and other provisions of the Affordable Care Act support [its] interpretation," along with "the legislative history," and that the Department's interpretation "is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole." 77 Fed. Reg. at 30,378.

So the final rule provided even further assurance that States forgoing a State-based exchange would not jeopardize federal premium tax-credit assistance for their citizens.

4. Governor McDonnell's correspondence with the federal government shows no understanding that Virginia would harm its low- and moderate-income citizens by forgoing a State-based exchange.

Virginia's official actions and correspondence with the federal government, before and after the May 2012 rulemaking, confirm that the Commonwealth was not on "clear notice" that it would jeopardize federal premium tax-credit assistance to its own citizens by forgoing a State-based exchange. In April 2011, the Virginia

legislature stated that it was "the intent of the General Assembly that the Commonwealth create and operate its own health benefits exchange or exchanges . . . ." 2011 Va. Acts ch. 823, § 1 (HB 2434) (App. 1a). The General Assembly requested a report and recommendations from the Governor for consideration during the 2012 session. *Id.* § 2.

But in November 2011, in advance of the 2012 session, Governor Robert F. McDonnell advised the General Assembly that HHS had not provided sufficient information to enable him to compare the advantages and disadvantages of State- and federally-facilitated exchanges. (App. 2a.) That made it "extremely difficult to evaluate whether ceding control of an exchange to the federal government or creating our own is in the Commonwealth's best interest." (App. 3a.)

The General Assembly took no action to create a Virginia exchange in its 2012 session. And the official correspondence between Governor McDonnell and the federal government, throughout 2012, never intimated that Virginia citizens might lose federal premium tax-credit assistance if the Commonwealth elected to forgo a State-based exchange. (App. 4a-26a.)

On December 14, 2012, Governor McDonnell advised HHS Secretary Kathleen Sebelius that the General Assembly had not authorized the creation of State-based exchange and that, as a result, he "anticipate[d] that the federal government will build, operate, and fund the required exchange . . . ." (App. 25a.)

There was not a whisper that Virginia's decision would result in the denial of premium tax credits to Virginia citizens. To the contrary, Governor McDonnell confirmed with Secretary Sebelius:

> You have stated, and the law makes clear, that the choice of a state based, federal, or hybrid/partnership exchange are all equally valid in complying with the law. (App. 25a.)

He further confirmed that HHS had not provided information to Virginia that suggested any "clear benefits of a state run exchange to our citizens" as compared to a federally-facilitated exchange. (App. 26a.)

Thus, the official correspondence by which Virginia elected to forgo building its own exchange demonstrates no awareness that it would result, if Appellants were correct, in the denial of premium tax-credit assistance to Virginia's citizens.

III. The doctrine of constitutional avoidance requires rejecting Appellants' interpretation because the Tenth Amendment would prohibit Congress from punishing citizens to coerce their States into building exchanges.

"'It is a cardinal principle' of statutory interpretation . . . that when an Act of Congress raises 'a serious doubt' as to its constitutionality, '[federal courts] will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided.'" *Zadvydas v. Davis*, 533 U.S. 678, 689 (2001) (quoting *Crowell v. Benson*, 285 U.S. 22, 62 (1932)); *Thompson v. Greene*, 427 F.3d 263,

269 n.7 (4th Cir. 2005) (applying "interpretive rule that courts should construe statutes . . . so as to avoid raising constitutional questions").

The doctrine of constitutional avoidance requires the Court to reject Appellants' legal theory here. The essence of their claim is that Congress sought to coerce States into creating their own exchanges by threatening to impose potentially devastating financial burdens directly on State citizens if State governments did not comply; State citizens were mere hostages in Congress's campaign. The scenario is implausible; members of Congress voting for a law that punishes State citizens would be punishing *their own constituents*. But if that had really occurred, it would have run afoul of the Tenth Amendment by unconstitutionally coercing States into action.

Such a scheme would be no run-of-the-mill use of the "spending power to create incentives for States to act in accordance with federal policies." *NFIB*, 132 S. Ct. at 2602 (Roberts, C.J.). It would have been, instead, an unprecedented threat to visit financial ruin on some of the States' most vulnerable citizens, a scheme that would be "far from the typical case." *Id.* at 2603. Such a threat would "'cross[] the line distinguishing encouragement from coercion.'" *Id.* (quoting *New York v. United States*, 505 U.S. 144, 175 (1992)). It would have "serve[d] no purpose other than to force unwilling States" to comply. *Id.*

Because Appellants' interpretation assumes that Congress acted unconstitutionally, it must be rejected if there is any way to fairly construe the statute to avoid it.

IV. The Commonwealth withdraws the argument of the prior Attorney General.

The Commonwealth withdraws the argument submitted in support of Appellants by the prior Attorney General of Virginia, as expressed in an *amicus* brief filed in the District Court. (ECF# 38-1, filed Nov. 26, 2013.) The legal argument in that brief focused too narrowly on the language of § 36B(b)(2)(A) without examining it in the broader context of the Affordable Care Act. The argument overlooked the significant financial harm that such an interpretation would visit on low- and moderate-income Virginians. It overlooked the Governor's stated assumption that *no* harm would befall Virginians by forgoing a State-based exchange. And although it praised "our federalism" and the importance of "States . . . as residuary sovereigns and joint participants in the governance of the Nation" (ECF# 38-1 at 2 (quoting *Alden v. Maine*, 527 U.S. 706, 748 (1999)), the argument overlooked the anomaly of the position it defended: approving Congress's supposed use of a weapon to financially harm the State's low- and moderate-income citizens as a means to coerce States into yielding to federal demands. States opposed to yielding to abusive "federal blandishments," (*id.* quoting *NFIB*, 132 S. Ct. at 2603) should not defend Congress's right to hold

State citizens hostage.

Because the district court neither mentioned nor accepted the legal position espoused in that *amicus* brief, and because the prior position involved a matter of law, not fact, the Commonwealth is not judicially estopped from disavowing it. *Reed Elsevier, Inc. v. Muchnick*, 559 U.S. 154, 169-70 (2010); *New Hampshire v. Maine*, 532 U.S. 742, 750-51 (2001); *Zinkand v. Brown*, 478 F.3d 634, 638 (4th Cir. 2007). We do so now.

