THE AFFORDABLE CARE ACT ENSURES PREMIUM ASSISTANCE FOR ELIGIBLE NEEDY INDIVIDUALS ON BOTH FEDERAL AND STATE-FACILITATED EXCHANGES.

Testimony of Simon Lazarus
Subcommittee on Energy Policy, Health Care, & Entitlements
Committee on Government Oversight & Reform
U.S. House of Representatives

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I thank the Subcommittee for inviting me to assist its members and their colleagues in evaluating the lawfulness of the Obama administration's decision to ensure that Affordable Care Act (ACA) premium assistance tax credits and subsidies are fully available to all individuals eligible for such assistance, whether they seek insurance through ACA-prescribed exchanges facilitated by state governments or by the federal government.

I have written and spoken extensively about this and other legal issues relating to the ACA since the legislation was under consideration by Congress in 2009. I have also studied and published on the general subject of statutory interpretation. I am currently Senior Counsel to the Constitutional Accountability Center. CAC is a public interest law firm, think tank, and action center, dedicated to realizing the progressive promise of our Constitution, and of laws which, like the ACA, are designed to realize that promise. I hope to contribute to the Subcommittee's understanding of the question whether providing premium assistance to needy Americans in federal as well as state-facilitated exchange states is faithful to the text, structure, purpose, and history of the ACA.

Introduction and Summary

I believe that the interpretation of the ACA adopted by the administration is correct, that reviewing courts must defer to it, and that they should not and will not overturn it. The critics' contrary claim focuses selectively on certain provisions, then lifts them out of context and imposes on them a nonsensical interpretation. The critics' misread ignores other relevant provisions, that confirm that the text of the ACA does not sabotage, but rather effectuates its stated purpose of ensuring near-universal coverage for the millions of Americans nationwide who have previously lacked access to affordable quality health insurance and health care.

When Congress enacted the Affordable Care Act, three years ago, there was substantial partisan debate about whether the law was a good idea. But there was bipartisan agreement about what the ACA's purpose was. The health reform law's fiercest critics concurred with its supporters that it had, and has, a clear and simply

stated goal – "to achieve near-universal health insurance coverage."[1] In addition, all sides recognized that a principal mechanism for achieving that goal is the "exchanges" prescribed by the ACA. These exchanges, organized state-by-state, are market-places where individuals not covered by employer-sponsored group health plans or government insurance programs can obtain affordable coverage and, hence, care. Although Congress expected that competition -- along with statutory insurance reforms -- would discipline the cost and quality of insurance offerings on the exchanges, it also recognized that many millions of uninsured individuals would require additional financial support to afford premiums. Hence, the universal, bipartisan expectation was that such premium assistance support would be available in states that chose to establish and run their own exchanges, and also in states that failed to do so, and instead left that responsibility to the federal government. Not until November 2011 – one and one half years after President Obama signed the ACA into law – did my co-panelist Professor Adler and his co-author, Michael Cannon of the CATO Institute, surface their claim to the contrary. They said at the time that they "were first made aware of this aspect of the ACA" in December 2010, nine months after enactment. To ACA opponents probing for any opportunity, no matter how far-fetched, to impede the law's implementation, the discovery of this apparent "glitch" must have been invigorating. As Michael Cannon has often repeated since, if their contention were to prevail in court, the result could "drive a stake through the heart of Obamacare."

However, the truth is, we were all right the first time. The text and purpose of the ACA are in harmony. The Congress that adopted this law did not intend, and the statute its authors drafted does not seek, to put this supposed "stake" in the hands of health reform opponents in state capitols, in effect stiffing the core constituency the law was enacted to benefit.

The ACA's text assures premium assistance to eligible individuals in all states, whether governed by state or federally facilitated exchanges.

