[ORAL ARGUMENT SCHEDULED FOR MARCH 25, 2014]

No. 14-5018

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

JACQUELINE HALBIG, ET AL.,

Appellants,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE
DISTRICT OF COLUMBIA (NO. 13-623 (PLF))

BRIEF FOR APPELLANTS

MICHAEL A. CARVIN
Lead Counsel
YAAKOV M. ROTH
JONATHAN BERRY
JONES DAY
51 Louisiana Ave. N.W.
Washington, DC 20001
Telephone: (202) 879-3939
Email: macarvin@jonesday.com

Counsel for Appellants

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Plaintiffs-Appellants certify as follows:

1. Parties and Amici

Plaintiffs in the district court were Jacqueline Halbig; David Klemencic; Carrie Lowery; Sarah Rumpf; Innovare Health Advocates; GC Restaurants SA, LLC; Olde England's Lion & Rose, LTD; Olde England's Lion & Rose at Castle Hills, LTD; Olde England's Lion & Rose Forum, LLC; Olde England's Lion & Rose at Sonterra, LTD; Olde England's Lion & Rose at Westlake, LLC; and Community National Bank. All plaintiffs are before this Court as appellants. Pursuant to Circuit Rule 26.1, undersigned counsel certifies the following:

1. Plaintiff Innovare Health Advocates has no parent, affiliate, or subsidiary companies.

2. Plaintiff GC Restaurants SA, LLC has no affiliates or subsidiaries, and is 99% owned by ATA Restaurant Holding Company, LLC and 1% owned by Allen Tharp and Associates, Inc.

3. Plaintiffs Olde England's Lion & Rose, LTD, Olde England's Lion & Rose at Castle Hills, LTD, Olde England's Lion & Rose Forum, LLC, Olde England's Lion & Rose at Sonterra, LTD, and Olde England's Lion & Rose at Westlake, LLC have no affiliates or subsidiaries, and are each 99% owned by Allen Tharp and 1% owned by Allen Tharp and Associates, Inc.

4. Plaintiff Community National Bank has no affiliates or subsidiaries, but it is wholly owned by Community Bancshares, Inc.

5. No publicly held corporation owns ten percent or more of the stock in any of the companies listed above.

Defendants before the district court were Kathleen Sebelius; the U.S. Department of Health and Human Services; Jacob Lew; the U.S. Department of the Treasury; Daniel Werfel; and the Internal Revenue Service. All defendants are before this Court as appellees, except that John Koskinen has been substituted for Daniel Werfel as Commissioner of Internal Revenue.

Amici before the district court were Jonathan Adler, Michael Cannon, the Commonwealth of Virginia, the American Hospital Association, and Families USA. Currently, the only amicus before this Court is AARP.

2. Ruling Under Review

Plaintiffs-Appellants appeal from the final order of the district court (Friedman, J.) entered on January 15, 2014, granting defendants' cross-motion for summary judgment. The district court's order can be found at A324.

3. Related Cases

This case was not previously before this Court or any other court, and there are no related cases within the meaning of Circuit Rule 28(a)(1)(C).

TABLE OF CONTENTS

Page

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES i

TABLE OF AUTHORITIES v

GLOSSARY xiii

JURISDICTIONAL STATEMENT 1

STATEMENT OF ISSUES 1

STATEMENT OF PERTINENT AUTHORITIES 2

STATEMENT OF THE CASE 2

A. Congress Calls for States To Establish Insurance Exchanges, with Federal Exchanges as a Fallback Mechanism 2

B. Congress Encourages States To Establish Exchanges Using a Mix of "Carrots" and "Sticks." 5

C. 34 States Decline To Establish Their Own Exchanges 7

D. The IRS Promulgates Regulations Expanding the Availability of Subsidies to HHS-Established Exchanges 8

E. The IRS Rule Triggers Other ACA Mandates and Penalties 9

F. Injured Individuals and Employers Challenge the IRS Rule 11

G. The District Court Rejects the Government's Motion To Dismiss, But Upholds the IRS Rule on the Merits 12

SUMMARY OF ARGUMENT 13

STANDARD OF REVIEW 16

ARGUMENT 16

I. THE IRS RULE IS SQUARELY FORECLOSED BY THE TEXT OF THE ACA, AND THE EFFORTS TO SAVE IT ARE MERITLESS 16

A. There Is No Remotely Plausible Reading of the ACA's Subsidy Provision That Could Support the IRS Rule 17

B. No Absurdity Arises from the Plain-Text Reading of the ACA's Subsidy Provision, and That Text Must Therefore Govern 27

TABLE OF CONTENTS
(continued)

Page

C. Though Irrelevant, Legislative Purpose and History Confirm the Plain Meaning of the Subsidy Provision 37

II. *CHEVRON* DEFERENCE CANNOT SAVE THE IRS RULE..................44

A. Because the Relevant Statutory Text Is Unambiguous, The IRS Has No Power To Construe It 45

B. No *Chevron* Deference Is Owed Given the ACA's Division of Authority Between HHS and the IRS 46

C. Moreover, *Chevron* Deference Is Displaced Here by the Venerable "Clear Statement" Rule for Tax Exemptions and Credits..49

D. In All Events, the IRS Rule Is Not a Reasonable Construction of the ACA's Text 53

III. ALTHOUGH IT DOES NOT MATTER HERE, THE EMPLOYERS' CLAIMS ARE NOT BARRED BY THE ANTI-INJUNCTION ACT 54

A. The Employer Mandate's "Assessable Payments" Are Not Taxes for AIA Purposes 54

B. In Any Event, the AIA Does Not Apply Because This Suit Does Not Seek To Invalidate or Enjoin the Employer Mandate 56

CONCLUSION 58

CERTIFICATE OF COMPLIANCE...60

CERTIFICATE OF SERVICE 61

STATUTORY AND REGULATORY ADDENDUM ....

TABLE OF AUTHORITIES

Page(s)

CASES

Alexander v. 'Americans United' Inc.,
416 U.S. 752 (1974)....................58

Am. Bar Ass'n v. FTC,
430 F.3d 457 (D.C. Cir. 2005)....................45

**Am. Fed'n of Gov't Empl. v. Shinseki*,
709 F.3d 29 (D.C. Cir. 2013)....................27, 47

**Am. Fed'n of Labor & Cong. of Indus. Orgs. v. Chao*,
409 F.3d 377 (D.C. Cir. 2005)....................53, 54

Appalachian Power Co. v. EPA,
249 F.3d 1032 (D.C. Cir. 2001) (per curiam)....................27

Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.,
250 F.3d 778 (D.C. Cir. 2001)....................46

Bd. of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.,
474 U.S. 361 (1986)....................16

Blackmon-Malloy v. U.S. Capitol Police Bd.,
575 F.3d 699 (D.C. Cir. 2009)....................19

Cal. State Bd. of Optometry v. FTC,
910 F.2d 976 (D.C. Cir. 1990)....................51

Carter v. Welles-Bowen Realty, Inc.,
736 F.3d 722 (6th Cir. 2013)....................49

**Chao v. Day*,
436 F.3d 234 (D.C. Cir. 2006)....................27

Cheney R.R. Co. v. R.R. Ret. Bd.,
50 F.3d 1071 (D.C. Cir. 1995)....................46

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

TABLE OF AUTHORITIES
(continued)

Page(s)

**Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*,
467 U.S. 837 (1984)....................16, 45, 46, 49

Cohen v. United States,
650 F.3d 717 (D.C. Cir. 2011) (en banc)....................57

**Conn. Nat'l Bank v. Germain*,
503 U.S. 249 (1992)....................39

**Consol. Rail Corp. v. United States*,
896 F.2d 574 (D.C. Cir. 1990)....................37

Cook v. FDA,
733 F.3d 1 (D.C. Cir. 2013)....................27

**Custis v. United States*,
511 U.S. 485 (1994)....................21

DeNaples v. Office of Comptroller of Currency,
706 F.3d 481 (D.C. Cir. 2013)....................48

Dep't of Treasury v. Fed. Labor Relations Auth.,
837 F.2d 1163 (D.C. Cir. 1988)....................47

**Duncan v. Walker*,
533 U.S. 167 (2001)....................20

EchoStar Satellite LLC v. FCC,
704 F.3d 992 (D.C. Cir. 2013)....................54

Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council,
485 U.S. 568 (1988)....................50

EEOC v. Arabian American Oil Co.,
499 U.S. 244 (1991)....................50

**EME Homer City Generation, L.P. v. EPA*,
696 F.3d 7 (D.C. Cir. 2012)....................53

TABLE OF AUTHORITIES
(continued)

Page(s)

**Engine Mfrs. Ass'n v. EPA*,
88 F.3d 1075 (D.C. Cir. 1996)....................39, 44

Fin. Planning Ass'n v. SEC,
482 F.3d 481 (D.C. Cir. 2007)....................16

Holland v. Nat'l Mining Ass'n,
309 F.3d 808 (D.C. Cir. 2002)....................16

INS v. St. Cyr,
533 U.S. 289 (2001)....................50, 51, 52

**Lamie v. United States Tr.*,
540 U.S. 526 (2004)....................27, 29

**Liberty University, Inc. v. Lew*,
733 F.3d 72 (4th Cir. 2013)....................55

Massachusetts v. U.S. Dep't of Transp.,
93 F.3d 890 (D.C. Cir. 1996)....................53

MedChem (P.R.), Inc. v. Comm'r,
295 F.3d 118 (1st Cir. 2002)....................51

Muscogee (Creek) Nation v. Hodel,
851 F.2d 1439 (D.C. Cir. 1988)....................51, 52

Nat'l Fed'n of Indep. Bus. v. Sebelius,
132 S. Ct. 2566 (2012)....................28, 31, 40, 56

Nat'l Mining Ass'n v. Kempthorne,
512 F.3d 702 (D.C. Cir. 2008)....................50

Norton v. United States,
581 F.2d 390 (4th Cir. 1978)....................21

O'Melveny & Myers v. FDIC,
512 U.S. 79 (1994)....................25

TABLE OF AUTHORITIES
(continued)

Page(s)

**Performance Coal Co. v. Fed. Mine Safety & Health Review Comn'n*,
642 F.3d 234 (D.C. Cir. 2011)..27, 30

Printz v. United States,
521 U.S. 898 (1997)..4

Proffitt v. FDIC,
200 F.3d 855 (D.C. Cir. 2000)..48

Randall v. Comm'r,
733 F.2d 1565 (11th Cir. 1984) (per curiam) 51

**Rodriguez v. United States*,
480 U.S. 522 (1987) (per curiam)..37

**Russello v. United States*,
464 U.S. 16 (1983)..20

Salleh v. Christopher,
85 F.3d 689 (D.C. Cir. 1996)...48

Sea-Land Serv., Inc. v. Dep't of Transp.,
137 F.3d 640 (D.C. Cir. 1998)...45

**Seven-Sky v. Holder*,
661 F.3d 1 (D.C. Cir. 2011)...57

**Stichting Pensioenfonds Voor De Gezondheid v. United States*,
129 F.3d 195 (D.C. Cir. 1997)...21, 51, 52

*Telecom*USA, Inc. v. United States*,
192 F.3d 1068 (D.C. Cir. 1999)...51

Trotter v. Tennessee,
290 U.S. 354 (1933)..21

U.S. Air Tour Ass'n v. FAA,
298 F.3d 997 (D.C. Cir. 2002)...46

TABLE OF AUTHORITIES
(continued)

Page(s)

***United States ex rel. Totten v. Bombardier Corp.*,
380 F.3d 488 (D.C. Cir. 2004)....................27, 29

United States v. Stewart,
311 U.S. 60 (1940)....................51, 52

United States v. Wells Fargo Bank,
485 U.S. 351 (1988)....................21, 51, 52

***Yazoo & Miss. Valley R.R. Co. v. Thomas*,
132 U.S. 174 (1889)....................21, 51

Zilkha Energy Co. v. Leighton,
920 F.2d 1520 (10th Cir. 1990)....................25

STATUTES

2 U.S.C. § 644....................42

11 U.S.C. § 544....................25

12 U.S.C. § 1821....................25

26 U.S.C. § 35....................41

26 U.S.C. § 223....................41

26 U.S.C. § 4980H....................10,12

26 U.S.C. § 5000A....................9, 10, 31

*26 U.S.C. § 7421....................1, 2, 54, 56

28 U.S.C. § 1291....................1

28 U.S.C. § 1331....................1

28 U.S.C. § 2679....................24, 25

42 U.S.C. § 1397ee....................36

TABLE OF AUTHORITIES
(continued)

Page(s)

ACA § 1302, *codified at* 42 U.S.C. § 18022 10

ACA § 1304, *codified at* 42 U.S.C. § 18024 19

*ACA § 1311, *codified at* 42 U.S.C. § 18031 ....2, 4, 5, 26

ACA § 1312, *codified at* 42 U.S.C. § 18032 ....20, 32, 33

*ACA § 1321, *codified at* 42 U.S.C. § 18041 ....2, 4, 5, 7, 25, 34

*ACA § 1323, *codified at* 42 U.S.C. § 18043 24

ACA § 1334, *codified at* 42 U.S.C. § 18054 35

*ACA § 1401, *codified at* 26 U.S.C. § 36B...................... 2, 6, 17, 18, 21, 30, 31, 48