CONCLUSION

The Appellants' legal position attributes to Congress an appalling and unconstitutional scheme to coerce States into building their own health-insurance exchanges by threatening to visit significant financial harm on citizens if their States elected instead to rely on federally-facilitated exchanges. The Appellants' theory defies common sense and is unsupported by the text, structure, policy, or legislative history of the ACA. The *Pennhurst* doctrine independently forecloses it because the federal government failed to give "clear notice" to the Commonwealth, *before* the General Assembly and the Governor elected in 2012 to forgo a State-based exchange, that a half million Virginians might lose their premium tax credits as a result.

The Court should affirm the ruling of the District Court.

Respectfully submitted,

COMMONWEALTH OF VIRGINIA

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font, and that it complies with the type-volume limitation of Fed. R. App. P. 29(d) and 32(a)(7)(B), because it contains 5,749 words, excluding the parts exempted by Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

/s/
Stuart A. Raphael

APPENDIX

VIRGINIA ACTS OF ASSEMBLY -- 2011 RECONVENED SESSION

CHAPTER 823

An Act to state the intent of the General Assembly to create and operate a health benefits exchange.

[H 2434]

Approved April 6, 2011

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That it is the intent of the General Assembly that the Commonwealth create and operate its own health benefits exchange or exchanges, hereafter referred to collectively as the "Virginia Exchange," to preserve and enhance competition in the health insurance market. The purpose of the Virginia Exchange shall be to facilitate the purchase and sale of qualified health plans in the individual market and to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. To accomplish this purpose, the Virginia Exchange shall, at a minimum: (i) meet the relevant requirements of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively referred to as the Affordable Care Act), regarding the establishment of an American Health Benefit Exchange or Small Business Health Options Program by the prescribed deadline imposed by the Affordable Care Act in order to avoid development and implementation of a federal exchange in the Commonwealth; (ii) ensure that no qualified health insurance plan that is sold or offered for sale through an exchange established or operating in the Commonwealth shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto; and (iii) the limitation set forth in (ii) shall not apply to an abortion performed (a) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (b) when the pregnancy is the result of an alleged act of rape or incest.*

§ 2. The General Assembly requests the Governor, through the Secretary of Health and Human Resources and with the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and stakeholders generally to provide recommendations for consideration by the 2012 Session of the General Assembly regarding the structure and governance of the Virginia Exchange. The Governor's recommendations shall address, at a minimum, the following: (i) whether to create the Virginia Exchange within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity; (ii) the make-up of a governing board for the Virginia Exchange; (iii) an analysis of resource needs and sustainability of such resources for the Virginia Exchange; (iv) a delineation of specific functions to be conducted by the Virginia Exchange; and (v) an analysis of the potential effects of the interactions between the Virginia Exchange and relevant insurance markets or health programs, including Medicaid. These recommendations shall be presented to the General Assembly by October 1, 2011, in order that any necessary amendments to the Code of Virginia and any appropriation necessary for establishment of the Virginia Exchange may be considered during the 2012 Session of the General Assembly.

2. That the provisions of this act shall expire on July 1, 2014.

3. That nothing in this act shall be construed or implied to recognize the constitutionality of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

4. That the provisions of this act constitute the election of the Commonwealth to prohibit abortion coverage in qualified health plans offered through an exchange in the Commonwealth as amended by § 1303(a)(1) of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Commonwealth of Virginia

Office of the Governor

Robert F. McDonnell
Governor

November 25, 2011

The Honorable William J. Howell
Speaker of The House of Delegates
Virginia House of Delegate
Post Office Box 406
Richmond, Virginia 23218

The Honorable Charles Colgan
President pro tempore
Senate of Virginia
Post Office Box 306
Richmond, Virginia 23218

Dear Speaker Howell and Senator Colgan:

I have significant concerns regarding the impact the Patient Protection and Affordable Care Act (PPACA) will have on the Commonwealth of Virginia. Our health care system is in need of significant reform, including Virginians having access to affordable health care. The challenge is how to provide that access in an economically responsible and constitutional manner. That is why I strongly support the cases challenging the constitutionality of the federal health care law and the individual mandate. I have long argued that this is an issue that will have an enormous impact on states and their citizens, and one that demands finality as soon as possible. While uncertainty looms over its constitutionality, each day that that these cases remain unresolved means that states must spend more time and money to prepare for the expensive and burdensome requirements of the health care law.

As I have previously stated, I believe PPACA is not the answer to our health care challenges. I have shared my concerns with Secretary Sebelius and have unified my voice with other Governors calling for the repeal of PPACA. If PPACA is not repealed, significant amendments are necessary. This unfunded mandate will significantly and negatively impact the Commonwealth's budget and those of every state in the Union.

As Governor, I have considerable issues with the federal Department of Health and Human Services (HHS) lack of a coordinated, organized strategy in working with states. I have specific concerns about key facets of the law and the unfunded mandates that if implemented as written, may put serious additional strain on the Commonwealth's economy and overwhelm our health care system. With less than two years remaining for Health Benefit Exchanges to be operational, HHS leadership has not provided the necessary guidance and critical information needed for states to make informed decisions around exchange planning and development. Of significant concern is that if Virginia does not create an operational exchange, the federal government threatens to operate a federally facilitated exchange in the Commonwealth. HHS has neither released a model of the federal Health Benefit Exchange nor addressed the underlying policies that will govern such an exchange. Without the necessary guidance and rules that will

govern a Virginia exchange and a federal model to review, it is extremely difficult to evaluate whether ceding control of an exchange to the federal government or creating our own is in the Commonwealth's best interest.

As Governor, I will act in the best interest of Virginians to mitigate against unfounded federal intrusion. In August 2010, Virginia began forming its own strategies through the creation of the Virginia Health Reform Initiative Advisory Council. After naming the membership, I charged them with seeking innovative and affordable solutions to the challenges facing health care in Virginia. The experts and stakeholders of this group have spent the last nine months discussing and considering much of the information provided in the attached report.

Please find attached, the report they prepared pursuant to House Bill 2434 of the 2011 Session of the Virginia General Assembly. The bill directed the Secretary of Health and Human Resources along with the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and stakeholders to provide recommendations for consideration by the 2012 Virginia General Assembly regarding the structure and governance of a Health Benefit Exchange (HBE), if one is created in Virginia.