To make their counter-intuitive, not to mention counterfactual, claim that the ACA's text subverts its fundamental purpose, ACA opponents focus on one subsection of one section of the law, Section 1401, which enacts a new Section 36B of the Internal Revenue Code. IRC §36B(a) provides that "In the case of an applicable taxpayer, there shall be allowed as a credit . . . . an amount equal to the premium assistance credit amount of the taxpayer for the taxable year." That says an applicable taxpayer -- someone who is under 400% of the federal poverty level -- gets the credit. Subsection 36B(b), which contains the language on which the opponents found their argument, details how this "premium assistance amount" is to be calculated, in other words, how much the applicable taxpayer gets. Subsection 36B(b)(2) specifies that this figure is the "amount equal to the lesser of" two options. The first option, spelled out in the immediately following Subsection 36B(b)(2)(A), pegs the premium *assistance amount to "monthly premiums" for insurance policies which "cover the taxpayer and which were enrolled in through an Exchange established by the state under [Section] 1311 of [the*

[1] Jonathan H. Adler and Michael F. Cannon, *Taxation Without Representation: The illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX 119, 126 (2013)

ACA]." (Emphasis added) This italicized passage, from the ACA's instructions on how to calculate the amount of an individual taxpayer's premium assistance tax credit, is what Professor Adler and his fellow ACA opponents have seized upon to ground their claim that the ACA bars participants in federal-facilitated exchanges from access to affordable health coverage via receipt of premium assistance credits and subsidies. As they read the statute, the statute says that taxpayers in federal-facilitated exchanges get the subsidy, but the amount of the subsidy is zero.

Initially, the opponents made this language essentially their whole case. They claimed that the passage meant that the text of the ACA – the entire ACA – *unambiguously* required that the Act be construed to defeat its acknowledged purpose of promoting near-universal health coverage. But this phrase, buried so deep in a provision devoted to measuring how much eligible individuals receive in premium assistance credits that it wasn't discovered for close to a year after the President signed the bill into law, is a fragile reed on which to hang so counter-intuitive and consequential an asserted interpretation. The opponents soon realized that this isolated and internally contradictory "glitch" could not, by itself, support their characterization of the ACA's text – i.e., the text of the whole statute.

So they came up with a new argument. In the summer of 2012, Professor Adler and Michael Cannon, in the first published version of their article, asserted that "our further research" proved that this self-destructive provision (as they interpreted it) was not a mere glitch, after all, but rather "intentional and purposeful . . . ." As will be explained below, this amended claim is not merely weak, but literally lacking any basis in the statute, its massive legislative history, contemporaneous claims about the provision by legislators, governors, administrators, academics, columnists, or reporters, or common-sense recognition of what the authors of the ACA actually intended. But, before turning to the "intentional and purposeful" issue, I will briefly address what I believe are the key weaknesses that prompted the opponents to abandon their notion that they could prevail with their initial, purely textual argument.

1. ACA opponents' misguided – and misleading – text-out-of-context "quarantine" approach to construing the text of the ACA.

As noted above, opponents claim that the "stake" they have found to drive through the ACA's heart consists of a phrase in a subsection measuring the amount of individual premium assistance credits, referencing policies "enrolled in through an Exchange established by the State under [Section] 1311." The basic problem with this claim is the approach itself. In a June 17, 2013 debate at the CATO Institute about the issue being considered in this hearing, my debate partner, Rob Weiner of Arnold & Porter and formerly of the U.S. Department of Justice, characterized this as the "quarantine" approach to statutory interpretation – quarantine a few words, and rip them from their context.[2] Here, as elsewhere, this is a path to an absurd result, not to plain

[2] The points made in this testimony are largely drawn from the presentation that I jointly made with Mr. Weiner at the above-noted June 17 debate. Mr. Weiner made significant contributions to these points, though I of course bear full responsibility for the final version of this testimony. (On the other side of the

meaning. This interpretive path requires, first, that anyone seeking the meaning of the Act ignore the most elemental aspects of context. For starters, they disregard Title I of the Act, where the provisions we are debating appear, and which expressly states what it's trying to achieve -- quality affordable care for all Americans. Not just Americans in some states. The subtitle that contains the relevant provisions reiterates the goal -- Affordable Coverage Choices for All Americans. The section that creates the tax credits also expressly says what it's about - tax credits for premium assistance - to help people afford insurance.

Several specific provisions of this title and subtitle, briefly discussed below, detail how the exchange mechanism is to contribute to achieving the statute's purpose – and make clear that IRC Section 36B(b)(2), alone or in combination with any other provisions, cannot bear the weight opponents would impute to it, of defeating that purpose.