ACA § 1412, *codified at* 42 U.S.C. § 18082 6

ACA § 1563 ....19, 33

*ACA § 2001, *codified at* 42 U.S.C. § 1396a 5, 35

ACA § 2701, *codified at* 42 U.S.C. § 300gg 35

REGULATIONS

*26 C.F.R. § 1.36B 2, 8, 18, 47

*45 C.F.R. § 155.20 ....2, 8, 18, 26

45 C.F.R. § 155.605 9

77 Fed. Reg. 18310 (Mar. 27, 2012)..7

77 Fed. Reg. 30377 (May 23, 2012) 9

78 Fed. Reg. 65046 (Oct. 30, 2013)...26

TABLE OF AUTHORITIES
(continued)

Page(s)

OTHER AUTHORITIES

Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule To Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX 119 (2013)....................42

Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO (Jan. 25, 2010)....................3, 38

CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 2012)............43

Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, N.Y. TIMES, Jan. 19, 2010....................42

Jennifer Corbett Dooren, *Two States Seek Help With Health Exchanges*, WALL ST. J. (May 22, 2013)....................7

Amy Goldstein & Juliet Eilperin, *Challenges Have Dogged Obama's Health Plan Since 2010*, 2013 WLNR 27607716, WASH. POST, Nov. 2, 2013.............26

*Timothy S. Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Institute, Georgetown Univ. Legal Ctr., April 27, 2009....................40

Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, Aug. 4, 2012....................7, 40

Roundtable Discussion on Expanding Health Care Coverage: Before S. Comm. on Finance, 111th Cong. (May 5, 2009)....................3

*S. 1679, § 3104, 111th Cong. (2009)....................41

SENATE DEMOCRATIC POLICY COMM., *Fact Check: Responding to Opponents of Health Insurance Reform* (Sept. 21, 2009), *available at* http://dpc.senate.gov/reform/reform-factcheck-092109.pdf....................3

State Decisions For Creating Health Insurance Exchanges, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ (last visited Jan. 29, 2014)....................7

TABLE OF AUTHORITIES
(continued)

Page(s)

Cass Sunstein, *Nondelegation Canons*, 67 U. CHI. L. REV. 315, 316 (2000)..........50

Elise Viebeck, *Obama Faces Huge Challenge in Setting up Health Insurance Exchanges*, THE HILL, Nov. 25, 2012..7, 40

W&L Law's Jost Invited to Health Care Bill Signing Ceremony, http://law.wlu.edu/news/storydetail.asp?id=758 (Mar. 23, 2010)......................40

GLOSSARY

A__	Joint Appendix
ACA	Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010
APA	Administrative Procedure Act
HHS	U.S. Department of Health and Human Services
IRS	Internal Revenue Service

JURISDICTIONAL STATEMENT

Plaintiffs-Appellants brought an action under the Administrative Procedure Act ("APA") to vacate and declare unlawful final regulations promulgated by the Internal Revenue Service ("IRS"). The district court had subject-matter jurisdiction pursuant to 28 U.S.C. § 1331. On January 15, 2014, the district court issued an opinion granting defendants' motion for summary judgment (A325), and entered final judgment dismissing the case. (A324) Appellants noticed an appeal. (Dkt. 68) This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF ISSUES

1. The Patient Protection and Affordable Care Act ("ACA") authorizes federal subsidies for health coverage obtained on an "Exchange established by the State under section 1311 [of the ACA, *codified at* 42 U.S.C. § 18031]." The issue is whether the IRS may promulgate regulations extending such subsidies to health coverage obtained on Exchanges established instead by the *federal government* under § *1321* of the ACA, *codified at* 42 U.S.C. § 18041.

2. The second issue is whether employers who face substantial penalties if any of their employees receive subsidies under the authority of those IRS regulations may challenge them under the APA, or instead are barred by the Anti-Injunction Act, 26 U.S.C. § 7421(a).

STATEMENT OF PERTINENT AUTHORITIES

The following provisions are reproduced in the addendum hereto: 42 U.S.C. §§ 18031 & 18041 (which are ACA §§ 1311 & 1321); 26 U.S.C. § 36B (which is ACA § 1401(a)); 26 U.S.C. § 7421(a) (the Anti-Injunction Act); 26 C.F.R. § 1.36B (excerpts); and 45 C.F.R. § 155.20 (excerpts).

STATEMENT OF THE CASE

This case concerns an IRS regulation that purports to implement—but in fact squarely contradicts—the provisions of the ACA authorizing federal tax-credit subsidies for certain individual health insurance policies.

A. Congress Calls for States To Establish Insurance Exchanges, with Federal Exchanges as a Fallback Mechanism.

The ACA regulates the individual health insurance market primarily through insurance Exchanges organized along state lines. According to the Department of Health and Human Services ("HHS"), an Exchange is "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality." (A327) Participation in Exchanges also facilitates federal regulation of both insurers (who must comply with numerous requirements to participate in an Exchange) and individuals (most of whom are required by the ACA's "individual mandate" to purchase comprehensive insurance policies).

Initially, there were some proponents of having the federal government establish and operate these Exchanges. But Congress heard extensive testimony criticizing that approach and urging instead that the Exchanges be run by states. *E.g.*, Roundtable Discussion on Expanding Health Care Coverage: Before S. Comm. on Finance, 111th Cong. 2, 4, 6 (May 5, 2009). And Senator Ben Nelson of Nebraska, whose vote was critical to the Act's passage, called the "national exchange" approach a "dealbreaker," expressing concern that such a regime would "start us down the road of … a single-payer plan." Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO (Jan. 25, 2010), http://www.politico.com/livepulse/0110/Nelson_National_exchange_a_dealbreaker.html.

Ultimately, Congress instead enacted a bill that called for *states* to establish and operate the Exchanges—a feature emphasized by proponents of the ACA, who thereby sought to downplay opponents' charges that the Act would nationalize the health care industry. *See, e.g.*, SENATE DEMOCRATIC POLICY COMM., *Fact Check: Responding to Opponents of Health Insurance Reform* (Sept. 21, 2009), *available at* http://dpc.senate.gov/reform/reform-factcheck-092109.pdf ("There is no government takeover or control of health care in any senate health insurance reform legislation …. All the health insurance exchanges … are run by states.").

In particular, the ACA provides: "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an

'Exchange') for the State." ACA § 1311(b)(1), *codified at* 42 U.S.C. § 18031(b)(1). The Act directs that such Exchanges "mee[t] the requirements of subsection (d)," *id.*, which in turn sets forth various rules regarding, among other things, the types of coverage that Exchanges may offer, how the Exchanges must operate, and how the Exchanges must help the federal government enforce the individual mandate, ACA § 1311(d), *codified at* 42 U.S.C. § 18031(d).

Under the Constitution's core federalism commands, however, the federal government cannot *compel* sovereign states to create Exchanges. *See Printz v. United States*, 521 U.S. 898, 935 (1997). Congress knew that, and so the Act recognizes that some states may not be "electing State[s]," because they may choose not "to apply the requirements" for establishing an Exchange or may otherwise "fai[l] to establish [an] Exchange." ACA § 1321(b)-(c), *codified at* 42 U.S.C. § 18041(b)-(c). To address that situation, the Act authorizes the federal government, through HHS, to establish fallback Exchanges in states that do not establish their own. If a state is "not an electing State" or if HHS determines, "on or before January 1, 2013," that a state "will not have any required Exchange operational by January 1, 2014," the Secretary "shall … establish and operate such Exchange within the State." ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). Thus, if a state declines the role that the ACA urges it to accept, that responsibility falls upon the federal government instead.

In short, the ACA provides for two basic types of Exchanges: those established by states under § 1311 of the Act (42 U.S.C. § 18031), and those established by HHS under § 1321 of the Act (42 U.S.C. § 18041).[1]

B. Congress Encourages States To Establish Exchanges Using a Mix of "Carrots" and "Sticks."

Because Congress could not directly compel states to establish Exchanges, the Act uses a variety of tools to encourage states to voluntarily play that role. For example, it authorizes federal grants to states for "activities (including planning activities) related to establishing an [Exchange]." ACA § 1311(a), *codified at* 42 U.S.C. § 18031(a). The Act also penalizes states that do not create their own Exchanges, such as by prohibiting them from tightening their Medicaid eligibility standards. *See* ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg) (requiring maintenance of eligibility standards until HHS "determines that an Exchange established by the State under section 1311 of the [ACA] is fully operational").

Most importantly, the Act authorizes premium assistance subsidies for individual health coverage purchased through state-established Exchanges. These subsidies take the form of refundable tax credits, paid by the federal treasury to the

[1] Section 1311 of the Act also provides for two variants on state-established Exchanges: regional Exchanges, which "may operate in more than one State" if such states agree; and subsidiary Exchanges, which a "State may establish [to] … serv[e] a geographically distinct area" within the state. *See* ACA § 1311(f)(1), (2), *codified at* 42 U.S.C. § 18031(f)(1), (2). These, like ordinary state-established exchanges, are established by states under § 1311 of the ACA, and thus are not distinguishable from ordinary state Exchanges in any respect relevant to this case.

taxpayer's insurer as an offset against the taxpayer's premiums. ACA § 1401(a), *codified at* 26 U.S.C. § 36B; ACA § 1412, *codified at* 42 U.S.C. § 18082.

Critically, the subsidy is available only for coverage through an Exchange *established by a state*. The Act provides that a tax credit "shall be allowed" in a particular "amount," 26 U.S.C. § 36B(a), with that amount calculated based on the number of "coverage months of the taxpayer occurring during the taxable year," *id.* § 36B(b)(1). The Act then defines a "coverage month" as a month for which, "as of the first day of such month the taxpayer … is covered by a qualified health plan … that was enrolled in through an Exchange *established by the State under section 1311* of the [ACA]." *Id.* § 36B(c)(2)(A)(i) (emphasis added). Unless the citizen buys coverage through a state-established Exchange, there are no "coverage months" and therefore no subsidy. Confirming that, the value of the subsidy for any particular "coverage month" is based on the monthly premium for a "qualified health pla[n] … which cover[s] the taxpayer … and which w[as] enrolled in through an Exchange established by the State under [§] 1311 of the [ACA]," *id.* § 36B(b)(2)(A); *see also id.* § 36B(b)(3)(B)(i) (referring back to "same Exchange … [as] under paragraph (2)(A)" for purpose of calculating another value bearing upon subsidy). Again, unless a citizen has enrolled in coverage through a state-created Exchange established under § 1311 of the ACA, he gets no subsidy.

Evidently believing its offer to be so irresistible that every state would establish an Exchange, Congress did not appropriate any funds in the ACA for HHS to establish Exchanges, even as it appropriated funds to help states establish theirs. "[L]awmakers assumed that every state would set up its own exchange." Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, Aug. 4, 2012, at A17; *see also* Elise Viebeck, *Obama Faces Huge Challenge in Setting up Health Insurance Exchanges*, THE HILL, Nov. 25, 2012 ("The law assumed states would create and operate their own exchanges ….").

C. 34 States Decline To Establish Their Own Exchanges.

Exercising the option granted by the Act (and required by the Constitution), 34 states decided not to establish Exchanges. (A328)[2] Two states also could not establish Exchanges in time, for a total of 36 states without state-established Exchanges for 2014. Jennifer Corbett Dooren, *Two States Seek Help With Health Exchanges*, WALL ST. J. (May 22, 2013), http://online.wsj.com/news/articles/SB10001424127887323336104578499444065609364. Pursuant to § 1321 of the

[2] The 34 states are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. *See State Decisions For Creating Health Insurance Exchanges*, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ ("*State Decisions*") (last visited Jan. 29, 2014). Of these, 7 states have chosen to assist HHS in certain ways with its operation of the federal Exchanges. *See id.*; 77 Fed. Reg. 18310, 18325 (Mar. 27, 2012) (categorizing such "partnership" Exchanges as federally established).

ACA, *codified at* 42 U.S.C. § 18041, HHS therefore established federal Exchanges—colloquially known as HealthCare.Gov—to serve those states.

D. The IRS Promulgates Regulations Expanding the Availability of Subsidies to HHS-Established Exchanges.

Notwithstanding the ACA's text, the IRS promulgated regulations (referred to here as "the IRS Rule") requiring the federal treasury to disburse subsidies for coverage purchases through *all* Exchanges, not only those established by states under § 1311 of the Act, but also those established by HHS under § 1321.

Specifically, the IRS Rule states that subsidies shall be available to anyone "enrolled in one or more qualified health plans through an Exchange," and then adopts an HHS definition of "Exchange" that includes *any* Exchange, "regardless of whether the Exchange is established and operated by a State … or by HHS." 26 C.F.R. § 1.36B-2; 45 C.F.R. § 155.20. In effect, the Rule eliminates the statutory language restricting subsidies to Exchanges "established by the State under section 1311." Under the IRS Rule, federal subsidies are thus available in *all* states, even those states that failed to establish their own Exchanges. Put another way, the IRS Rule authorizes subsidies for coverage purchased through HealthCare.Gov, not just for coverage purchased through state-established Exchanges.

Responding, in its description of the Rule, to comments pointing out this facial inconsistency with the statute, the IRS offered only the following:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

77 Fed. Reg. 30377, 30378 (May 23, 2012).

E. The IRS Rule Triggers Other ACA Mandates and Penalties.

By expanding federal subsidies to coverage on HHS-established Exchanges, the IRS Rule triggers mandates and penalties under the Act for millions of individuals and thousands of employers in the 36 states served by HealthCare.Gov.