The report includes recommendations of the Virginia Health Reform Initiative and reflects the documents, discussions, stakeholder public comment, and recommendations made over the past several months by the Advisory Council and interested parties. The Advisory Council worked to address the five questions posed by the General Assembly as well as other questions deemed relevant by the Advisory Council members and stakeholders.

The decisions ahead are not easy and I will neither compromise the financial integrity of Virginia nor leave us vulnerable to the overreaching federal government. I will continue to evaluate these recommendations while working with Secretary Hazel and other trusted advisors in order to identify and pursue the best course of action for the Commonwealth. When it comes time to make a final decision regarding the best path for Virginia, I will appreciate your assistance and leadership in this effort to ensure the best outcome for our citizens.

Sincerely,

Robert F. McDonnell

CC: The Honorable G. Paul Nardo
Clerk, Virginia House of Delegates

The Honorable Susan Schaar
Clerk, Senate of Virginia

COMMONWEALTH of VIRGINIA

Office of the Governor

Robert F. McDonnell
Governor

February 6, 2012

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

As Governor of the Commonwealth of Virginia, I have stated clearly that Virginia will build and operate its own Health Benefits Exchange if an exchange is required under federal law. The challenges that we face in doing so are typical of those faced by Governors across the country. There are three issues that must be addressed if states are to implement health benefit exchanges without unnecessary waste.

The first issue is the designated timelines for establishment and funding of exchanges. It is imperative that these be extended to allow the Supreme Court to rule on the various elements of the Patient Protection and Affordable Care Act (PPACA) prior to requiring states to commit to an establishment of an exchange. States need to know what aspects of PPACA will be enforceable in order to establish the potential value and cost of an exchange. To build an expensive infrastructure that may ultimately be of little or no benefit if the mandate to purchase insurance is overturned is not a prudent use of scarce public resources. The implementation funding deadline should be no earlier than December 1, 2012 to allow states to plan following the Supreme Court ruling.

Additionally, I am concerned with the absence of critical regulations that will define how the exchange functions and provides continuity with Medicaid. A major problem for us is the absence of a lawful definition of the essential benefit plan. This affects how states will regulate the insurance markets both inside and outside of the exchange. States must also be able to reconcile the essential benefit package with their existing insurance mandates in order to budget state funds for insurance premium subsidies or to modify our mandated benefits. Virginia and many other states are in a different position of not being able to act until there is a basis for action and greater clarity is provided at the federal level.

My third concern is that states need to receive freedom from Medicaid maintenance of effort so that we can effectively absorb the "woodwork effect" of additional numbers into our system, absent additional funding. Despite the promise of federal funding for all "newly eligible", there will likely be a number of currently eligible individuals who will enroll at the state's expense, if mandated to do so. In these difficult budget times, it is essential that states be

given the tools to adapt the base Medicaid plan to meet the needs of their citizens as effectively and efficiently as possible.

In conclusion, I ask that you extend all deadlines to file in order to receive additional funding from the federal government for PPACA implementation to the earliest of December 1, 2012.

Sincerely,

Robert F. McDonnell

RMF/es

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 20, 2012

The Honorable Robert F. McDonnell
Governor of Virginia
Richmond, VA 23219

Dear Governor McDonnell:

Thank you for your letter and questions regarding Virginia's implementation of the Affordable Insurance Exchanges and other aspects of the Affordable Care Act. I appreciate your taking the time to share your thoughts and would like to directly address the issues you have raised.

In your letter you requested an extension of the Exchange grant funding deadline. In November 2011, the Department of Health and Human Services (HHS) indicated our intent to extend the last date by which states can apply for and receive assistance to build their Exchanges. We will be releasing a Funding Opportunity Announcement shortly that will clarify that HHS will continue to award federal funds through the end of 2014 that states can use to establish Exchanges.

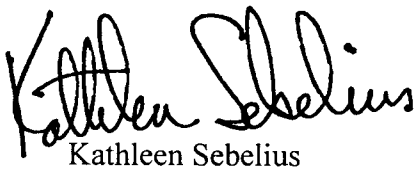
Regarding your second point, on February 17, 2012, HHS published Frequently Asked Questions on the Essential Health Benefits Bulletin that address your questions about the selection of a benchmark plan for essential health benefits and the impact of state mandates on essential health benefits. Our intended approach with respect to essential health benefits strives to balance comprehensiveness, affordability, and state flexibility. We intend to use the comments we receive on the Bulletin to inform the development of regulations in the near future.

You also asked about Medicaid maintenance of effort (MOE) and states' need for flexibility in order to effectively serve all Medicaid beneficiaries—both those newly eligible in 2014 and those currently eligible. Under section 2001(b)(2) of the Affordable Care Act, the MOE requirement for adults ends as soon as the Centers for Medicare & Medicaid Services determines that a state's Exchange is fully operational. All states will have either a State-based or Federally-facilitated Exchange beginning January 1, 2014, so states will not be subject to Medicaid MOE for adults when newly eligible individuals begin enrollment in the Medicaid program or receive premium tax credits to purchase coverage in Exchanges. Additionally, nothing in the Affordable Care Act limits states' ability to manage the costs of their Medicaid program through the policies they pursue in other non-eligibility areas including choice of delivery system, benefits offered, and provider rates.

Again, thank you for your letter on these important issues. I believe the flexibility we have provided to states by working to extend the Exchange funding deadline, supporting states' management of their Medicaid populations, and strengthening state regulation of the insurance market supplies the

tools you need to build a successful State-based Exchange in Virginia. I look forward to hearing about your progress.

Sincerely,



Kathleen Sebelius

July 10, 2012

The Honorable Barack Obama
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Obama:

On June 28 the United States Supreme Court ruled in *National Federation of Independent Business vs. Sebelius* that the Medicaid expansion provisions in the Patient Protection and Affordable Care Act (PPACA) were unconstitutionally coercive of state sovereignty.

Despite the ruling which upheld the individual mandate as a tax, we have written before and continue to maintain that the PPACA remains seriously flawed both conceptually and technically. It favors dependency over personal responsibility and will ultimately destroy the private insurance market. In its current form, the law will increase health care costs and likely lead to the disruption or discontinuation of millions of Americans' insurance plans. The new federal subsidies anticipated that enable exchanges are unaffordable given the crushing federal budget deficits and record national debt, and states cannot afford significant Medicaid expansions. For most governors, Medicaid growth even before PPACA, was exorbitant, and consuming an even larger share of state budgets.