2. Section 1321(c)(1) provides that, where a state fails to establish the type of exchange that Section 1311 provides that it "shall" establish, the Secretary of HHS "shall establish and operate such Exchange."

The single provision of the Act that most straightforwardly undermines opponents' self-defeating spin on Section 36B and Section 1311 is Section 1321, which prescribes the federal alternative to state-established exchanges. Subsection 1321(c)(1) provides that, if a state fails to establish an exchange, as prescribed by the Act, the Secretary of Health & Human Services "shall establish and operate *such* Exchange and shall take such actions as are necessary to implement such other requirements [required of state-facilitated exchanges]." The logical, common-sense interpretation of that simple language is that, the exchange under HHS stewardship shall remain "such Exchange" as it would have been under state stewardship, shall be its functional equivalent, shall be subject to the same "requirements," and have the authority and responsibility to "take such actions as are necessary to implement" its functions. As the steward of "such Exchange," the Secretary, as numerous commentators have noted, stands in the shoes of, or acts on behalf of, or substitutes for, or stands in for the defaulting state government. This type of surrogacy or stewardship is commonplace in the law. There is no textual indication – nor any logical reason – why this language should be read to mean that, instead of establishing and operating an equivalent "such" Exchange, the Secretary shall operate a second-class exchange – indeed, one which, to quote Professor Adler's co-author Cannon would be unable to serve a majority of eligible uninsured or under-insured individuals, a circumstance that "would bring Obamacare's Exchange engine to a screeching halt."

3. The ACA's definition of "Exchange" applies equally to federal and state-established and operated exchanges.

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debate were Michael Cannon, CATO's Director of Health Studies, and Michael Carvin, partner at Jones Day and counsel to the plaintiffs in one of the lawsuits challenging the Obama administration's interpretation of the ACA at issue in this hearing.) A video of the debate is accessible on CATO's website, CATO.org.

The common-sense interpretation of "such Exchange," noted above, in Section 1321 is confirmed by the statute's definition of "Exchange," and the appearance of that defined term in Section 1321 and elsewhere in the Act. The definition and function of an Exchange are laid out in Section 1311. That section creates American Health Benefit Exchanges. And it says the statute will refer to them as an "Exchange*," with a capital E*. It has defined the term. And Section 1311(d), labeled "requirements," fills out the definition:

> An Exchange *shall be* a governmental agency or nonprofit *entity that is established by a State.* (Emphasis added)

That is a mandatory definition ("shall" is mandatory). Hence, whenever the term "Exchange" appears in the statute with a capital "E," it means an exchange established by the State under Section 1311. (The definition is repeated in Section 1563(b).) So, turning to Subsection 1321(c)(1): It says that if the State does not establish an Exchange:

> the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

An "Exchange," with a capital E, as we have seen, is defined as an entity established by the State. So, if, as this provision directs, the federal government establishes an Exchange with a capital "E," it can *only* be an Exchange with capital E, as understood by the Act, if it fits the definition set forth in Section 1311 for capital "E" exchanges – i.e., if it is an entity covered by the law's definitional term of art, as an "Exchange established by the state under section 1311." The opponents' contrary, anti-common-sense interpretation would mean that the Secretary is commanded by Section 1321 to do what it cannot possibly do -- establish and operate a Capital "E" Exchange, which is in fact not, and cannot be a Capital "E" exchange. That, obviously, makes no sense. It also flouts the "plain meaning" conclusion that, once defined, that term must have the same meaning wherever it appears throughout the statute. The only exception to this rule is in circumstances where an alternative interpretation is made indisputably clear in a given provision, and/or the definitional meaning would produce absurd results, or contradict a manifest statutory purpose. None of those exceptions are applicable here.

There is in fact only one way to make sense of this provision. It says the secretary shall establish "such Exchange" and do what is necessary to make it work. It doesn't say "an exchange," with a small "e," or "a federal exchange." It says "such Exchange," with a capital E. Which exchange is provision referring to? There's only one such Exchange created and defined in the statute -- the one established by the State under 1311. And the only way the federal government could establish such an Exchange, as the statute defines it, is to act on behalf of, or substitute for, or stand in for, or step into the shoes of the State. That's very common in the law – under the

common law, in statutory civil law settings, and in federal statutes which, like the ACA, create federal-state "cooperative federalism" partnerships with state governments.