For individuals, the availability of the subsidy triggers the Act's individual mandate penalty for many who would otherwise be exempt. That mandate requires all "applicable" individuals to obtain "minimum essential coverage." 26 U.S.C. § 5000A(a). Failure to comply triggers a penalty. *Id.* § 5000A(b). But that penalty does not apply to those "who cannot afford coverage" or who would suffer "hardship" if forced to buy it. *Id.* § 5000A(e)(1), (5). Under HHS regulations implementing these exemptions, an individual may obtain an advance exemption from the individual mandate penalty, called a "certificate of exemption," if the annual cost of health coverage exceeds eight percent of his projected household income. *See* 45 C.F.R. § 155.605(g)(2); *see also* 26 U.S.C. § 5000A(e)(1)(A). For

individuals only able to purchase coverage in the individual market, that cost is calculated as the annual premium for the cheapest insurance plan available in the Exchange in that person's state, minus "the credit allowable under section 36B." 26 U.S.C. § 5000A(e)(1)(B)(ii). Thus, by purporting to make a credit "allowable" in states served by HealthCare.Gov, the IRS Rule increases the number of people in those states subject to the individual mandate's penalty. Now ineligible for certificates of exemption, those individuals are no longer free to forgo coverage, or to buy less expensive "catastrophic" coverage (otherwise restricted to those under age 30, ACA § 1302(e)(1)(A), (2), *codified at* 42 U.S.C. § 18022(e)(1)(A), (2)).

For employers, the broader availability of subsidies triggers the "assessable payments" used to enforce the Act's "employer mandate." The Act provides that large employers will be subject to assessable payments if they do not offer full-time employees the opportunity to enroll in affordable, employer-sponsored health coverage. But the payment is only triggered if at least one employee enrolls in coverage for which "an applicable premium tax credit … is allowed or paid." 26 U.S.C. § 4980H. Thus, if no subsidies are available in a state because that state has not established an Exchange, employers in that state may offer their employees non-compliant coverage, or no coverage at all, without being threatened with this liability. Since the IRS Rule authorizes subsidies in all states, however, it exposes businesses in those states to the employer mandate and its assessable payments.

F. Injured Individuals and Employers Challenge the IRS Rule.

Appellants in this case are individuals residing, and employers operating, in states that declined to establish their own Exchanges and therefore are being served by HealthCare.Gov. (A332) Of the four individual plaintiffs, proceedings in the district court focused on David Klemencic, a resident of West Virginia (which has declined to establish its own Exchange). Klemencic does not want to purchase health coverage in 2014, and, given his low income, would not be subject to any penalty for failing to do so—but for the IRS Rule, which renders him eligible for a subsidy that would reduce the net cost of his coverage to below 8% of his projected income and so disqualify him from the mandate's hardship exemption. (A334-35) The IRS Rule thus "places Klemencic in a position where he has to purchase subsidized health insurance … or he will have to pay … [a] tax penalty." (A335)

Of the employer plaintiffs, the parties focused on a group of restaurants based in Texas, which has declined to establish an Exchange. (A36 ¶ 1) These businesses are under common control and so are treated, under the ACA, as one employer with over 350 full-time employees. (*Id.*) They do not wish to offer health coverage to all such employees. (A37 ¶ 4) These businesses are only subject to the employer mandate because of the IRS Rule. That Rule allows their employees to collect subsidies through HealthCare.Gov (A36 ¶ 3), and a single employee's receipt of a subsidy will trigger huge assessable payments under the

employer mandate. 26 U.S.C. § 4980H(a), (c)(1).

G. The District Court Rejects the Government's Motion To Dismiss, But Upholds the IRS Rule on the Merits.

Senior District Judge Paul Friedman expedited the proceedings below after this case was assigned to him in September 2013. On October 21, he held oral argument on the Government's motion to dismiss, and issued an oral ruling denying the motion the next day. (Dkt. 42, 43) In that ruling, the court concluded that Klemencic had Article III and prudential standing to challenge the rule, that his challenge was ripe, and that the APA offered him a cause of action. (Dkt. 46)

On January 15, 2014, the district court upheld the IRS Rule, concluding that while the subsidy provision's "plain language … appears to support plaintiffs' interpretation," Congress clearly intended just the contrary. (A350, 359) The court inferred that counter-textual intent from (i) Congress' policy goal "to provide affordable health care" (A357); (ii) the absence of legislative history confirming the plain text (A358, 361); (iii) supposed "anomalies" in operation of some of the Act's other provisions (A354); and (iv) a contorted construction of statutory cross-references to imply that HHS acts as a state when it establishes an Exchange, even though the Act says no such thing (A352-53). (The court also held that the *employer* plaintiffs were barred by the Anti-Injunction Act (A340), but, since Klemencic had standing, that holding had no practical effect.) Appellants filed a notice of appeal (Dkt. 68), and this Court ordered expedited briefing and argument.

SUMMARY OF ARGUMENT

I. No legitimate method of statutory construction would interpret the phrase "Exchange established by the State under section 1311" in the ACA's subsidy provision to mean "Exchange established by the State under section 1311 *or, if the state fails to establish one, by HHS under section 1321*." The Act expressly contemplates both state-established Exchanges (the default) and HHS-established Exchanges (in states that refuse to establish their own); where it specifically refers to one type or the other, courts must give effect to that language. The district court instead accepted the backwards claim that, because HHS may establish Exchanges in states that *failed to*, those HHS-established Exchanges are actually created "on behalf of" the states and thus are somehow "state-established." The court reached that result even though it is a state's *failure* to establish an Exchange that triggers HHS's authority in the first place; even though Congress elsewhere in *the same provision* referred expressly to HHS-established Exchanges as distinct from state-established Exchanges; and even though Congress demonstrably knew how to deem other Exchanges to be state-established when it wanted to, as it did with Exchanges established by U.S. territories.

Because the plain text of the subsidy provision creates no absurdity, either in that provision itself or any other part of the ACA, that text would be conclusive even if legislative history and purpose undermined it. But they do not. Indeed, the

ACA's restriction of subsidies to state-established Exchanges is neither novel nor remotely surprising. Congress has often evaded the constitutional bar on commandeering states by offering them "deals" they could not refuse, conditioning federal benefits for the state or its residents on state compliance with federal directives. Indeed, Congress indisputably did so *in the ACA*, threatening states with the cut-off of all Medicaid funds unless they expanded its eligibility criteria. The ACA's subsidy provision offered an analogous "deal" to entice states to establish Exchanges—because Congress (wisely, in hindsight) knew it had to offer huge incentives for the states to assume responsibility for that logistically nightmarish and politically toxic task. And just as there is no indication in the legislative record that anyone worried about states rejecting the Medicaid "deal," there is no indication that anyone worried about rejection of the Exchanges "deal."

If a state nonetheless *had rejected* the Medicaid "deal," that would plainly have required cutting off its Medicaid funds, notwithstanding Congress's obvious purpose of *expanding* Medicaid. Similarly, while denying subsidies to states rejecting the Exchanges "deal" will mean fewer subsidies than Congress optimally desired, that is the inevitable effect of a state rejecting a deal that Congress *had* to offer to induce the state action it clearly sought. Of course, it is likely (if not certain) that Congress would have accomplished *both* its policy goals—state-run Exchanges *and* universal subsidies—had the IRS not preemptively *eliminated* the

irresistible incentive of subsidies, replacing a deal that was too good to refuse with a "deal" that offered states nothing (and which 34 states unsurprisingly declined).

II. *Chevron* deference cannot save the IRS Rule, for four reasons. *First*, deference is triggered only if the statutory text is *ambiguous* and intended as an implicit delegation to the agency. Yet the ACA's subsidy provision directly and unambiguously answers the question presented. *Second*, the *IRS* is entitled to *no* deference in construing the statutory language that was critical to the district court's analysis, which is found in Title 42 of the U.S. Code, *not* the Internal Revenue Code. *Third*, any deference would be displaced by the venerable canon requiring all tax credits to be provided *unambiguously*. *Fourth*, ambiguity only allows the IRS to adopt reasonable constructions of the statute—and rendering express statutory text nugatory is the epitome of an *unreasonable* construction.

III. Though this Court need not reach the issue given Klemencic's indisputable standing, the district court was wrong to hold the employer plaintiffs' claims barred by the Anti-Injunction Act. *First*, the "assessable payments" under the ACA's employer mandate are not taxes under the AIA. *Second*, in any event, this case is plainly not "for the purpose of restraining the assessment or collection" of those payments. It is, rather, an APA suit for the purpose of invalidating the IRS Rule. Any effects of that relief on the employer mandate are merely the sort of downstream, collateral consequences that may arise from *any* litigation.

STANDARD OF REVIEW

"In a case like the instant one, in which the District Court reviewed an agency action under the APA, we review the administrative action directly, according no particular deference to the judgment of the District Court." *Holland v. Nat'l Mining Ass'n*, 309 F.3d 808, 814 (D.C. Cir. 2002).

ARGUMENT

I. THE IRS RULE IS SQUARELY FORECLOSED BY THE TEXT OF THE ACA, AND THE EFFORTS TO SAVE IT ARE MERITLESS.

"If the statute is clear and unambiguous 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *Bd. of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 368 (1986) (quoting *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984)). An agency's "failure to respect the unambiguous textual limitations" of a statutory provision is therefore "fatal" to its regulatory efforts. *Fin. Planning Ass'n v. SEC*, 482 F.3d 481, 490 (D.C. Cir. 2007). Here, the relevant text of the ACA is "clear and unambiguous," *Dimension Fin.*, 474 U.S. at 368; and the IRS Rule "fail[s] to respect" its "unambiguous textual limitations," *Fin. Planning Ass'n*, 482 F.3d at 490. The ACA states that subsidies are available only for coverage purchased on *state-established* Exchanges, but the IRS Rule wholly eliminates that prerequisite. The Rule is therefore invalid.

A. There Is No Remotely Plausible Reading of the ACA's Subsidy Provision That Could Support the IRS Rule.

1. The ACA provides that an eligible taxpayer shall be entitled to a tax credit "equal to the premium assistance credit amount of the taxpayer." 26 U.S.C. § 36B(a). That "premium assistance credit amount" is defined as the sum of the monthly premium assistance amounts for "all coverage months of the taxpayer occurring during the taxable year." *Id.* § 36B(b)(1). A "coverage month" is one in which "the taxpayer … is covered by a qualified health plan … enrolled in through an *Exchange established by the State under section 1311* of the [ACA, *codified at* 42 U.S.C. § 18031]." *Id.* § 36B(c)(2)(A)(i) (emphasis added). These provisions are thus perfectly clear: Unless a taxpayer enrolls in coverage "through an Exchange established by the State under section 1311 of the [ACA]," he has no "coverage months" and therefore no "premium assistance amounts." Accordingly, if a taxpayer's state is served by HealthCare.Gov, no subsidy is available to him.

Reinforcing that point, the Act specifies that the premium assistance amount for a coverage month is equal to the lesser of two values: *First*, "premiums for such month for [a] qualified health pla[n] … which cover[s] the taxpayer … and which w[as] enrolled in through an Exchange established by the State under [§] 1311 [of the ACA, *codified at* 42 U.S.C. § 18031]." *Id.* § 36B(b)(2)(A). *Second*, the excess, over a certain percentage of the taxpayer's average monthly household income, of the "adjusted monthly premium for such month for the applicable

second lowest cost silver plan" that is "offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered"—namely, the Exchange "established by the State under [section] 1311 of the [ACA, *codified at* 42 U.S.C. § 18031]." *Id.* § 36B(b)(2)(B), (3)(B). These figures likewise only make sense, and can only be computed, if the taxpayer purchases health coverage through an Exchange established by a state.

2. In stark contrast, the regulations promulgated by the IRS provide that a taxpayer is eligible for a premium assistance subsidy so long as he "[i]s enrolled in one or more qualified health plans through an Exchange," with no qualification based on the entity that established the Exchange. 26 C.F.R. § 1.36B-2(a)(1). The regulations then adopt a definition of "Exchange" from HHS regulations that define it to include *any* Exchange, "regardless of whether [it] is established and operated by a State … or by HHS." 26 C.F.R. § 1.36B-1(k); 45 C.F.R. § 155.20. Under these regulations, therefore, an individual who enrolls in coverage even through the HHS-established Exchange is eligible for a subsidy. The regulations, again in contrast to the ACA, also adopt a broad definition of "coverage month," including any month if, "[a]s of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange," not only an Exchange established by a state under § 1311 of the ACA. 26 C.F.R. § 1.36B-3(c)(1)(i).

3. The IRS Rule thus contradicts the plain and unambiguous text of the ACA. The latter expressly restricts subsidies to coverage obtained through "an Exchange established by the State under section 1311" of the Act, but the former expands those subsidies to coverage obtained through *any* Exchange.