Three years ago, you correctly told Senate Democrats, "[a]s we move forward on health reform, it is not sufficient for us to simply add more people to Medicare or Medicaid to increase the rolls, to increase coverage in the absence of cost controls and reform. And let me repeat this

principle: If we don't get control over costs, then it is going to be very difficult for us to expand coverage. These two things go hand in hand. Another way of putting it is we can't simply put more people into a broken system that doesn't work."

Unfortunately, that is precisely what has been done—PPACA, if implemented by the states, would put more people, 16-20 million individuals, into a broken Medicaid system. Three years ago, you stated clearly that would be a mistake. We fully agree. Today, states have less flexibility over the administration of the program, even though some states pay a share of the cost equal to that of the federal government. Governors of both parties, who are the primary managers of Medicaid delivery in our states, were not invited to engage in meaningful dialogue with your administration in 2010 when the PPACA was drafted-- and ultimately passed--- on a party-line vote.

We are still waiting for the real tools and flexibility we need to reform Medicaid and lower costs as you promised. Last year, Republican governors stressed the need to reform Medicaid, and we put forward 31 specific policy ideas to achieve that goal. We sent you and the Congressional leadership the detailed plan documents to craft such reforms. Since we received virtually no response from you, we are enclosing another copy for your team to review. We now renew our call for Medicaid reform.

PPACA uses Medicaid as the vehicle for expansion because it would be cheaper for the federal government through cost-shifting to the states. Despite promises of higher federal matches for the expansion populations, we also cannot ignore the policies proposed by your Administration that would cut the enhanced match rate for newly eligibles.

While overall spending on health care has slowed, the cost of health care has not. Spending has slowed, but for the wrong reason—the lingering recession that has cost jobs and thus lost health coverage. According to the most recent federal government projections, the number of individuals without health insurance will have increased from 42.7 million in 2008 to 48.6 million in 2013.

While we continue to believe the best option is to fully repeal and replace the PPACA, states now confront numerous deadlines and face major policy decisions in the wake of the Supreme Court decision. Before making any final policy decisions, governors must carefully consider the short and long-term implications of an expanded entitlement program and the consequences of significantly increasing the size of government to manage these programs.

The states' burden of the expansion population as well as administrative costs remains significant, as noted in the attached updated state estimates of cost. Increased spending on Medicaid crowds out resources available to states to spend on other meaningful priorities like education, the environment, public safety and infrastructure.

Moreover, even before increasing the Medicaid-eligible population as prescribed by PPACA, Medicaid has been on an unsustainable path, comprising a growing share of state budgets every year. It is difficult to see how expanding Medicaid without reform would do anything other than put more strain on state budgets and the taxpayers, especially when considering that many pernicious provisions that curtail state flexibility remain.

While the Supreme Court decision focused on the states' role in determining whether a Medicaid expansion is in the best interest of its citizens, states also face other PPACA-related decisions, like whether to establish a state based health-insurance exchange or accept the default of a federal exchange. As the exchange issue is currently interpreted, states are essentially being tasked with shouldering all the responsibility without any authority.

If states determine that a Medicaid expansion is not in the best interests of its citizens, it is likely that there will be a significant gap in coverage for low-income individuals who do not qualify for tax credits. We believe it is incumbent upon the authors of PPACA and your Administration to detail precisely how you intend to address this situation.

We also believe that it is unlikely that the federal government will have fully functional exchanges in place by the fall of 2013 in order for millions of Americans to be able to purchase coverage beginning January 2014. We respectfully request the Administration provide the detailed work plan that demonstrates these deadlines will be met. If they cannot be met, the responsible course would be for HHS to level with us and the American people. We also do not understand how the federal government can begin to afford to implement PPACA, with deficits already over $1 trillion in every year of your presidency, and the debt growing $5 trillion in the past 3 years to an outrageous record of nearly $16 trillion.

The consequences of governors' decisions will impact our states – and the nation – for decades to come, so we must have all the information needed to choose wisely. We have taken the liberty of compiling below just some of the critical questions that must have answers before states can determine best how to proceed in light of the Court's decision. We undertake this task with a sense of great responsibility, and resolve to only move forward when we have full and complete knowledge of all the implications of our decision.

Healthcare Exchanges:

1) Please provide a complete list of regulations that will have to be reviewed, revised and re-opened for public comment prior to implementation as a result of the Supreme Court ruling (e.g., the Medicaid eligibility regulations, exchange regulations related to interface with Medicaid)? What is the schedule for re-issuing these regulations?

2) When will either additional guidance or actual rules be issued on essential health benefits, actuarial value and rating areas be issued?

3) The federal government has already extended deadlines for applying for Level 1 and Level 2 Exchange Establishment funding into 2014. Can we expect extensions of the deadlines for implementation given the uncertainty caused by the Supreme Court ruling and the linkage between Medicaid expansion and exchange eligibility and enrollment functions? In addition, will the deadlines change for states implementing a partnership exchange? Will the deadlines be extended for states implementing a federal exchange?

4) When will the details of the federal partnership options be available? These cannot be considered as an option without details including cost estimates. How will the long term funding of the federally-facilitated healthcare exchanges be sustained?

5) States considering a state-based exchange need to know whether there will be a charge and by how much to use the federal data hub, advance premium tax credit/cost-sharing reduction service, risk adjustment and transitional reinsurance programs.

6) When will states learn the details of the operational systems for a federal exchange? The procedural, technical, and architectural requirements for linking to the federal exchange have not been released. It is not feasible to know if a state-based exchange is better for our citizens until we know what the contents of a federal exchange will be. Taking grant money at this time for state exchange creation may be wasted if a federal exchange makes more sense for a particular state.

7) When will information from the establishment of a federal exchange be available for states to use if a state opts to build its own exchange? It is costly for each state to have to start from scratch and still not know how interfaces will work.

8) If states choose to build a state-based exchange, what dollars will the federal government contribute now and in the future? For the federal exchange states, when will the regulations regarding the imposition of taxes on a state's insurers be released?

9) It has been widely reported that Congressional leaders who have to appropriate money will seek to defund exchanges. Please explain how the enactment provisions of the law allow the Executive Branch to continue to fund exchanges without Congressional action to appropriate money.