4. Excluding federally-facilitated exchanges from the statutory definition of "Exchange" produces pervasive absurd results throughout the ACA.

The consequences of the opponents' approach go beyond rendering 1321 nonsensical. If section 1321 does not permit the federal government to stand in for the state, then the states can never, ever reduce their Medicaid benefits or eligibility requirements. Why? Because the statute says unequivocally that the benefits and eligibility requirements have to stay the same "*until* the Secretary determines that an Exchange established by the State under section 1331 is fully operational."

Here are some other examples:

No CHIP back-up coverage: If a State doesn't have the money to ensure coverage for low-income children under the Children's Health Insurance Program, known as CHIP, the State has to make sure the children are enrolled in a qualified health plan "offered through an Exchange established by the State under section 1311." Under the opponents' definition, states with a federally facilitated exchange can't do this. So the opponents' cramped definition makes the statute impose another impossible requirement.

No qualified health plans on federally-facilitated exchanges. Because an Exchange is an only an exchange with a capital E when it's established by the State, if 1321 does not allow the federal government to step in for the State, then the states with federally facilitated exchanges can have no qualified health plans, because those are only ones sold through an exchange. With no qualified health plans, nothing works. The ACA become a health insurance statute without health insurance.

No accounting controls or screening for lawful U.S. residents. If an exchange, as § 1311 says, must be established by a state, and if §1321 doesn't change that, then under section 1313(a) (1), a federally-facilitated Exchange doesn't have to keep an accurate accounting of activities and expenditures, and under section 1411, a federally facilitated exchange doesn't have to make sure that people covered through an Exchange are not illegal aliens.

The only way to give meaning to the above-noted provisions, and avoid absurd results in these and other similar situations covered and referenced by the ACA, is to adopt the intended, common-sense definition of the statutory term "Exchange." That is, in federally-facilitated exchange states, the Federal government is acting on behalf of the State. Then, citizens in those states can get tax credits, because an exchange established by the state includes one where the federal government is standing in for the state.

5. Opponents' misreading of the defined term "Exchange" in ACA §1401 and its creature, IRC §36B, produces an absurd interpretation of §36B itself.

On its own terms -- within the four corners of that provision -- viewing the federal government as the stand-in for the state is the only way that the plain language of Section 36B itself makes sense and is internally consistent.

Subsection (a) provides:

> In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

An applicable taxpayer is defined as someone whose income is between 100% and 400% of the poverty level. So under this provision, if you meet the income test, *there shall be allowed* a premium assistance credit. The plain language of this provision says that low income taxpayer gets a credit.

The exchanges come into play in the next subsection, 36B(a)(2). The caption tells you what the subsection is about – the *calculation* of the premium assistance *amount* -- the amount of the credit to *assist* the taxpayer in affording insurance:

> (2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—
> ‘‘(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or
> ‘‘(B) the excess (if any) of—
> ‘‘(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over
> ‘‘(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

In other words, if you accept the opponents' reading, Congress is saying, "If your income is between 100% and 400% of the poverty level, you get a tax credit to assist you in buying insurance – except if you happen to live in a federally facilitated exchange state. In that event, Catch-22: the amount of premium assistance you get from this provision designed to help you afford insurance is zero. Is Catch-22 a more plausible reading of a statute designed to help lower income people afford insurance, than the common-sense understanding that the federal government stands in for and steps into the shoes of a state that fails to establish and manage an Exchange itself?

Opponents' "Purpose and Intent" Argument – that the 111th Congress *Deliberately* Barred Premium Assistance from Participants on Federally Facilitated Exchanges – Is Preposterous and Has Literally Zero Support in the ACA's Legislative Record.

As noted above, the first time ACA opponents surfaced their argument, they said their "gotcha" spin on two isolated provisions of text was all they needed to win their case. They soon recognized that this is not true. The individual provisions on which they rely are not self-explanatory. Moreover, they are contradicted by other textual provisions of the Act. So the opponents have moved off their original text-only argument. They have moved to a claim about the ACA's legislative history and its purpose. This is truly a remarkable claim.