At the risk of belaboring the obvious, an Exchange established by HHS under the authority of § 1321 of the Act is not "an Exchange established by the State under section 1311 of the [Act]." HHS is not a "State." If there could be any doubt, the Act clarifies: "[T]he term 'State' means each of the 50 States and the District of Columbia." ACA § 1304(d), *codified at* 42 U.S.C. § 18024(d). Moreover, sections 1311 and 1321 of the Act are distinct grants of authority to distinct entities, the former directing each "State" to "establish an American Health Benefit Exchange" and the latter directing HHS to "establish and operate such Exchange" in states that fail to. Thus, as even the district court acknowledged, "the plain language of 26 U.S.C. § 36B … appears to support plaintiffs' interpretation." (A350) "As the text is clear, [this Court's] inquiry is complete." *Blackmon-Malloy v. U.S. Capitol Police Bd.*, 575 F.3d 699, 705 (D.C. Cir. 2009).[3]

[3] The ACA's generic definition of "Exchange" as "Exchange established under section 1311," ACA § 1563(b)(21), *i.e.*, the provision directing *state*-created Exchanges, bolsters this plain reading. Given that definition, there would have been an argument against subsidies on federal Exchanges even if the subsidy provision had referred to an "Exchange," *without* specifying "established by the State under section 1311." That the Act nonetheless added those qualifiers further demonstrates Congress' intent to restrict subsidies to state-established Exchanges.

4. This text is corroborated by every conceivable canon of construction. *First*, if "Exchange established by the State under section 1311" is read to include *all* Exchanges, including those established by HHS under § 1321, then the two statutory modifiers "established by the State" and "under section 1311 of the [ACA]" would serve no purpose at all, violating the "cardinal principle" that "no clause, sentence, or word [of a statute] shall be superfluous, void, or insignificant." *Duncan v. Walker*, 533 U.S. 167, 174 (2001). The problem here is not merely that Congress could have expressed itself more concisely, but that the addition of these two modifiers suggests the very *opposite* of what the Government contends that Congress intended. Why would Congress have added clauses that, on the Government's view, are not only completely redundant but entirely misleading?[4]

Second, Congress elsewhere in the ACA used the broader phrase "Exchange established *under this Act*." ACA § 1312(d)(3)(D)(i)(II), *codified at* 42 U.S.C. § 18032(d)(3)(D)(i)(II) (emphasis added). That phrase clearly does include HHS-established Exchanges. The IRS Rule, however, says that the narrower phrase "Exchange established *by the State*" means "established under this Act," violating the canon that "differing language" in "two subsections" of a statute should not be given "the same meaning." *Russello v. United States*, 464 U.S. 16, 23 (1983).

---

[4] The district court dismissed this canon, reasoning that the plain reading of the subsidy provision would also result in superfluity, in another provision of the ACA. (A353 n.11) That is not true, as explained below. *See infra* Part I.B.2.a.

Third, in the *very same subsidy provision*, Congress referred expressly to *both* state-established *and* HHS-established Exchanges distinctly, proving that it knew that one did not encompass the other—and that it knew how to capture both. Specifically, a subsection of § 36B that requires Exchanges to report information to the Treasury clarifies that it applies to an "Exchange under Section 1311(f)(3) or 1321(c)." 26 U.S.C. § 36B(f)(3). This conclusively proves that when Congress wanted to refer to both state-established *and* HHS-established Exchanges, it "knew how to do so." *Custis v. United States*, 511 U.S. 485, 492 (1994).

Fourth, a venerable canon of construction holds that tax credits, deductions, and exemptions "must be expressed in clear and unambiguous terms." *Yazoo & Miss. Valley R.R. Co. v. Thomas*, 132 U.S. 174, 183 (1889). These benefits must be "unquestionably and conclusively" established, *Stichting Pensioenfonds Voor De Gezondheid v. United States*, 129 F.3d 195, 198 (D.C. Cir. 1997); they "are not to be implied," *United States v. Wells Fargo Bank*, 485 U.S. 351, 354 (1988). If "doubts are nicely balanced," that defeats the claimed tax exemption. *Trotter v. Tennessee*, 290 U.S. 354, 356 (1933). Thus, any doubts over whether the subsidies apply to federal Exchanges must be resolved *against* expanding the credit. *Norton v. United States*, 581 F.2d 390, 397 (4th Cir. 1978) (where rule would "impose a potentially burdensome enough impact on the federal treasury" then "it should be supported by a clear expression of legislative intent").

5. Notwithstanding the above, the district court held that § 36B's reference to "an Exchange established by the State" could be read to mean "an Exchange established by the State *or by HHS when the state fails to establish one*." Its reasoning was that the ACA "directs the Secretary of HHS to establish such Exchange and bring it into operation if the state does not do so." (A352) That is, because federal Exchanges may *replace* state Exchanges, they are somehow necessarily included in any reference to state Exchanges.

That makes no sense. The *question* is why a reference to state-established Exchanges includes HHS-established Exchanges that are created in states that fail to establish them. The district court's "answer" is: Because the Act requires HHS-established Exchanges to be created in states that fail to establish them. But the fact that the Act *envisions* HHS Exchanges (when states default) obviously cannot suggest that the subsidy provision's reference to "Exchange established by the State" somehow connotes an HHS Exchange. To the contrary, it reinforces that the reference to state Exchanges does not include federal Exchanges. It is precisely *because* the ACA calls for two distinct entities to establish Exchanges that the phrase "Exchange established by the State" cannot be read to include one established by HHS. Congress knew that it was authorizing both state- and HHS-established Exchanges; its reference to *one* of those cannot be construed as a reference to *both* simply because both exist.

The district court seems to have concluded that, when HHS establishes an Exchange because a state fails to do so, HHS acts "*on behalf of*" the state and thus, by some bizarre transitive property, an HHS-established Exchange is "established by the State." (A352-53) That also makes no sense. An Exchange is established either by a state or by HHS; it cannot be both at once. A "federally established state-established Exchange" is an oxymoron. If Congress asked states to build certain airports, and described these airports in great detail (specifying, *e.g.*, air traffic and security procedures), but added that the Secretary of Transportation should construct "such airports" if states fail to, would anyone think to refer to the latter as "state-constructed airports," simply because they are supposed to be built if the state-constructed ones are not? Obviously not.

An Exchange established by HHS "on behalf of" a state refusing to establish one is plainly not "established by the *State*"; it is established *by HHS* in the refusing state. Indeed, HHS's authority to create an Exchange is only *triggered* by the state's *failure* to do so, making the district court's reading particularly illogical: The ACA's *premise* is thus that an HHS Exchange is *not* an Exchange *established by the State*, because the former can be created only if the latter is not.

The only way one could equate HHS- and state-established Exchanges would be if the Act's plain language instructed that the HHS Exchanges should be "deemed" to be established by the state. But the Act does no such thing, which is

particularly significant because the Act *does* contain such express language for Exchanges established by U.S. territories. Section 1323 provides that if a territory establishes an Exchange, it "shall be treated as a State" for such purposes. ACA §1323(a)(1), *codified at* 42 U.S.C. § 18043(a)(1). This conclusively demonstrates that Congress knew how to create such equivalence when it wanted to, but there is no provision adopting that type of language for federal Exchanges.

Likewise, an earlier House version of the ACA—which created a single, national Exchange but allowed states to "opt-in" to run Exchanges themselves—also stated *expressly* that, if a state did opt-in, "any references in this subtitle to the Health Insurance Exchange … shall be deemed a reference to the State-based Health Insurance Exchange." (A247-48 (H.R. 3962, § 308(e), 111th Cong. (2009)) One can search the ACA, as enacted, for some equivalent language regarding Exchanges established by the federal government—but none exists.

It is one thing to say that the ACA allows HHS to "step into the shoes" of the state and establish an Exchange in its place. But it is quite another thing to say that the HHS-established Exchange therefore *is* "established by the State." When Congress wants the federal government to step into the shoes of an entity *and be treated as if it were that entity*, it always says so expressly. For example, 28 U.S.C. § 2679(d)(1) allows the United States to "step into the shoes" of federal officers who are sued: It expressly provides that such a suit "shall be *deemed* an

action against the United States." *Id.* (emphasis added). Likewise, the Bankruptcy Code allows a bankruptcy trustee "to stand in the shoes of an hypothetical creditor of the debtor to effect a recovery from a third party." *Zilkha Energy Co. v. Leighton*, 920 F.2d 1520, 1523 (10th Cir. 1990). That law, too, expressly provides that the trustee "shall have … the rights and powers of" such creditors. 11 U.S.C. § 544(a). And federal law allows the FDIC to "ste[p] into the shoes" of failed banks, *O'Melveny & Myers v. FDIC*, 512 U.S. 79, 86 (1994); it does so by expressly providing that the FDIC "shall … succeed to … all rights, titles, powers, and privileges" of such banks. 12 U.S.C. § 1821(d)(2)(A)(i).

In all of the U.S. Code, there is not a single example of a situation in which Congress "deems" one entity to be another *without saying so*. Yet not only does the ACA not use any such express language; it does not even say that HHS should establish an Exchange "for" or "on behalf of" the state, which would have been a more natural (albeit insufficient) way of indicating that HHS was acting *qua* state. Instead, it says only that HHS shall establish an Exchange "within" the refusing state, ACA § 1321(c)(1), *codified at* 42 U.S.C. § 18041(c)(1), which has no such connotation at all. It simply designates the geography where the federal Exchange will operate, without any hint that it is *equivalent* to an Exchange established by the state, or even that it is established *on behalf of* the state.

6. Even the Government does not actually believe that HHS Exchanges are, in fact, state-established. HHS regulations themselves concede that federal Exchanges are "established … *by the Secretary* under *section 1321(c)(1)*" of the ACA, not by a *state* under *§ 1311* of the ACA. 45 C.F.R. § 155.20 (emphases added). And the very definition of "Exchange" that the IRS Rule adopts provides that it covers any Exchange, "regardless of whether [it] is established and operated *by a State* … or *by HHS*." *Id.* (emphases added). HHS, at least, is under no illusions about who establishes state- and HHS-established Exchanges—and, quite sensibly, refers to the two as distinct. *E.g.*, 78 Fed. Reg. 65046, 65048 (Oct. 30, 2013) ("In this final rule, we use the terms 'State Exchange' or 'FFE' [federally facilitated Exchange] when we are referring to a particular type of Exchange.").

Moreover, the ACA appropriated unlimited sums to help "States" establish Exchanges. ACA § 1311(a), *codified at* 42 U.S.C. § 18031(a). If the Government truly believed that HHS acts as a "State" when it establishes a fallback Exchange, then it would have used that appropriation to pay for creation of federal Exchanges. Yet it did not. *See* Amy Goldstein & Juliet Eilperin, *Challenges Have Dogged Obama's Health Plan Since 2010*, 2013 WLNR 27607716, WASH. POST, Nov. 2, 2013 (noting that lack of funds hampered HealthCare.Gov, because the ACA "provided plenty of money to help states build their own insurance exchanges," but "no money for the development of a federal exchange").

B. No Absurdity Arises from the Plain-Text Reading of the ACA's Subsidy Provision, and That Text Must Therefore Govern.

Because the subsidy provision itself is concededly "plain and unambiguous," this Court's analysis should "en[d] with the text." *Chao v. Day*, 436 F.3d 234, 235 (D.C. Cir. 2006); *Performance Coal Co. v. Fed. Mine Safety & Health Review Comn'n*, 642 F.3d 234, 238-39 (D.C. Cir. 2011) ("Just a plain reading of that text alone satisfies us that the provision is unambiguous."); *Am. Fed'n of Gov't Empl. v. Shinseki*, 709 F.3d 29, 33 (D.C. Cir. 2013) (confirming that where "the text is unambiguous, our analysis also ends with the text").

The only permissible basis for departing from plain text is if it creates an *absurd* result. *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488, 494 (D.C. Cir. 2004) (Roberts, J.) (noting that "extraordinary power" to "ignore the plain language … is limited to the situation in which adherence to the plain text leads to an 'absurd' result"). "[W]hen the statute's language is plain, the sole function of the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms." *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). And, given the risks of substituting judges' policy views for those of Congress, the absurdity doctrine is "rarely applied." *Cook v. FDA*, 733 F.3d 1, 9 (D.C. Cir. 2013). To invoke it requires "an extraordinarily convincing justification." *Appalachian Power Co. v. EPA*, 249 F.3d 1032, 1041 (D.C. Cir. 2001) (per curiam). No such justification is even remotely present here.

1. Construing the ACA to provide subsidies only for coverage purchased on state-established Exchanges is plainly not absurd. Given the plausible concern that states would be reluctant to undertake the thankless job of establishing and operating Exchanges, offering them a seemingly irresistible incentive—billions of dollars in federal subsidies to their citizens—is extraordinarily sensible. Congress could quite reasonably believe that elected state officials would not want to explain to their voters that they had deprived them of billions of dollars by failing to establish an Exchange. Looked at another way, it is eminently sensible not to treat states that reject the invitation to establish an Exchange just as well as those who agree to bear that difficult burden, but instead to allocate scarce resources to those states that do not require the federal government to bear the additional expenditure and hardship of setting up a federal Exchange. The decision to eschew federal subsidies in federally run Exchanges is thus hardly irrational or absurd.