10) What happens to a state that has taken exchange planning and implementation grants if their exchange is not financially viable after 2015? Can a state refuse to increase taxes on either its residents or insurers, thus putting the financial underpinning of an exchange at risk? What penalties does the federal government envision in this case?

11) What happens if a state accepts grant money now to begin to build a state exchange, and subsequently determines that a federal exchange may be better? Will the federal government claw back these grant dollars from the states?

12) What impact will changes to the Medicaid expansion have on exchange implementation? The federal exchange is currently structured to provide Medicaid eligibility determination. How will this work if some states participate and others do not?

13) Last month the Congressional Budget Office (CBO) pointed out a provision in the law that reduces exchange subsidies after 2018, which means fewer and fewer people will qualify for subsidies, and the people who do qualify will get a smaller and smaller subsidy. Does the Administration support that change, and if so, how would you pay for it? If you do not, why do you think people should be forced to buy insurance if federal subsidies are shrinking?

14) CMS has released 90/10 funding under ARRA and HITECH in order for states to improve their eligibility systems for Medicaid and other social service programs. Will that funding continue?

15) Alongside the considerable challenge of greatly expanding the Medicaid program, states are charged by the PPACA with creating a single, seamless point of entry for all of the insurance affordability programs affected by the Act--Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Plan (where offered), advance tax credits for individual and Small Business Health Options Program (SHOP) exchange enrollees. This leaves another major question on the table. What about all of the other social service programs? Will states still be able to create an eligibility system for all social service programs under the 90/10 funding mechanism?

16) In order to minimize disruptions to a state's insurance market, The Office of Personnel Management (OPM) is required to certified multi-state plans that must be included in every exchange, when will the rules be released detailing the requirements and timeline for multi-state plans. How OPM structures these rules can be very disruptive to a state's insurance market.

17) Does the federal government intend to maintain high risk pools and how will they be financed? What actions will they take in a state that has opted not to operate a high risk pool or an exchange?

Medicaid

1) When can we expect to receive updated guidance on Medicaid expansion and related topics?

2) Is there a deadline for letting the federal government know if a state will be participating in the Medicaid expansion? How does that relate to the exchange declaration deadline? The two programs are currently scheduled to be implemented simultaneously in January 2014.

3) Will states that expand Medicaid coverage up to a level below 138% of the federal poverty level (FPL), for example up to 100% of FPL, still receive the enhanced federal medical assistance percentage (FMAP) available for "newly covered" populations?

4) Will states be allowed to phase in Medicaid coverage up to 138% of FPL (or 100% FPL) years after 2013 and still receive the enhanced FMAP?

5) Does the MOE requirement apply to the expansion population or does it apply only to the current Medicaid population? If a state accepts the expansion, but the federal match goes away, can we drop out of the expansion program? Will you waive the MOE under your 1115 waiver authority? What will be the penalties for failure to comply with MOE requirements? Since the MOE was a direct result of the expansion funding, if a state chooses not to expand is the MOE no longer effective?

6) Regarding the two year increase in Medicaid reimbursement for primary care codes, are you going to extend it? If so, how are you going to pay for it? Congressional Republicans have expressed opposition to any funded for PPACA.

7) Will states still be required to convert their income counting methodology to MAGI for purposes of determining eligibility regardless of whether they expand to the optional adult group? If so, how do states link the categorical eligibility criteria to the MAGI? How will the federal exchanges utilize the state's criteria?

8) If a state expanded Medicaid through a waiver prior to enactment of the PPACA, but then chooses not to expand coverage further, are they still eligible for the 75% to 90% enhanced FMAP for the previously expanded population?

9) Will the federal government support options for the Medicaid expansion population that encourage personal responsibility – cost sharing or accountability provisions, the use of high deductible plans such as Health Savings Accounts, and other options at the state's choice?

10) What specific plans and timeline do you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?

11) You have stated that you will not deport undocumented aliens who have not committed a crime. You have also said that these undocumented aliens will be exempt from the individual mandate. How will the state be reimbursed for medical services given to these individuals?

12) Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?

13) The Disproportionate Share allotments will be reduced every year with a methodology based in the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population will the remaining state absorb the full reduction? In addition, can a state implement a new DSH Diversion program as part of the optional expansion? Can a state implement new DSH Diversion programs for services to the uninsured/uncompensated care services?

There will inevitably be more questions that will arise as additional guidance flows from your Administration. With just 18 months until the anticipated implementation date of PPACA, we would appreciate prompt answers.

Thank you for your attention to this important matter facing states and the country. We look forward to learning from your responses.

Sincerely,

Governor Bob McDonnell, RGA Chairman
Commonwealth of Virginia

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUL 13 2012

The Honorable Robert McDonnell
Chairman
Republican Governors Association
1747 Pennsylvania Ave., NW
Washington, DC 20006

Dear Governor McDonnell:

I am responding to your July 10, 2012 letter. Since the passage of the Affordable Care Act on March 23, 2010, the Administration has worked steadily with states, including Virginia, to implement the law and ensure that hard-working middle class families have the security of affordable health coverage and care they deserve. We have issued a number of guidance documents and answers to frequently asked questions. We have hosted dozens of meetings at the national and regional levels, conference calls, and webinars to directly engage state officials. We will have staff at the National Governors Association conference to answer any questions, as we have for the past three years. And we intend to do more of the same, with four new regional implementation sessions announced just this week. Our door is open.

A big part of our effort has been working closely with states to begin building new health insurance marketplaces, the Affordable Insurance Exchanges, where Americans will be able to choose private health insurance plans based on price and quality. These marketplaces will open in 2014, the same time when insurance companies will no longer be able to discriminate against Americans with a preexisting health condition. Insurance companies also will not be able to charge more just because an enrollee is a woman or bill insured people into bankruptcy. Exchanges will help ensure millions of consumers get quality, affordable health care.

The Affordable Care Act gives states significant flexibility in how these Exchanges are set up and run. States can run Exchanges on their own, in collaboration with other states, or in a transitional or permanent partnership with our Department. And, already, well before the November deadline, 13 states where a third of Americans live have committed to establishing an Exchange. With the Supreme Court's clear and final ruling on the Affordable Care Act, all other states should do the same.