They say that the legislative history of the statute reveals that the 111th Congress *deliberately designed* the exchange provisions to block premium assistance for residents of federal exchange states. If true, what the Act really means, and what its sponsors really intended, is a result that would not only cancel the core benefit the law sought to confer, for the core constituency it aimed to benefit. Further, under the opponents' misread, the ACA's sponsors would have intentionally handed over to ACA opponents in state capitols the power to subvert the law in their states, enabling them to "drive a stake through the heart of Obamacare" in the colorful language of Professor Adler's collaborator, Michael Cannon.

How do the opponents explain why the ACA's sponsors would come up with this self-defeating, indeed self-destructive strategy? Because, they explain, in structuring the premium assistance provisions of the Act, the sponsors' overriding purpose was to pressure states into establishing exchanges, and to do so by stiffing millions of their low-and moderate income constituents. If this seems like a rather odd pressure tactic for Democratic leaders to have adopted, closer examination makes clear that it is, quite simply, pure fiction.

In the first place, in the massive record of Congress' debate, drafting, and deliberation over the ACA, there is literally not one reference to this implausible purpose. Not one. It's the dog that didn't bark. Not at all. Not ever. The Senate Finance Committee's markup of the provisions at issue took from September 22 to October 13, and take up 2,823 pages of transcript. Senate floor debate went from November 21 to very late, as I recall, on Christmas eve, December 24, comprising 393 pages in the Congressional Record. Not once in this entire record did anyone in either party, member or staff, ever suggest that if states declined to set up exchanges, not only would they cede control to the feds, but they would deny benefits to their constituents.

It bears emphasis that ACA opponents impute this supposed design as a threat to pressure state political leaders. Now, to be effective, a threat can't be kept secret. But this supposed threat was never communicated by those to whom our opponents impute it. As I noted earlier, Professor Adler and his co-author Michael Cannon, a full-time opponent of the ACA, didn't even notice this issue until a year-and-a-half after the statute was adopted.

Nor was this supposed threat received or noticed by those for whom it was supposedly intended – state governments. Not that those state governments were asleep at the switch. On the contrary, state governments and their representatives were a vigilant, vigorous, and potent omnipresence in the process of drafting the ACA. They pushed demands and were responsible for many changes – including, securing for themselves the option of operating exchanges, rather than the House bill's version of a national Federal exchange.

But state representatives never spotted this supposed threat. On May 5, 2009, the National Governors Association presented testimony to the Senate Finance Committee on what the states considered "the important issues involving health care coverage proposals." Right after the bill passed, on March 26, 2010, the NGA circulated an 8 page single-space document laying out a timeline and spotting key implementation issues for their members. On September 16, 2011, the NGA published an Issue Brief on "State Perspectives on Insurance Exchanges," again, laying out state concerns regarding implementation of the exchange provisions. Not once is there the slightest suggestion that the NGA or its members saw the possibility that federally facilitated exchanges could not offer premium assistance, let alone that they viewed – or would have viewed -- this as an unwanted coercive threat.

In sum, the opponents' confection is a threat that was never made and never received. By itself, this fact demonstrates that such a threat or incentive was not *and could not* have been the purpose of the Congress that drafted and enacted the ACA. Without that purpose, the opponents' self-defeating interpretation of the law's definition of "Exchange" is insupportable.

Of course, Congress did include a mechanism designed to encourage states to set up exchanges themselves. It was precisely that if they did not the federal government would do it for them, and in effect deprive them of an opportunity to provide a valuable, visible, ongoing service to hundreds of thousands or in some cases millions of voters.

Significantly, Congress did provide precisely the sort of financial carrot-and-stick incentive that ACA opponents falsely read into the exchange provisions, when structuring the ACA's expansion of Medicaid. Hence, when Congress wished to go

down this road, they knew how to do it, and how to say they were doing it. They didn't do it with respect to the establishment and operation of the exchanges.

Courts Must and Will Defer to the Administration's Reasonable and Permissible Interpretation of "Exchange" to Cover Federally and State-facilitated exchanges.