Indeed, Congress in the ACA indisputably imposed an analogous condition on states' receipt of Medicaid funds: Unless the states expanded their eligibility criteria for Medicaid benefits, they would lose *all* of their Medicaid funds. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012) ("*NFIB*") ("Congress is coercing the States to adopt the changes it wants by threatening to withhold all of a State's Medicaid grants, unless the State accepts the new expanded funding and complies with the conditions that come with it."). To be

sure, Congress wanted and expected all states to comply with those new conditions, and in that sense intended for all states to continue to receive Medicaid grants. Yet, quite obviously, if a state had nonetheless refused to comply with the new rules, it could not have asked a court to ignore the ACA's plain text on the ground that it would be "absurd" to deprive it of all of its Medicaid funds, given the Act's strong "purpose" of expanding, not contracting, Medicaid. In other words, it is hardly absurd to impose conditions on states' receipt of federal benefits.

The district court claimed that there was "no evidence … in the legislative history of any intent by Congress" to offer states this deal as a means of inducing them to establish Exchanges. (A358) That is not true (*see infra* Part I.C.2)—but the more basic point is that the legislative history is *irrelevant*; the district court fundamentally misconceived the inquiry. When text is plain, the only relevant question is whether its meaning is *absurd*. *Lamie*, 540 U.S. at 534. An argument "that a plain language reading would yield results at variance with the legislative history" thus has no force. *Totten*, 380 F.3d at 494. To require legislative history proving that Congress intended the text's *rational* (indeed, *clearly reasonable*) result eviscerates the absurdity rule. "[T]here would be no need for a rule … that there should be no resort to legislative history when language is plain and does not lead to an absurd result, if the rule did not apply precisely when plain language and legislative history may seem to point in opposite directions." *Id.* at 494-95.

Indeed, given the Act's plain text, even legislative history explicitly stating that subsidies are *not* limited to state Exchanges would not suffice to overcome it. *Performance Coal*, 642 F.3d at 238 ("[R]esort to legislative history is inappropriate when the statute is unambiguous."). Obviously, then, the purported absence of legislative history *echoing* the statute's language, or expressing the self-evident point that limiting federal subsidies to state Exchanges would induce states to create their own Exchanges, is utterly meaningless.

2. Nor would giving the subsidy provision its plain-text meaning create absurdity with respect to any *other* provision in the ACA. While the district court claimed that certain "anomalies" would result if the statute were given its plain meaning (A354), those supposedly anomalous results either do not result, or are not anomalous. None rises anywhere close to the level of absurdity.

a. *First*, the court claimed that a reporting rule, which expressly calls for both state- and HHS-run Exchanges to report information about who has signed up for coverage, the cost of premiums, and the amount of any subsidies they obtain, 26 U.S.C. § 36B(f), would "serve no purpose" if federal Exchanges could not offer subsidies, showing that "Congress assumed that premium tax credits would be available on any Exchange." (A355) But that premise is false.

Treasury has obvious, good reasons to want this data for individuals who do not receive subsidies. That is why the reporting requirement extends to *all*

individuals who obtain coverage through the Exchanges—including all those who fail one of the *other* subsidy eligibility requirements (*e.g.*, have incomes above 400% of the poverty level) and therefore do not apply for or receive any subsidies. Most obviously, Treasury needs enrollment information to enforce the Act's individual mandate to buy insurance. *See* 26 U.S.C. § 5000A; *NFIB*, 132 S. Ct. at 2584. Moreover, the very same section of the ACA calls for a comprehensive "study on affordable coverage" to be conducted, ACA § 1401(c); to conduct it, the Government obviously needs enrollment and premium data, even with respect to individuals who do not obtain subsidies. The district court ignored these purposes, assuming that reporting was intended only to allow the IRS "to track" *subsidy* payments. (A354) But there is no basis for such an assumption, and the broad scope of the reporting requirement—which *indisputably* extends to enrollees not receiving subsidies—refutes it. The Government has an obvious interest in tracking who has enrolled in the Exchanges, whether they receive a subsidy or not.

In sum, it is hardly odd—and not remotely absurd—for Congress to have subjected HHS Exchanges to the same reporting requirements as state-established Exchanges, even though coverage obtained therefrom is not subsidized. Indeed, the reporting rule *confirms* § 36B's plain meaning, because it is expressly directed at any "Exchange under section 1311(f)(3) or 1321(c)," 26 U.S.C. § 36B(f)(3), proving that Congress knew how to refer to both when it wanted to.

b. *Second*, the court cited an ACA provision defining "qualified individuals" as those persons who, *inter alia*, "resid[e] in the State that established the Exchange." ACA § 1312(f)(1)(A), *codified at* 42 U.S.C. § 18032(f)(1)(A). In states that did not establish Exchanges, the court reasoned, there would thus be no "qualified individuals," and nobody could enroll in Exchanges established by HHS—which would be absurd. (A355-56) The only way to avoid the absurdity, in the court's view, was to adopt the semantically nonsensical notion that HHS somehow establishes an Exchange "established by the State" when it steps in after the state fails to establish its own. (A356-57) The district court thus rewrote not only the subsidy provision's plain language, but also this provision's.

This argument fails on multiple levels. At the threshold, and contrary to the district court, the provision does not establish a *minimum eligibility* requirement, limited to "qualified individuals" and excluding all others. Entitled "Consumer Choice," the provision says only that a qualified individual "may enroll in any qualified health plan available to such individual and for which such individual is eligible." ACA § 1312(a)(1), *codified at* 42 U.S.C. § 18032(a)(1). It does not address enrollment by individuals who are *not* "qualified individuals." In other words, this is a *non-exclusion* or *non-discrimination* provision—to ensure that "qualified individuals" are allowed to "enroll in any qualified health plan" they choose. It is not a provision that *restricts* enrollment. Even if nobody in the states

served by HealthCare.Gov is a "qualified individual," that does *not* mean that they may *not* be allowed to enroll through HealthCare.Gov, and so no absurdity arises.

Moreover, even if the "qualified individual" language is understood as an implicit *restriction* on enrollment, it would apply only to Exchanges established by states—not HHS-established Exchanges. The cited definition says that a "qualified individual"—"*with respect to an Exchange*"—is one who "resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A) (emphasis added). And the ACA elsewhere defines the term "Exchange" as "Exchange established under *section 1311* of the [ACA, *codified at* 42 U.S.C. § 18031]." ACA § 1563(b)(21) (emphasis added). Since § 1311 is the provision directing *states* to establish Exchanges, the definition of "qualified individual" only applies to state-established Exchanges; it does not, therefore, limit enrollment on federal Exchanges.

Alternatively, even if the "qualified individual" definition is read as a limit on enrollment *and* as applicable to federal Exchanges, an applicant should still be understood to satisfy it based solely on its *other* prong. After all, one who seeks to enroll through a federal Exchange does not *fail* the requirement that he "resid[e] in the State that established the Exchange." That definition *assumes* a state-created Exchange; it thus can readily be construed as not prohibiting eligibility where that assumption proves false. By contrast, the subsidy provision does not assume a state-created Exchange; it simply limits subsidies to such.

At the very least, all of these are far narrower and more plausible ways to avoid any potential absurdity, as opposed to adopting throughout the Act the bizarre theory, found nowhere in its text, that HHS somehow acts as a state when it establishes an Exchange in that state. Stated differently, if this provision really did create a Catch-22, the way to resolve would be to interpret it in one of the fashions described above, not to alter it to mean the opposite of what it says. *A fortiori*, the district court should not *leverage* its rewriting of this provision to *also* rewrite the subsidy provision's (similar) plain language, particularly when interpreting the subsidy provision to mean what it says creates *no* absurdity or tension.[5]

The district court apparently worried that, if a residency requirement were not applied to federal Exchanges, *anyone* could enroll on HealthCare.Gov. (A355) Thus, the absurdity switches from *no one* being eligible to *everyone* being eligible. But that is likewise not a real concern. For one thing, the ACA authorizes HHS to "take such actions as are necessary to implement," for federal Exchanges, the requirements applicable to state Exchanges. ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). So HHS could, by regulation, restrict HealthCare.Gov enrollment as it

[5] Worse, the district court's revision of the subsidy provision does not even resolve the (imagined) problem with the "qualified individual" provision. Even if "Exchange established by the State" encompassed Exchanges established by HHS, on some theory that the two are equivalent, that still does not mean that the state *actually established* the HHS-established Exchange. It thus remains true, even on the district court's revision of the subsidy provision, that nobody in the federal-Exchange states "resides in the State that established the Exchange."

saw fit. Anyway, subject to only a narrow exception for "multi-state plans," ACA § 1334, *codified at* 42 U.S.C. § 18054, all ACA plans are rated based on state residency. *See* ACA § 2701(a)(2), *codified at* 42 U.S.C. § 300gg(a)(2). So there is no risk of, say, New Yorkers enrolling through a federal Exchange in Texas.

In short, contrary to the district court's concern, the plain-text reading of "Exchange established by the State" in the subsidy provision does not in any way preclude enrollment on an HHS-established § 1321 Exchange, or suggest that a countertextual reading of that phrase must be adopted to avoid absurdity.

c. *Third*, the district court claimed that "strange or absurd results" would arise under a provision that precludes states from tightening their Medicaid "eligibility standards" until "the date on which the Secretary determines that an Exchange established by the State under section 1311 of [the ACA, *codified at* 42 U.S.C. § 18031] is fully operational." ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg)(1). (A356) This plain language prevents a state from restricting Medicaid eligibility in that state unless it first establishes an Exchange.

But, far from being "strange or absurd," this makes perfect sense. Again, Congress wanted to induce states to run Exchanges, and the maintenance-of-effort proviso creates a substantial "stick" if they fail to. Further, it is perfectly rational for Congress to want to preserve Medicaid benefits for the most impoverished in states where low-income people were already doing without Exchange subsidies.

d. The district court also cited, but did not discuss, one other ACA provision, codified at 42 U.S.C. § 1397ee(d)(3)(B). (A356) That provision says that if state "funding shortfalls" prevent all eligible children in a state from being covered by the Children's Health Insurance Program ("CHIP"), "the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that … is offered through an Exchange established by the State under section 1311 of the [ACA, *codified at* 42 U.S.C. § 18031]." It further provides that, in such a case, the children who so enroll shall be deemed eligible for subsidies, even though children eligible for CHIP are generally excluded.

Again, there is nothing at all surprising or troubling about this provision, if "established by the State" is given its ordinary, plain-text meaning. For states served by federal Exchanges, it would make no sense to require "the State" to adopt procedures for enrolling children affected by funding shortfalls. Given that HHS is operating the Exchange in those states, it is obviously *HHS* that should be tasked with enrolling these children. Moreover, the point of this provision is to prevent these children's CHIP eligibility from disqualifying them from *subsidies* that they would otherwise be eligible for. But those who live in the states served by HealthCare.Gov are not eligible for subsidies *anyway*, and so this provision would be of no use to them. As such, it is not "strange or absurd" for the ACA to say—*and really mean*—"Exchange established by the State" in this provision.

C. Though Irrelevant, Legislative Purpose and History Confirm the Plain Meaning of the Subsidy Provision.

Because the text of the statute is clear and does not lead to any absurd results, there is no warrant to consider legislative purpose or consult legislative history. *Supra*, Part I.B. In any event, such inquiries would not lead to another conclusion.

1. The district court simplistically reasoned that the ACA's goal was to make insurance "affordable," and blocking subsidies in federal Exchanges would hinder that goal. (A357) Yet particularly with a complex Act like the ACA, "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam). Rewriting a law "to further what a court perceives to be Congress's general goal … is simply too susceptible to error to be tolerated within our scheme of separated powers." *Consol. Rail Corp. v. United States*, 896 F.2d 574, 578 (D.C. Cir. 1990).

Again, adopting the court's amorphous "purpose" analysis would mean that if a state had rejected the Medicaid "deal," courts and agencies could nonetheless send it billions of federal Medicaid dollars in the face of the Act's plain language foreclosing such expenditures to states that do not adopt the expanded Medicaid eligibility criteria. After all, just as is purportedly the case with the subsidy provision's condition, no legislative history echoes the plain Medicaid statutory language or "warns" states about the calamitous consequences of rejecting the

Medicaid "deal," and everyone, including the Congressional Budget Office (*infra* at 43), assumed the expanded Medicaid coverage would be adopted by *all* states. But that would be a clearly improper rewriting of the Act's Medicaid condition, just as the district court's analysis rewrote the subsidy provision here.

Granted, Congress wanted subsidies to be uniformly available—but it also wanted states to establish Exchanges. And it knew it could not accomplish the latter goal without creating the (far-fetched) possibility of not fully accomplishing the former—since any offer, even if it is "too good to refuse," might be rejected. Contrary to the district court (A358), authorizing states to run the new Exchanges was not some type of *favor* to them. Nobody *wanted* to take on the politically, financially, and logistically arduous task of creating these novel websites—and, as recent events have shown, that reluctance was well-founded. Rather, the point of having the states establish the Exchanges was precisely to keep the federal government out of the entire business: As critical swing vote Senator Ben Nelson put it, a federal Exchange "would start us down the road of federal regulation of insurance and a single-payer plan." Brown, *Nelson: National Exchange a Dealbreaker*, *supra*. Conditioning subsidies on state creation of Exchanges was a perfectly sensible (and probably the only) way to induce such participation (just as the ACA's condition on Medicaid funds was a sensible way to ensure that states expanded Medicaid). Only because the IRS Rule gave states the "quid" of

subsidies without demanding the "quo" of Exchanges did the scheme collapse. And only if the Rule is vacated, and the original "deal" restored, will we find out whether Congress was right to expect total state participation in Exchanges.