Another way that the Affordable Care Act improved the affordability of health care is by extending eligibility for Medicaid to help hard-working, responsible Americans struggling to make ends meet. This expansion of coverage is 100 percent federally funded for the first three years and at least 90 percent federally funded thereafter. The Supreme Court's decision leaves in place all aspects of the law affecting Medicaid, including this funding, with one exception: A state may not, as a consequence of not participating in this expansion, lose federal funding for its existing Medicaid program. The Court's decision did not affect other provisions of the law.

States have asked some questions about their choices going forward in light of the decision. To answer some of the major ones, there is no deadline for a state to tell our Department its plans on the Medicaid eligibility expansion. A state can receive extra funding for Medicaid IT costs and Exchange implementation costs even if it has not yet decided whether to expand Medicaid eligibility or to run its own Exchange. And, if a state ultimately decides not to do so, it will not have to pay those resources back. More guidance will be issued in the year and a half before the Medicaid eligibility expansion and the Exchanges begin.

We expect that, as states study their options, they will recognize that this is a good deal. Significant new federal funding will flow to their states. Their hospitals will get paid for what would otherwise be uncompensated care provided to uninsured patients. Their local economies will benefit and jobs will be created when their hospitals remain viable and their workers remain healthy. And the improved health of their residents who gain access to health care will be invaluable.

We hope that states will not turn down the resources and flexibility offered in the Affordable Care Act, and will put aside old political battles to move forward with implementation. We stand ready to help.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner
Acting Administrator

cc: The Honorable Dave Heineman, Chair, National Governors Association
The Honorable Martin O'Malley, Chair, Democratic Governors Association

November 14, 2012

The Honorable Barack Obama
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Obama:

Congratulations on your election victory. The American people have made their decision and Republican governors stand ready to work with your Administration on issues of critical importance to our states and the nation. Our American political system once again showed the world democracy in action, where policy differences are debated in the public arena and settled with one vote per person. We wish you well and are hopeful that you and the Congress will promptly address the crushing problems of debt, unemployment, and spending reform by the end of the year to create certainty for the states and businesses.

We write today on behalf of the 29 Republican governors and two governor-elects representing 60 percent of the states, with an urgent matter related to implementation of the Patient Protection and Affordable Care Act (PPACA). It is clear that putting in place the new programs you championed will be an enormous strain on state governments and budgets, as well as the federal government. From the financial obligations and complex technicalities to ensuring the healthcare workforce and infrastructure will be in place to meet the new demand, the timeframe and many of the provisions in the PPACA are simply unworkable. With the pending deadline of November 16 for governors to make a decision on state based health insurance exchanges, we ask you to push back the date until your team has answered the numerous

previous questions for governors and other groups, and promulgated the final regulations, so that all stakeholders have had the opportunity to comment, and those comments have been incorporated into a final rule. The guidance Friday from Secretary Sebelius extends the date only for the election of a partnership exchange, and subsequently for the federal exchange.

The PPACA, as written, requires many changes, but most immediate are the implementation deadlines for the health insurance exchange models. While the January deadline to certify if a state is prepared to implement a state based exchange is statutory, most other deadlines are written within the discretion of the United States Department of Health and Human Services (HHS). Other than the minor amendments made last Friday, to date, HHS has been unwilling to establish a more manageable timeline. The rulemaking process has been unduly condensed, and in some cases, important rules have not been promulgated at all. Rather, the administrative guidance that has been shared holds limited legal authority for states or the federal government.

States are struggling with many unanswered questions and are not able to make comprehensive far-reaching decisions prudently. In the past months, we have sent letters with many specific questions to help us make an informed choice, and our letters have been generally ignored. Many important questions remain unanswered as the deadlines loom. We include our previous letters as an attachment.

Also, the clear truth is that the PPACA does not contain much-needed Medicaid or Medicare reform designed to control costs. As you correctly told Senate Democrats, "[a]s we move forward on health reform, it is not sufficient for us to simply add more people to Medicare or Medicaid to increase the rolls, to increase coverage in the absence of cost controls and reform. And let us repeat this principle: If we don't get control over costs, then it is going to be very difficult for us to expand coverage. These two things go hand in hand. Another way of putting it is we can't simply put more people into a broken system that doesn't work." We governors, facing crushing Medicaid budget pressure from Medicaid before PPACA implementation, wholeheartedly agree with your statement. Expansion without reform is not responsible and would bust the state budgets. With the Supreme Court striking the punitive provisions of PPACA to penalize states that do not expand, we renew our pleas for an honest discussion on reform, flexibility, and waivers to allow governors to manage Medicaid costs better.

As has been stated many times, before making any final policy decisions, governors must carefully consider the short and long-term implications of an expanded entitlement program and the consequences of significantly increasing the size of government to manage these programs. In the near term, we need to better understand how the federal government will implement a federal exchange as it is clear most states will not be ready on their own. We also have concerns about future cost shifting to states, and need certainty as we prepare our budgets, many of which are biennial budgets. We also remain very apprehensive about the unsustainable deficits and

national debt, and the reality that imprudent implementation of PPACA will contribute dramatically to an increase in both.

Lastly, we respectfully request that you meet as soon as possible with a group of concerned governors, Republicans and Democrats. We wish to discuss our specific proposals for Medicaid reform that we sent you in August 2011, as you work with the Congress to address the fiscal cliff the country faces. We hope you can appreciate the real challenges all states face in implementing the PPACA under compressed schedules with insufficient information to make good decisions.

Mr. President, again, congratulations on your team's impressive victory. We all look forward to working together.

Sincerely,

Governor Bob McDonnell
Commonwealth of Virginia

Governor Bobby Jindal
State of Louisiana

Enclosure
CC: Republican Governors

Healthcare Exchanges:

1) Please provide a complete list of regulations that will have to be reviewed, revised and re-opened for public comment prior to implementation as a result of the Supreme Court ruling (e.g., the Medicaid eligibility regulations, exchange regulations related to interface with Medicaid). What is the schedule for re-issuing these regulations?

2) When will final rules be issued on essential health benefits, actuarial value and rating areas?

3) The federal government has already extended deadlines for applying for Level 1 and Level 2 Exchange Establishment funding into 2014. Can we expect extensions of the deadlines for other areas of implementation given the uncertainty caused by the Supreme Court ruling and the linkage between Medicaid expansion and exchange eligibility and enrollment functions? In addition, will the deadlines change for states implementing a partnership exchange? Will the deadlines be extended for states implementing a federal exchange? Can you confirm that states will be able to switch from a federal model to a partnership or state model until 2019 and that funding will be available to enable that transition?