Opponents know they cannot prevail without their claim that the legislative history reveals a purpose of threatening denial of premium assistance to pressure states into setting up exchanges. They know that, without that argument, their claim that the meaning of the text is "unambiguous" is unambiguously wrong. Otherwise, of course, the IRS' rule is at worst, a "permissible" interpretation, even if not the only permissible interpretation. As Justice Antonin Scalia reaffirmed and explained, barely two months ago, if a statute is "silent or ambiguous with respect to [a] specific issue," then the courts must defer to "a permissible construction of the statute" by the agency to which Congress has assigned responsibility for administering it.[3] At a minimum, Treasury's interpretation – by which the statutory term "Exchange" (with a capital "E") means both state and federally-facilitated exchanges – is reasonable and permissible. In a word, that ices the case for upholding the rule as construed by the Administration, and ensuring that eligible residents in all states will have access to affordable, quality health insurance, as Congress intended they should. As Justice Scalia observed, *Chevron* (the landmark Supreme Court case establishing the principle of judicial deference to reasonable agency statutory interpretations)[4] "provides a stable background rule against which Congress can legislate: Statutory ambiguities will be resolved, within the bounds of reasonable interpretation, not by the courts but by the administering agency."[5] There can be little real-world doubt that courts will find the Administration's interpretation "reasonable" and "permissible," and uphold it.

Conclusion: ACA Opponents Overreach, with a Last-Ditch Bail-out Bid for the Supreme Court to Drive a "StakeThrough the Heart of Obamacare."

Challenging the legality of premium assistance on federally facilitated exchanges is just one of many last-ditch strategems ACA opponents are promoting to ensure a still birth for the ACA in states that refuse to cooperate with its implementation. ACA opponents have fought hard to vindicate their passionate belief that government-facilitated universal health care is bad public policy and bad public morality. They have largely lost that fight, in the political arenas where in a democracy it should be fought – in Congress and in two national elections. Now they are asking judges and justices

[3] City of Arlington, Texas v. Federal Communications Commission, No. 11-1545, Slip. Op.at pages 4-5 (May 20, 2013)
[4] Chevron v. Natural Resources Defense Council, 467 U.S. 837 (1984)
[5] Id. At 5

who, one guesses they believe, may share their ideological and political aversion to Obamacare and its namesake, for a last-ditch, 11th hour bailout.

What help are ACA opponents providing to these potentially sympathetic judges and justices?

- A theory that the Congress that enacted the ACA deliberately engineered it to fail in states governed by hostile governors and legislators;

- An alleged purpose never endorsed anywhere by anyone at any point in the legislative record, and antithetical to what everyone knows was Congress' actual intent in enacting the ACA.

How likely is it that a majority of the Supreme Court, or any court, will endorse that perverse premise, and bar access to affordable quality health care for millions of people whom Congress specifically intended to benefit? Such a decision, especially if rendered by an ideologically divided court, will likely appear to the public as a radical ratcheting up of the regrettable tradition of *Bush v. Gore* – though less principled and more transparently political. I doubt that the judiciary will take the bait these lawsuits tender, and venture out on that limb.

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Before joining Constitutional Accountability Center, Si was Public Policy Counsel to the National Senior Citizen Law Center. Si served as Associate Director of President Jimmy Carter's White House Domestic Policy Staff (1977-81), as a partner in Powell, Goldstein, Frazer, and Murphy LLP (1981-2002), and as Senior Counsel to Sidley Austin LLP (2002-2006). He is a Trustee of the Center for Law and Social Policy and a member of the Administrative Conference of the United States. His articles have appeared in the Atlantic, the Washington Post, The American Prospect, Roll Call, Slate, The Hill, Newsweek/ Daily Beast, Politico, The New Republic, the Huffington Post, as well as law reviews. Si writes frequently for the American Constitution Society's ACS Blog and has published several ACS issue briefs, including "Mandatory Health Insurance: Is It Constitutional?", which was released during the Senate health care reform debate in December 2009, and "The Health Reform Lawsuits: Unraveling a Century of Constitutional Law and the Fabric of Modern Government," published in February 2011. His Atlantic article, "The Most Dangerous Branch?", has been republished in two anthologies, The Best American Political Writing 2003 Royce Flippin, ed. (Avalon Press 2003), and Principles and Practice of American Politics: Classic and Contemporary Readings, 2d ed., Samuel Kernell and Steven S. Smith, eds. (CQ Press 2003). He graduated from Yale Law School, where he was Note & Comment Editor of the Yale Law Journal.

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1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

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