2. The district court reasoned, however, 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." (A358) The proof "in the statute," of course, is its *text*; the best evidence of what Congress "means in a statute [is] what it says there." *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992). And requiring *confirmation* of the plain meaning through legislative history is plainly improper. *Absence* of legislative history "cuts *against*" the Rule, as it yields "no basis for the court to conclude that [Congress] voted for a regulatory scheme other than that provided by the words in the statute." *Engine Mfrs. Ass'n v. EPA*, 88 F.3d 1075, 1091-92 (D.C. Cir. 1996) (emphasis added). As the Court noted there in an observation equally applicable here, "[t]he haste and confusion attendant upon the passage of this massive bill do not license the court to rewrite it; rather, they are all the more reason for us to hew to the statutory text because there is no coherent alternative to be gleaned from the historical record." *Id.* at 1092.

Anyway, the limited legislative history firmly supports the proposition that Congress conditioned the subsidies on state creation of Exchanges as a means to induce states to act. To be sure, Congress barely discussed federal Exchanges

during legislative debate, apparently because the overwhelming consensus was that states would submit to the Act's pressures and establish Exchanges. *See* Pear, *U.S. Officials Brace for Huge Task*, *supra* ("Mr. Obama and lawmakers assumed that every state would set up its own exchange."); Viebeck, *Obama Faces Huge Challenge*, *supra* ("It's a situation no one anticipated when the [ACA] was written. The law assumed states would create and operate their own exchanges …."). But what little history does exist shows that conditioning subsidies on state Exchanges was proposed early on, adopted by the Senate, and forced onto the House when ACA supporters lost their filibuster-proof Senate majority.

When the Senate began to consider a state-based Exchange model, an influential commentator—so influential that he was invited to the ACA's signing ceremony, *W&L Law's Jost Invited to Health Care Bill Signing Ceremony*, http://law.wlu.edu/news/storydetail.asp?id=758 (Mar. 23, 2010)—proposed "tax subsidies for insurance only in states that complied with federal requirements." Timothy S. Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Institute, Georgetown Univ. Legal Ctr., no. 23 at 7, April 27, 2009, http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1022&context=ois_papers.

That was hardly a novel suggestion; Congress, after all, used—*in the very same Act*—the same "too good to turn down" offer of huge federal grants to coerce states to expand Medicaid. *NFIB*, 132 S. Ct. at 2601. And Congress previously

conditioned *other* tax credits on state compliance with federal wishes as to health coverage. *E.g.*, 26 U.S.C. § 35(a), (e)(2) (tax credit for individuals enrolled in certain state-sponsored coverage, if state coverage satisfied federal criteria)[6]; 26 U.S.C. § 223(a), (c)(1)-(2) (tax credit for individuals enrolled in high-deductible health plans, dependent on states' authorizing such plans). More generally, using federal grants to coerce state action is a common congressional tool, forming the basis for the Medicaid program and the Children's Health Insurance Program.

In all events, the Senate Committees working on ACA legislation took up Professor Jost's suggestion. The Health, Education, Labor, and Pensions ("HELP") Committee proposed a draft bill that would have conditioned subsidies for a state's residents on the state's adoption of certain "insurance reform provisions" and on its agreement to sponsor coverage for state and local employees. S. 1679, § 3104(a), (d), 111th Cong. (2009). If a state failed to take those steps, "the residents of such state *shall not be eligible for credits*." *Id.* § 3104(d)(2) (emphasis added). That alone is ample evidence that Congress was contemplating conditioning subsidies on states' participation in advancing the goals of the federal law.

[6] Just like the ACA's subsidy provision, this credit imposed the condition of state cooperation through its definition of "coverage month," thereby refuting the district court's speculation that the "statutory formula for calculating the tax credit seems an odd place to insert a condition." (A359 n.12)

The Senate Finance Committee, whose bill ultimately became law, simply conditioned subsidies on state establishment of Exchanges, rather than on states' adoption of insurance reforms. Its chair, Senator Max Baucus, used the conditional nature of the subsidies to justify his jurisdiction over the Exchanges and related regulations of health coverage in the draft ACA; that is, the *Finance* Committee had jurisdiction over health issues only because the bill *conditioned* "tax credit" subsidies, within its bailiwick, on states creating Exchanges subject to regulation. (A319-22)[7] *See* Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule To Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX 119, 156 (2013).

The House had little choice but to accede to the Senate bill after the election of Senator Scott Brown deprived ACA supporters of a filibuster-proof majority. *See* Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, N.Y. TIMES, Jan. 19, 2010, at A1. To be sure, limited changes to the Senate bill could still be approved during reconciliation, but measures that would have increased the deficit, like expanding subsidies, would (absent countervailing revenues) have been extraneous under the "Byrd Rule" and so could not have been implemented. 2 U.S.C. § 644.

[7] The official transcript erroneously quotes Senator Baucus as saying that taxes "aren't" the jurisdiction of the Finance Committee. (A322) As is very clear from context, he actually said that taxes "are in" the Committee's jurisdiction.

3. There is no legislative history contradicting the subsidy provision's text. The district court invoked a Congressional Budget Office ("CBO") report, which, in forecasting the cost of premiums, assumed that subsidies would be available everywhere. (A361) Of course, that analysis was conducted in March 2010, before any state had opted out of establishing an Exchange, so there would have been no principled basis to assume that any of them would. Rather, the most natural assumption—the one Congress evidently made—was that no state would turn down the irresistible "deal" that Congress offered. Indeed, CBO has admitted that it "did not perform a separate legal analysis" of subsidy availability. (A275)

Tellingly, CBO *also* assumed that all states would accept the Medicaid deal and expand their Medicaid programs. CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* 1-2 (July 2012), http://cbo.gov/publication/43472 ("CBO['s] ... previous estimates reflected the expectation that every state would expand eligibility for coverage under its Medicaid program …"). Just as that obviously does not suggest that Congress did not believe Medicaid was *conditioned* on states' acceptance of expanded Medicaid eligibility, the assumption about subsidies does not suggest that Congress did not believe subsidies would also be conditioned on states' running the Exchanges. Both CBO assumptions merely reflected the very plausible belief that every state would participate in both programs.

Beyond the CBO report, the court also cited a Senate Report explaining that the HHS Secretary would establish "state exchanges" in states that failed to do so. (A193) But that surely meant "state-*based*" Exchanges, not the semantically nonsensical "HHS-established state-*established*" Exchanges.

* * *

This Court's "role is not to 'correct' the text so that it better serves the statute's purposes, for it is the function of the political branches not only to define the goals but also to choose the means for reaching them." *Engine Mfrs.*, 88 F.3d at 1089. Congress reasonably did so here, and neither the IRS nor this Court may overturn its clearly articulated judgment about the availability of federal subsidies.

II. *CHEVRON* DEFERENCE CANNOT SAVE THE IRS RULE.

For four independent reasons, the analysis above is unaffected by the principle of *Chevron* deference. *First*, the relevant ACA text is unambiguous, and so there is no room for agency interpretation. *Second*, even if there were some ambiguity, it would only be in provisions of Title 42 of the U.S. Code, not the Internal Revenue Code—yet the IRS may construe only the latter. *Third*, the deference principle is trumped by the "clear statement" rule for tax exemptions and credits. *Fourth*, the IRS Rule is in any case not a reasonable construction of any ambiguity that may exist.

A. Because the Relevant Statutory Text Is Unambiguous, The IRS Has No Power To Construe It.

Where, as here, Congress has "unambiguously expressed [its] intent" in the statute, "that is the end of the matter," and no deference is afforded the agency. *Chevron*, 467 U.S. at 842-43. Two points are worth noting as to "Step One" of *Chevron*. *First*, judges "owe the agency no deference on the existence of ambiguity." *Am. Bar Ass'n v. FTC*, 430 F.3d 457, 468 (D.C. Cir. 2005) ("*ABA*"). Rather, the court must determine *de novo* whether the statute is ambiguous. *Second*, the inquiry into ambiguity is intended to identify whether Congress intended an "implicit delegation of authority to the agency." *Sea-Land Serv., Inc. v. Dep't of Transp.*, 137 F.3d 640, 645 (D.C. Cir. 1998). Thus, "ambiguity is not enough per se to warrant deference to the agency's interpretation. The ambiguity must be such as to make it appear that Congress either explicitly or implicitly delegated authority to cure that ambiguity." *ABA*, 430 F.3d at 469.

Here, the Government must therefore convince this Court, *de novo*, that "Exchange established by the State" is *ambiguous* as to whether it includes an Exchange established by HHS; and that, through that ambiguity, Congress was *implicitly directing the IRS to exercise its discretion* as to whether to make subsidies available in federal Exchanges. Neither is plausible. The Government has offered an attenuated, bizarre construction of the statute, but has not shown the sort of open-ended ambiguity that suggests a congressional intent to delegate. To

the contrary, Congress "has directly spoken to the precise question" of subsidy availability, and "that is the end of the matter." *Chevron*, 467 U.S. at 842.

B. No *Chevron* Deference Is Owed Given the ACA's Division of Authority Between HHS and the IRS.

1. The ACA subsidy provision is codified in the Internal Revenue Code, but neither the district court nor the Government contends that the language of *26 U.S.C. § 36B* is ambiguous. To the contrary, the court found that, standing alone, that provision favored Appellants' reading. (A350) It was only the provisions establishing state and federal Exchanges that purportedly made it plausible to construe the Act as extending subsidies to the latter. (A352-53) Yet the provisions that were critical to the district court's analysis are codified in a chapter of Title 42 of the U.S. Code—the domain of *HHS*, not the IRS. 42 U.S.C. §§ 18031, 18041.

Because the IRS has no power to enforce or administer those provisions, it is entitled to no deference when it purports to construe them. *U.S. Air Tour Ass'n v. FAA*, 298 F.3d 997, 1015-16 (D.C. Cir. 2002) (no deference to *FAA* where *Secretary of Interior* had "authority to interpret that [disputed] statutory term"); *Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.*, 250 F.3d 778, 782 (D.C. Cir. 2001) (no deference where agency interpretation rested, "in part," on "legislative enactments that are not part of its enabling statute"); *Cheney R.R. Co. v. R.R. Ret. Bd.*, 50 F.3d 1071, 1073-74 (D.C. Cir. 1995) (no deference where issue "turn[ed] on the interpretation" of laws that were "not the Board's governing

statutes"); *Dep't of Treasury v. Fed. Labor Relations Auth.*, 837 F.2d 1163, 1167 (D.C. Cir. 1988) ("[W]hen an agency interprets a statute other than that which it has been entrusted to administer, its interpretation is not entitled to deference."). Indeed, the IRS itself recognizes that it has no authority to construe the term "Exchange" in 42 U.S.C. §§ 18031 & 18041, which is why its Rule simply adopts *HHS's* definition. 26 C.F.R. § 1.36B-1(k). Subsidy eligibility under the IRS Rule is thus wholly dependent on *HHS's* definition of "Exchange," which was written for other purposes (*viz.*, for use in HHS's own regulations) and which HHS can change at any time, without any IRS input or control.

It does not matter that the subsidy provision in the Internal Revenue Code uses the term "Exchange" and cross-references one of the Title 42 provisions. The same dynamic was present in *American Federation of Government Employees v. Shinseki*, where a law administered by the Secretary of Veterans Affairs ("VA") used the term "collective bargaining" and cross-referenced the distinct Federal Service Labor-Management Relations Statute ("FSLMRS"). *See* 709 F.3d at 33. The latter statute defined "collective bargaining," and this Court held that it owed no deference "to the VA's interpretation of the FSLMRS because the VA does not administer that statute." *Id.* The same is true here: The key provisions under the district court's theory are provisions of Title 42 (§§ 18031 & 18041), but the IRS "does not administer" those, and so it is owed no deference. *See id.*

Conversely, the IRS Rule would not be entitled to deference had it been promulgated by HHS rather than the IRS. HHS administers §§ 18031 & 18041, but it does *not* administer the subsidy provision, 26 U.S.C. § 36B. It thus is owed no deference with respect to construction of the latter. *See supra*.

2. The impropriety of deference in this case is bolstered by this Court's precedents concerning situations in which more than agency administers the same statute. "When a statute is administered by more than one agency, a particular agency's interpretation is not entitled to *Chevron* deference." *Proffitt v. FDIC*, 200 F.3d 855, 860 (D.C. Cir. 2000). In such circumstances, "it cannot be said that Congress implicitly delegated to one agency authority to reconcile ambiguities or to fill gaps." *Salleh v. Christopher*, 85 F.3d 689, 692 (D.C. Cir. 1996); *accord DeNaples v. Office of Comptroller of Currency*, 706 F.3d 481, 488 (D.C. Cir. 2013) ("We have repeatedly pointed to the agencies' joint administrative authority … to justify refusing deference to their interpretations.").

The fact that deference is withheld even in the case of joint administration of the same statute establishes *a fortiori* that there is no deference here. Where two agencies enforce *one* statute, Congress could arguably have intended to delegate interpretive authority to both, but no such inference is possible where the agencies administer two *different* volumes of the U.S. Code. Put another way, since the statute at issue is *26* U.S.C. § 36B, Congress' delegation to *HHS* to administer *42*

U.S.C. §§ 18031 & 18041 is beside the point. HHS has authority to regulate the establishment of Exchanges. But its views are irrelevant to *tax* issues, as presented here. And the courts do not need the *IRS's* help to construe the tax provision, because it is concededly unambiguous; there are no "gaps" for the IRS to fill.