4) When will the details of the federal partnership options be available? These cannot be considered as an option without details including cost estimates and how state and federal systems are expected to link. How will the long term funding of the federally-facilitated healthcare exchanges be sustained?

5) States considering a state-based exchange need to know whether there will be a charge to use the federal data hub, advance premium tax credit/cost-sharing reduction service, risk adjustment and transitional reinsurance programs. Will there be a charge? And, if so, how much will it be?

6) When will states learn the details of the operational systems for a federal exchange? The procedural, technical, and architectural requirements for linking to the federal exchange have not been released. It is not feasible to know if a state-based exchange is better for our citizens until we know what the contents of a federal exchange will be. Taking grant money at this time for state exchange creation may be wasted if a federal exchange makes more sense for a particular state.

7) When will information from the establishment of a federal exchange be available for states to use if a state opts to build its own exchange? It is costly for each state to have to start from scratch and still not know how interfaces will work.

8) If states choose to build a state-based exchange, what dollars will the federal government contribute now and in the future? For the federal exchange states, when will the regulations regarding the imposition of taxes on a state's insurers be released?

9) It has been widely reported that Congressional leaders who have to appropriate money will seek to defund exchanges. Can you explain how the enactment provisions of the law allow the Executive Branch to continue to fund exchanges without Congressional action to appropriate money?

10) What happens to a state that has taken exchange planning and implementation grants if their exchange is not financially viable after 2015? Can a state refuse to increase taxes on either its residents or insurers, thus putting the financial underpinning of an exchange at risk? What penalties does the federal government envision in this case?

11) What happens if a state accepts grant money now to begin to build a state exchange, and subsequently determines that a federal exchange may be better? Will the federal government claw back these grant dollars from the states?

12) The Congressional Budget Office (CBO) has pointed out a provision in the law that reduces exchange subsidies after 2018, which means fewer and fewer people will qualify for subsidies, and the people who do qualify will get a smaller and smaller subsidy. Does the Administration support that change, and if so, how would you pay for it? If you do not, why do you think people should be forced to buy insurance if federal subsidies are shrinking?

13) Alongside the considerable challenge of greatly expanding the Medicaid program, states are charged by the PPACA with creating a single, seamless point of entry for all of the insurance affordability programs affected by the Act--Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Plan (where offered),advance tax credits for individual and Small Business Health Options Program(SHOP) exchange enrollees. This leaves another major question on the table. What about all of the other social service programs?

14) In order to minimize disruptions to a state's insurance market, The Office of Personnel Management (OPM) is required to certify multi-state plans that must be included in every exchange. When will the rules be released detailing the requirements and timeline for multi-state plans? How OPM structures these rules can be very disruptive to a state's insurance market.

15) Does the federal government intend to maintain high risk pools and how will they be financed? What actions will they take in a state that has opted not to operate a high risk pool or an exchange?

16) How do states with a federal exchange ensure that Web Based Entities (WBE) are an option in their state?

17) Will HHS and the United States Department of the Treasury offset the advance payments of premium assistance tax credits to issuers for an applicant's outstanding tax, alimony, and/or child support debts?

18) Will state-based exchanges have the flexibility to retroactively adjust past due premium amounts for interim changes in income?

19) How will the Center for Consumer Information and Insurance Oversight (CCIO) handle Qualifed Health Plans (QHP) to Medicare transitions to prevent enrollee confusion and the potential for unpaid QHP premiums due to the enrollee not terminating the QHP timely?

20) How will CCIIO minimize the adverse impact of its overly-broad employer notice requirement?

Medicaid:

1) When can we expect to receive updated guidance on Medicaid expansion and related topics?

2) Will states that expand Medicaid coverage up to a level below 138% of the federal poverty level (FPL), for example up to 100% of FPL, still receive the enhanced federal medical assistance percentage (FMAP) available for newly covered populations?

3) Will states be allowed to phase in Medicaid coverage up to 138% of FPL (or 100%FPL) years after 2013 and still receive the enhanced FMAP?

4) Does the MOE requirement apply to the expansion population or does it apply only to the current Medicaid population? If a state accepts the expansion, but the federal match goes away, can we drop out of the expansion program? Will you waive the MOE under your 1115 waiver authority? What will be the penalties for failure to comply with MOE requirements? Since the MOE was a direct result of the expansion funding, if a state chooses not to expand is the MOE no longer effective?

5) How will the federal exchanges utilize the state's criteria for eligibility that will be included in MAGI?

6) If a state expanded Medicaid through a waiver prior to enactment of the PPACA, but then chooses not to expand coverage further, are they still eligible for the 75% to 90% enhanced FMAP for the previously expanded population?

7) Will the federal government support options for the Medicaid expansion population that encourage personal responsibility cost sharing or accountability provisions, the use of high deductible plans such as Health Savings Accounts, and other options at the state's choice?

8) What specific plans and timeline do you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?

9) You have stated that you will not deport undocumented aliens who have not committed a crime. You have also said that these undocumented aliens will be exempt from the individual mandate. How will the state be reimbursed for medical services given to these individuals?

10) Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?

11) The Disproportionate Share allotments will be reduced every year with a methodology based in the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population, will the remaining states absorb the full reduction? In addition, can a state implement a new DSH Diversion program as part of the optional expansion? Can a state implement new DSH Diversion programs for services to the uninsured/uncompensated care services?

12) What assurance can states be provided the federal share will be 100 % for the first 3 years and 90% into perpetuity? If the 90% federal match for the expanded population is ever reduced, will states be able to repeal the expansion without penalty or clawbacks. Likewise, if the existing match for the current Medicaid population is reduced, will states be able to repeal the expansion without penalty or clawbacks?

13) How much nationwide will Medicaid expansion contribute to annual federal deficits and the national debt?

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 15, 2012

The Honorable Bob McDonnell
The Honorable Bobby Jindal
Republican Governors Public Policy Committee
Republican Governors Association
1747 Pennsylvania Avenue NW, Suite 250
Washington, DC 20006

Dear Governor McDonnell and Governor Jindal:

Thank you for your recent letter regarding the implementation of the Affordable Care Act. Giving states the flexibility they need has been a critical principle in our work to implement the Affordable Care Act since it was signed into law more than two years ago. Our team has worked closely with Governors from across the country to answer their questions and gather their input.

States have and will continue to be partners in implementing the health care law and we are committed to providing states with the flexibility, resources, and time they need to deliver the benefits of the health care law to the American people. We will continue to work directly with individual states to address their particular questions and concerns.

You recently requested additional time to declare whether states will elect to run a State-based Exchange. Under the law, we are required to certify states' plans to run their own Exchange in 2014 by January 1, 2013. While receiving a letter of intent now will help us assist states in finalizing their application, a state may submit both a letter of intent and an application to operate its own Exchange by December 14. States may also apply to operate their Exchange in partnership with the federal government by February 15, 2013. And a state may apply at any time to run an Exchange in future years.

As we have worked to implement the Affordable Care Act, we have issued information and guidance to states regarding provisions of the health care law. Additional guidance will be released in the coming days and weeks and our team will do everything possible to answer questions and provide technical assistance to state leaders.

We are confident Governors will have enough time to decide whether they want to establish an Exchange, work in partnership with the federal government or have a federally- facilitated Exchange in their state. We look forward to working with Governors as we continue to implement the law.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

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COMMONWEALTH of VIRGINIA

Office of the Governor

Robert F. McDonnell
Governor

December 14, 2012

The Honorable Secretary Kathleen Sebelius
Secretary of Health and Human Services
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

I have long opposed the approach taken in the Patient Protection and Affordable Care Act (PPACA) for addressing America's health care challenges. The partisan, bureaucratic, and expensive federal mandates, rules, taxes and spending are not the way to improve access, reduce costs and facilitate innovation in America's first class medical care system.

Today, I write to express Virginia's ongoing concerns about both the state and federal ability to responsibly implement health benefits exchanges by January 1, 2014. Nearly two and half years after passage of the PPACA, and despite numerous requests for information, there remains a lack of details and certainty about the states' ability to receive the necessary flexibility, control and funding of their own exchanges. Only in the past two weeks did we begin to receive some answers via draft regulations and general guidance to our numerous prior written requests, leaving inadequate time to fully analyze the long-term implications of selecting a state based exchange. Therefore, consistent with your request for a decision by December 14, 2012, while grateful for the extra thirty days to consider the best approach for the Commonwealth, Virginia will not build and operate a state based health benefits exchange by January 1, 2014. Pursuant to the PPACA, we anticipate that the federal government will build, operate, and fund the required exchange, be it a federally facilitated or hybrid exchange. You have stated, and the law makes clear, that the choice of a state based, federal, or hybrid/partnership exchange are all equally valid in complying with the law.

We look forward to having the Administration work with Virginia and other states to find a way to ensure that when exchanges come on line, they can function as intended and limit wasteful construction and implementation expense. We understand some states have already spent up to a staggering $100 million apiece in federal funds to build such exchanges, with millions more needed for operations.

Virginia, like many other states, cannot establish a health benefits exchange without the action of our legislature. They have acted responsibly in previous years and have given me the

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authority I requested to plan and prepare for a potential future state health benefits exchange. However, lacking necessary information to make good decisions, many members of the legislature have been similarly inclined to defer to a federal exchange.

Guidance recently received from your office this week continues to affirm that states can continue to apply for state based exchange planning grants from now through October 2014, and that a partnership exchange can still be chosen by February 2013. Thus, if the federal government's exchange is inadequate, or more concrete information becomes available from your office suggesting the clear benefits of a state run exchange to our citizens, a later decision to revert to a state based exchange is permissible under the law.

We are hopeful for the opportunity of continued dialogue between your staff and mine in order to ensure that input is considered from governors and from participating health plans that choose to be qualified to participate in any form of health benefits or hybrid exchange. We do believe that controlling our own insurance market in Virginia is in the best interests of our citizens.

As I indicated previously, I also have significant concerns about the second major issue before the states pursuant to the PPACA, that is, the expansion of Medicaid. Virginia cannot consider such expansion, unless there is a dramatic reform of the program at the federal level, to include state flexibility and waivers, and state methods to address the significant growth in Medicaid spending in state budgets. The explosive growth in Medicaid in Virginia of 1600% in the past 30 years, combined with the federal government's unsustainable $16 trillion debt, makes Medicaid expansion, without significant reform, irresponsible.

My primary point of contact for health benefits exchange and Medicaid reform discussions will be Dr. Bill Hazel, Secretary of Health and Human Resources. He and his staff have led the planning process among all stakeholders, including the Bureau of Insurance, and will continue to be the main point of contact until a formal health benefits exchange entity is established.

We remain willing to work with CCIIO and HHS to ensure decisions made on behalf of Virginian's are responsible and cost effective.

Sincerely,

Robert F. McDonnell

cc: The Honorable Marilyn Tavenner
Mr. Gary Cohen
State Legislators
Congressional Delegation

CERTIFICATE OF SERVICE

I hereby certify that on March 20, 2014, I electronically filed the foregoing brief with the Clerk of this Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/

Stuart A. Raphael

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

APPEARANCE OF COUNSEL FORM

BAR ADMISSION & ECF REGISTRATION: If you have not been admitted to practice before the Fourth Circuit, you must complete and return an Application for Admission before filing this form. If you were admitted to practice under a different name than you are now using, you must include your former name when completing this form so that we can locate you on the attorney roll. Electronic filing by counsel is required in all Fourth Circuit cases. If you have not registered as a Fourth Circuit ECF Filer, please complete the required steps at www.ca4.uscourts.gov/cmecftop.htm.

THE CLERK WILL ENTER MY APPEARANCE IN APPEAL NO. 14-1158 as

☐ Retained ☐ Court-appointed(CJA) ☐ Court-assigned(non-CJA) ☐ Federal Defender ☐ Pro Bono ☑ Government

COUNSEL FOR: Commonwealth of Virginia

_____ as the
(party name)

☐ appellant(s) ☐ appellee(s) ☐ petitioner(s) ☐ respondent(s) ☑ amicus curiae ☐ intervenor(s)

/s/ Stuart A. Raphael
(signature)

Stuart A. Raphael
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CERTIFICATE OF SERVICE

I certify that on 03/20/2014 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

/s/ Stuart A. Raphael
Signature

March 20, 2014
Date

11/17/2011
SCC