In short, no *Chevron* deference applies to the IRS Rule because the IRS does *not* administer the provisions purportedly creating the ambiguity to be resolved and the provision it *does* administer creates no ambiguity needing resolution. Since Congress intended neither for the IRS to construe Title 42 nor for HHS to construe the Internal Revenue Code, *Chevron* is simply inapplicable.

C. Moreover, *Chevron* Deference Is Displaced Here by the Venerable "Clear Statement" Rule for Tax Exemptions and Credits.

The premise of *Chevron* deference is that the agency has authority to resolve statutory ambiguity and consequently may expand the statute's reach beyond what its language unambiguously compels. But, under *Chevron*, ambiguity exists only if it remains after "employing traditional tools of statutory construction." *Chevron*, 467 U.S. at 843 n.9. Thus, "[i]f an interpretive principle resolves a statutory doubt in one direction, an agency may not reasonably resolve it in the opposite direction." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722 (6th Cir. 2013) (Sutton, J. concurring). Indeed, "[a]ll manner of presumptions, substantive canons and clear-statement rules take precedence over conflicting agency views." *Id.* Thus, where established principles of statutory construction require a clear or unambiguous

statement of congressional intent to infer certain results, an agency cannot construe ambiguous statutory text to achieve those results. A contrary rule would eliminate these canons entirely in the agency context. *See* Cass Sunstein, *Nondelegation Canons*, 67 U. CHI. L. REV. 315, 316 (2000) (such canons deprive agencies of their "ordinary discretion" to resolve ambiguity).

Thus, for example, if a statute is ambiguous but one construction "would raise serious constitutional problems," there is no deference to an agency adopting it; rather, the court will adopt the contrary construction unless "plainly contrary to the intent of Congress." *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 574-75 (1988); *accord Nat'l Mining Ass'n v. Kempthorne*, 512 F.3d 702, 711 (D.C. Cir. 2008) ("canon of constitutional avoidance trumps *Chevron* deference"). Similarly, in *EEOC v. Arabian American Oil Co.*, 499 U.S. 244 (1991), a statute was "ambiguous" as to whether it applied overseas, but the Court held that the EEOC's view that it did could not "overcome the presumption against extraterritorial application." *Id.* at 250, 258. Justice Scalia elaborated that, in light of that presumption, the EEOC could not infer extraterritoriality from "mere implications" from ambiguous language. *Id.* at 260 (Scalia, J., concurring in part and in judgment). Likewise, in *INS v. St. Cyr*, 533 U.S. 289 (2001), the Court held that the presumption against retroactivity means that "a statute that is ambiguous with respect to retroactive application is

construed … to be unambiguously prospective," such that "there is, for *Chevron* purposes, no ambiguity in such a statute." *Id.* at 320 n.45. There are many more examples of cases holding that various presumptions and clear statement rules effectively trump or displace *Chevron* by giving the ambiguity itself a dispositive meaning. *See, e.g.*, *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444-45 & n.8 (D.C. Cir. 1988) (refusing to defer because Indian law canon provides that if law "can reasonably be construed" in Tribe's favor, "it *must* be construed that way"); *Cal. State Bd. of Optometry v. FTC*, 910 F.2d 976, 982 (D.C. Cir. 1990) ("An agency may not exercise authority over States as sovereigns unless that authority has been unambiguously granted to it."). In short, in these circumstances the interpretive principle, rather than the agency, resolves the ambiguity.

As explained earlier, the Supreme Court has adopted a canon holding that tax credits "must be expressed in clear and unambiguous terms." *Yazoo*, 132 U.S. at 183; *accord Wells Fargo Bank*, 485 U.S. at 354; *Stichting*, 129 F.3d at 198.[8] Such benefits "must rest … on more than a doubt or ambiguity." *United States v. Stewart*, 311 U.S. 60, 71 (1940); *see also Telecom*USA, Inc. v. United States*, 192 F.3d 1068, 1072 (D.C. Cir. 1999) ("[A] taxpayer who seeks a deduction bears the

---

[8] While some of these cases speak of tax *exemptions*, the same principle governs tax *deductions* and *credits*, too. *See MedChem (P.R.), Inc. v. Comm'r*, 295 F.3d 118, 123 (1st Cir. 2002) ("deduction or credit"); *Randall v. Comm'r*, 733 F.2d 1565, 1567 (11th Cir. 1984) (per curiam) ("deductions or credits").

burden of demonstrating a clear entitlement."). Only that admittedly "extremely high standard" properly respects Congress's "exclusive authority" over taxation and public spending. *Stichting*, 129 F.3d at 197-98.

In light of this well-established rule for how to treat ambiguity in the Tax Code—namely, allowing money to be drawn from the Treasury only when the congressional custodian of the federal purse has unambiguously authorized a withdrawal—*Chevron* deference is displaced with respect to this dispute over the proper interpretation of 26 U.S.C. § 36B. Just as canons prevent agencies from applying ambiguous laws extraterritorially, retroactively or to create constitutional doubts, the clear statement rule of *Yazoo* and *Wells Fargo Bank* prevents agencies from providing a tax credit unless Congress has *unambiguously* allowed it. The availability of § 36B tax credits in federal Exchanges "must be unambiguously proved," *Wells Fargo Bank*, 485 U.S. at 354; the IRS cannot by regulation extend or expand the credits by resting on "doubt or ambiguity" in the ACA, *Stewart*, 311 U.S. at 71. As such, any ambiguity in § 36B must as a matter of law be construed against availability of the subsidy, and so "there is, for *Chevron* purposes, no ambiguity in [the] statute for [the IRS] to resolve." *St. Cyr*, 533 U.S. at 320 n.45. Put another way, so long as § 36B "can reasonably be construed" to restrict the ACA's premium tax credit to state-established Exchanges, "it *must* be construed that way." *Muscogee (Creek) Nation*, 851 F.2d at 1445.

D. In All Events, the IRS Rule Is Not a Reasonable Construction of the ACA's Text.

Even setting aside all of the above, and assuming there exists some ambiguity in the ACA and that the IRS has been delegated authority to construe it, the IRS Rule would *still* fail at "Step Two" of the *Chevron* analysis, which asks whether the agency's construction is "reasonable."

As this Court has explained, "[i]f a statute is ambiguous, an agency that administers the statute may choose a reasonable interpretation of that ambiguity—but the agency's interpretation *must still stay within the boundaries of the statutory text*." *EME Homer City Generation, L.P. v. EPA*, 696 F.3d 7, 23 (D.C. Cir. 2012) (emphasis added). Under Step Two of *Chevron*, "the court's deference to the [agency] is still limited by the particular language" of the statute; "whatever ambiguity may exist cannot render nugatory restrictions that Congress has imposed." *Am. Fed'n of Labor & Cong. of Indus. Orgs. v. Chao*, 409 F.3d 377, 384 (D.C. Cir. 2005). *Chevron*'s second step is "thus not independent of the first: what a court may consider a reasonable interpretation largely depends on the nature and extent of the ambiguity already identified in *Chevron*'s first step." *Massachusetts v. U.S. Dep't of Transp.*, 93 F.3d 890, 893 (D.C. Cir. 1996).

For reasons discussed above, the IRS Rule is not a *reasonable* construction of the ACA. Any ambiguity that may exist cannot justify ignoring the statutory text, rejecting the numerous applicable canons of construction, and eliminating the

incentives Congress created for states to establish Exchanges. The IRS Rule "render[s] nugatory" Congress's restrictions on subsidies, and therefore cannot survive. *Am. Fed'n of Labor*, 409 F.3d at 384. Even assuming the IRS has "some wiggle room …, the statute's language is not as capacious as the agency suggests." *EchoStar Satellite LLC v. FCC*, 704 F.3d 992, 997 (D.C. Cir. 2013).

III. ALTHOUGH IT DOES NOT MATTER HERE, THE EMPLOYERS' CLAIMS ARE NOT BARRED BY THE ANTI-INJUNCTION ACT.

With respect to the employer plaintiffs, the district court held that their claims were barred by the Anti-Injunction Act ("AIA"), which prohibits suits "for the purpose of restraining the assessment or collection of any tax." 26 U.S.C. § 7421(a). Although this issue is of no practical relevance given that Klemencic indisputably has standing and concededly is not barred by the AIA (A335 & A340 n.8), the district court was wrong on this point.

A. The Employer Mandate's "Assessable Payments" Are Not Taxes for AIA Purposes.

The premise of the AIA objection to the employers' challenge is that the "assessable payments" imposed by the ACA for violation of the employer mandate are a "tax" for purposes of the AIA. But that basic premise fails. As the Fourth Circuit has squarely held—in a decision acknowledged but rejected by the district court—those assessable payments are *not* taxes for AIA purposes.

In *Liberty University, Inc. v. Lew*, the Fourth Circuit held that the AIA did not bar a direct challenge to the employer mandate. The court observed that "the AIA applies only where Congress intends it to," and so the dispositive question was whether Congress intended the assessable payments to be treated as a "tax" for AIA purposes. 733 F.3d 72, 87 (4th Cir. 2013). To resolve that question, the court looked to the ACA's text, which "initially identifies the employer mandate exaction as an 'assessable payment,'" not a "tax," and proceeds to so characterize it "six more times." *Id.* at 88. Congress used the word "tax" only twice, and the court found that one of the two uses was only because "use of another word would create confusion" elsewhere about how to determine deductibility. *Id.* Reviewing the word's other appearance, the court refused to "place much significance on a *single* unexplained use of that term," because "Congress initially and primarily refers to the exaction as an 'assessable payment' and not a 'tax,'" suggesting that "Congress did not intend the exaction to be treated as a tax for purposes of the AIA." *Id.* Confirming that, Congress "did not otherwise indicate that the employer mandate exaction qualifies as a tax for AIA purposes." *Id.* And it would be "anomalous" if an individual could challenge the *individual* mandate pre-enforcement yet an employer "could bring only a *post*-enforcement suit" challenging the employer mandate. *Id.* Congress likely intended the mandates to be treated equivalently, with neither subject to the AIA. *See id.*

Liberty University's straightforward reasoning is persuasive and should be followed here. Because the employer mandate's "assessable payments" were not intended to be "taxes" under the AIA, the employer plaintiffs are clearly not barred.

Rejecting the Fourth Circuit's reasoning, the district court concluded "that Congress saw no distinction between the two terms." (A343) But the Supreme Court in *NFIB* held that the Internal Revenue Code makes a "consistent distinction between the terms 'tax' and 'assessable penalty.'" 132 S. Ct. at 2584. The district court also relied on the fact that the employer mandate appears in the Internal Revenue Code, is enforced by the IRS, and serves a "revenue-raising function." (A344-45) But each of those points was equally true of the individual mandate penalty, yet the Supreme Court held that it was *not* a tax for AIA purposes, given that it was not labeled as such. *NFIB*, 132 S. Ct at 2582-84. Finally, the district court noted that Congress created a mechanism by which employers can recoup assessable payments triggered by employees who improperly collected subsidies to which they were not entitled. (A345) But provision of an after-the-fact remedy for that unique scenario hardly suggests that Congress intended to bar employers from pursuing *all* challenges to the mandate (even *facial* ones) pre-enforcement.

B. In Any Event, the AIA Does Not Apply Because This Suit Does Not Seek To Invalidate or Enjoin the Employer Mandate.

1. The text of the AIA limits its force to suits that whose "purpose" is to "restrai[n] the assessment or collection" of a tax. 26 U.S.C. § 7421(a). "The Anti-

Injunction Act only bars suits that seek to restrain the IRS's assessment and collection of taxes." *Seven-Sky v. Holder*, 661 F.3d 1, 9 (D.C. Cir. 2011). Thus, "the Act does not apply to an IRS regulation that does not, by its terms, pertain to the assessment or collection of taxes." *Id.* (citing *Foodservice & Lodging Inst., Inc. v. Regan*, 809 F.2d 842 (D.C. Cir. 1987) (per curiam)). Nor does it preclude "other claims seeking to enjoin the IRS, regardless of any attenuated connection" to taxes. *Cohen v. United States*, 650 F.3d 717, 727 (D.C. Cir. 2011) (en banc). In short, precedent "does not support reading the AIA to reach all disputes tangentially related to taxes. Quite the opposite." *Id.*

Even if the employer mandate's assessable payments were "taxes," this suit does not "seek to restrain the IRS's assessment and collection" of such. *Seven-Sky*, 661 F.3d at 9. The employers (like the individual plaintiffs) seek "a declaratory judgment that the IRS Rule is illegal under the Administrative Procedure Act, and injunctive relief barring its enforcement," not a declaration or injunction restraining the *employer mandate*. (A18 ¶ 8) And the IRS Rule, of course, has nothing to do with assessing or collecting taxes. Rather, it concerns *subsidies*. Invalidating the Rule thus only restrains granting a subsidy, not collecting a tax.

To be sure, an *effect* of success in this challenge would be to prevent any assessable payments from being triggered in certain states—but the AIA is not concerned with downstream effects, only the suit's direct "purpose." The AIA

bars suits with the "*purpose*" of "*restraining*" taxes, not those with the "*effect*" of "*reducing*" them. Tellingly, there is not a *single case* that has applied the AIA to bar a challenge based merely on downstream tax *consequences*; expanding the AIA to preclude such suits would be a novel and dramatic change in the law.

2. The district court reasoned that that the employer plaintiffs' *motive* is to avoid the subsidies' downstream, collateral consequence—the employer mandate penalty. (A341-42) True. But the AIA turns on the *suit's object*, not the *plaintiff's subjective motive*. Such judicial psychoanalysis produces the absurd result that *Klemencic's* suit is not barred by the AIA, but the employer plaintiffs' is, even though they are co-plaintiffs on the *same* Complaint. Again, not a single case has applied the AIA to bar a suit that did not directly seek to enjoin a tax, simply due to the plaintiff's subjective motive. *Alexander v. 'Americans United' Inc.*, 416 U.S. 752 (1974), challenged IRS revocation of tax-exempt status; *restraining* the IRS from *taxing* the organization's donors was the *direct* object and *only* practical effect of the suit. That is not true of this suit, which seeks to invalidate *subsidies* (not the employer mandate penalty) and has obvious non-tax consequences.

CONCLUSION

For these reasons above, Appellants respectfully ask this Court to reverse the judgment below and vacate the IRS Rule.

January 30, 2014

Respectfully submitted,

/s/ Michael A. Carvin
MICHAEL A. CARVIN
Lead Counsel
YAAKOV M. ROTH
JONATHAN BERRY
JONES DAY
51 Louisiana Ave. N.W.
Washington, DC 20001
Telephone: (202) 879-3939
Email: macarvin@jonesday.com

Counsel for Appellants

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 13,941 words, excluding the parts of the brief exempted by that Rule and D.C. Cir. R. 32(a)(1), as counted using the word-count function on Microsoft Word 2007 software.

January 30, 2014

/s/ Michael A. Carvin
MICHAEL A. CARVIN
Counsel for Appellants

CERTIFICATE OF SERVICE

I hereby certify that, on this 30th day of January 2014, I electronically filed the original of the foregoing document with the clerk of this Court by using the CM/ECF system. I certify that the participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system. Pursuant to this Court's order, I also filed eight copies of the foregoing document, by hand delivery, with the clerk of this Court.

January 30, 2014

/s/ Michael A. Carvin
MICHAEL A. CARVIN
Counsel for Appellants

STATUTORY & REGULATORY ADDENDUM

No. 14-5018

Jacqueline Halbig, *et al.*, Appellants
v.

Kathleen Sebelius, Secretary of Health and Human Services *et al.*, Respondents.

APPELLANTS' STATUTORY & REGULATORY ADDENDUM TABLE OF CONTENTS

Reproduction of Relevant Authorities:

42 U.S.C. § 18031 (ACA § 1311) 1A

42 U.S.C. § 18041 (ACA § 1321) 16A

26 U.S.C. § 36B (ACA § 1401(a)) 19A

26 U.S.C. § 7421(a) 30A

26 C.F.R. § 1.36B (Excerpts) 31A

45 C.F.R. § 155.20 (Excerpts) 33A

42 U.S.C. §18031 (ACA § 1311)

§18031. Affordable choices of health benefit plans

(a) Assistance to States to establish American Health Benefit Exchanges

(1) Planning and establishment grants.--There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) Amount specified.--For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) Use of funds.--A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) Renewability of grant.--

(A) In general.--Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant-

(i) is making progress, as determined by the Secretary, toward-

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) Limitation.-- No grant shall be awarded under this subsection after January 1, 2015.

(5) Technical assistance to facilitate participation in SHOP Exchanges.-- The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) American Health Benefit Exchanges.--

(1) In general.-- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title 1 as an "Exchange") for the State that-

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title 1 referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) Merger of individual and SHOP Exchanges.--A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary.--

(1) In general.--The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum-

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act [42 U.S.C. 300gg–1(c)]), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and

providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r–8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options;

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act [42 U.S.C. 280j–2], as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act [42 U.S.C. 1320b–9a].

(2) Rule of construction.--Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such

paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) Rating system.--The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) Enrollee satisfaction system.--The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) Internet portals.--

The Secretary shall-

(A) continue to operate, maintain, and update the Internet portal developed under section 18003(a) of this title and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 1 of the Public Health Service Act and to a copy of the plan's written policy.

(6) Enrollment periods.--The Secretary shall require an Exchange to provide for-

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of title 26 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.]; and

(D) special monthly enrollment periods for Indians (as defined in section 1603 of title 25).

(d) Requirements.--

(1) In general.--An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) Offering of coverage.--

(A) In general.--An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) Limitation.--

(i) In general.--An Exchange may not make available any health plan that is not a qualified health plan.

(ii) Offering of stand-alone dental benefits.--Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of title 26 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 18022(b)(1)(J) of this title).

(3) Rules relating to additional required benefits.--

(A) In general.--Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law

that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

(B) States may require additional benefits.--

(i) In general.--Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.

(ii) State must assume cost.--A State shall make payments-

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).

(4) Functions.--An Exchange shall, at a minimum-

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act [42 U.S.C. 300gg–15];

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social

Security Act [42 U.S.C. 1396 et seq.], the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.], or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of title 26 and any costsharing reduction under section 18071 of this title;

(H) subject to section 18081 of this title, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of title 26, an individual is exempt from the individual requirement or from the penalty imposed by such section because-

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury-

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of title 26 because-

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such title to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 18081(b)(4) of this title that they have changed employers and of each individual who ceases coverage under a

qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) Funding limitations.--

(A) No Federal funds for continued operations.--In establishing an Exchange under this section, the State shall ensure that such Exchange is selfsustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds.--In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) Consultation.--An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including-

(A) educated health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs.--An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Certification.--

(1) In general.--An Exchange may certify a health plan as a qualified health plan if-

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan-

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) Premium considerations.--The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act [42 U.S.C. 300gg–94(b)(1)] (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(3) Transparency in coverage.--

(A) In general.--The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under this title.

(ix) Other information as determined appropriate by the Secretary.

(B) Use of plain language.--The information required to be submitted under subparagraph (A) shall be provided in plain language. The term “plain language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) Cost sharing transparency.--The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) Group health plans.--The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

(f) Flexibility.--

(1) Regional or other interstate exchanges.--An Exchange may operate in more than one State if-

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) Subsidiary Exchanges.--A State may establish one or more subsidiary Exchanges if-

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act [42 U.S.C. 300gg(a)].

(3) Authority to contract.--

(A) In general.--A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) Eligible entity.--In this paragraph, the term "eligible entity" means-

(i) a person-

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of title 26 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

(g) Rewarding quality through market-based incentives.--

(1) Strategy described.--A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for-

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) Guidelines.--The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) Requirements.--The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) Quality improvement.--

(1) Enhancing patient safety.--Beginning on January 1, 2015, a qualified health plan may contract with-

(A) a hospital with greater than 50 beds only if such hospital-

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act [42 U.S.C. 299b–21 et seq.]; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) Exceptions.--The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) Adjustment.--The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) Navigators.--

(1) In general.--An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) Eligibility.--

(A) In general.--To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or selfemployed individuals likely to be qualified to enroll in a qualified health plan.

(B) Types.--Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that-

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) Duties.--An entity that serves as a navigator under a grant under this subsection shall-

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act [42 U.S.C. 300gg–93], or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) Standards.--

(A) In general.--The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not-

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) Fair and impartial information and services.--The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) Funding.--Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) Applicability of mental health parity.--Section 2726 of the Public Health Service Act [42 U.S.C. 300gg–26] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) Conflict.--An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subchapter.

42 U.S.C. §18041 (ACA § 1321)

§18041. State flexibility in operation and enforcement of Exchanges and related requirements

(a) Establishment of standards.--

(1) In general.--The Secretary shall, as soon as practicable after March 23, 2010, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to-

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part E; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act [42 U.S.C. 201 et seq.].

(2) Consultation.--In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) State action.--Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect-

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) Failure to establish Exchange or implement requirements.--

(1) In general.--

If-

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State-

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement-

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

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.

(2) Enforcement authority.--The provisions of section 2736(b) 1 of the Public Health Services 2 Act [42 U.S.C. 300gg–22(b)] shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) No interference with State regulatory authority.--Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) Presumption for certain State-operated Exchanges.--

(1) In general.--In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process

established under paragraph (2), that the Exchange does not comply with such standards.

(2) Process.--The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

26 U.S.C. §36B (ACA § 1401(a))

§36B. Refundable credit for coverage under a qualified health plan

(a) In general.--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.

(b) Premium assistance credit amount.--For purposes of this section-

(1) In general.--The term "premium assistance credit amount" means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(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 1 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.

(3) Other terms and rules relating to premium assistance amounts.--For purposes of paragraph (2)-

(A) Applicable percentage.--

(i) In general.--Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a

linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%.

(ii) Indexing.--

(I) In general.--Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

(II) Additional adjustment.--Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) Failsafe.--Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

(B) Applicable second lowest cost silver plan.--The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which-

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides-

(I) self-only coverage in the case of an applicable taxpayer-

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

(C) Adjusted monthly premium.--The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) Additional benefits.—

If-

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

(E) Special rule for pediatric dental coverage.--For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) 2 of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) Definition and rules relating to applicable taxpayers, coverage months, and qualified health plan.--For purposes of this section-

(1) Applicable taxpayer.--

(A) In general.--The term “applicable taxpayer” means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

(B) Special rule for certain individuals lawfully present in the United States.--

If-

(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status, the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) Married couples must file joint return.--If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(D) Denial of credit to dependents.--No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) Coverage month.--For purposes of this subsection-

(A) In general.--The term “coverage month” means, with respect to an applicable taxpayer, any month if-

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) Exception for minimum essential coverage.--

(i) In general.--The term “coverage month” shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) Minimum essential coverage.--The term “minimum essential coverage” has the meaning given such term by section 5000A(f).

(C) Special rule for employer-sponsored minimum essential coverage.-- For purposes of subparagraph (B)-

(i) Coverage must be affordable.--Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage-

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) Coverage must provide minimum value.--Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

(iii) Employee or family must not be covered under employer plan.-- Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) Indexing.--In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in

the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) Definitions and other rules.--

(A) Qualified health plan.--The term “qualified health plan” has the eaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) Grandfathered health plan.--The term “grandfathered health plan” has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(d) Terms relating to income and families.--For purposes of this section-

(1) Family size.--The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) Household income.--

(A) Household income.--The term “household income” means, with respect to any taxpayer, an amount equal to the sum of-

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who-

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) Modified adjusted gross income.--The term “modified adjusted gross income” means adjusted gross income increased by-

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) Poverty line.--

(A) In general.--The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) Poverty line used.--In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) Rules for individuals not lawfully present

(1) In general.--If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present-

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which-

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction-

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present.--For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority.--The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Reconciliation of credit and advance credit.--

(1) In general.--The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) Excess advance payments

(A) In general.--If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) Limitation on increase

(i) In general.--In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in

no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	$600
At least 200% but less than 300%	$1,500
At least 300% but less than 400%	$2,500.

(ii) Indexing of amount.--In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to-

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(3) Information requirement.--Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) Regulations.--The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for-

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

26 U.S.C. §7421(a)

§7421. Prohibition of suits to restrain assessment or collection

(a) Tax.--Except as provided in sections 6015(e), 6212(a) and (c), 6213(a), 6225(b), 6246(b), 6330(e)(1), 6331(i), 6672(c), 6694(c), and 7426(a) and (b)(1), 7429(b), and 7436, no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed.

<u>26 C.F.R. § 1.36B (Excerpts)</u>

§1.36B-1 Premium tax credit definitions.

…

(k) *Exchange.* Exchange has the same meaning as in 45 CFR 155.20.

…

§1.36B-2 Eligibility for premium tax credit.

(a) *In general.* An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that one or more members of the applicable taxpayer's family (the applicable taxpayer or the applicable taxpayer's spouse or dependent)—

(1) Is enrolled in one or more qualified health plans through an Exchange; and

(2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

…

§1.36B-3 Computing the premium assistance credit amount.

(a) *In general.* A taxpayer's premium assistance credit amount for a taxable year is the sum of the premium assistance amounts determined under paragraph (d) of this section for all coverage months for individuals in the taxpayer's family.

(b) *Definitions.* For purposes of this section—

(1) The cost of a qualified health plan is the premium the plan charges; and

(2) The term *coverage family* refers to members of the taxpayer's family who enroll in a qualified health plan and are not eligible for minimum essential coverage (other than coverage in the individual market).

(c) *Coverage month*—(1) *In general.* A month is a coverage month for an individual if—

(i) As of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange;

(ii) The taxpayer pays the taxpayer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the taxpayer's income tax return for that taxable year, or the full premium for the month is paid by advance credit payments; and

(iii) The individual is not eligible for the full calendar month for minimum essential coverage (within the meaning of §1.36B-2(c)) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(2) *Premiums paid for a taxpayer.* Premiums another person pays for coverage of the taxpayer, taxpayer's spouse, or dependent are treated as paid by the taxpayer.

…

45 C.F.R. 155.20 (Excerpts)

§155.20 Definitions.

The following definitions apply to this part:

…

Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a SHOP serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.

…

Federally-facilitated Exchange means an Exchange established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

…