[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.,

Plaintiffs-Appellants,

v.

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

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA (No. 1:13-cv-00623-PLF) (Hon. Paul L. Friedman)

BRIEF FOR THE APPELLEES

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CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

A. Parties and Amici

Plaintiffs-appellants are 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.

Defendants-appellees are the U.S. Department of Health and Human Services (HHS); HHS Secretary Kathleen Sebelius; the U.S. Department of the Treasury; Treasury Secretary Jacob J. Lew; the Internal Revenue Service (IRS), and IRS Commissioner John Koskinen.

The following *amici* are listed on the Court's docket: America's Health Insurance Plans; Pacific Research Institute; AARP; National Federation of Independent Business Legal Center; Cato Institute; American Hospital Association; Jonathan Adler; Michael Cannon; States of Oklahoma, Alabama, Georgia, West Virginia, Nebraska, South Carolina, Kansas, Michigan; Consumer's Research; Galen Institute; Members of Congress John Cornyn, Ted Cruz, Orrin G. Hatch, Mike Lee, Rob Portman, Marco Rubio, Dave Camp, and Darrell Issa. Families USA and the Commonwealth of Virginia participated as amici in district court.

B. Ruling Under Review

Plaintiffs have appealed the final judgment entered in the government's favor on January 15, 2014. The order (Docket Entry #66) and accompanying opinion (Docket Entry #67) were issued by the Honorable Paul L. Friedman in No. 1:13-cv-00623-PLF (D.D.C.).

C. Related Cases

This case has not previously been before this Court or any other court. We are unaware of any related cases within the meaning of Circuit Rule 28.

/*s/ Alisa B. Klein*
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Counsel for the Appellees

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GLOSSARY

ACA	Patient Protection and Affordable Care Act
APA	Administrative Procedure Act
CBO	Congressional Budget Office
HHS	U.S. Department of Health & Human Services
NAIC	National Association of Insurance Commissioners

STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331. The district court entered final judgment on January 15, 2014. Plaintiffs filed a notice of appeal on January 15, 2014. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly rejected plaintiffs' contention that the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") authorizes federal premium tax credits only for individuals who purchase health insurance on a state-run Exchange, and not for individuals who purchase health insurance on a federally-run Exchange.

2. Whether plaintiffs' claims also fail on threshold grounds.

STATUTES AND REGULATIONS

Pertinent provisions are reproduced in appellants' addendum.

STATEMENT OF THE CASE

I. Statutory Background

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119,[1] "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB v.*

[1] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

Sebelius, 132 S. Ct. 2566, 2580 (2012). This case concerns interrelated provisions of Title I of the Act that, working in tandem, will substantially increase participation in private health insurance markets.[2]

A. The Group and Non-group Health Insurance Markets

Most Americans with private health insurance coverage receive that coverage through an employer-sponsored group health plan. *See* Congressional Budget Office ("CBO"), *Key Issues in Analyzing Major Health Insurance Proposals* xi (2008) ("*Key Issues*"). "One fundamental reason such plans are popular is that they are subsidized through the tax code." *Ibid*. Congress has provided these tax subsidies for many decades and, in 2007 alone, the federal tax subsidy for employment-based health coverage was $246 billion. *Id*. at 31.

Congress has long regulated certain terms of employer-sponsored group health coverage. Federal law generally bars group health plans from excluding individuals based on health status-related factors or charging different premiums for similarly situated employees based on such factors. *See id*. at 79; *see also* 42 U.S.C. § 300gg-1 (2006); 29 U.S.C. § 1182 (2006 & Supp. III 2009).

Before the Affordable Care Act, these federal efforts to make affordable health coverage widely available left a significant gap. Health insurance purchased

[2] Other titles of the Affordable Care Act address public health benefits programs such as Medicaid and Medicare.

in the "non-group market" (also known as the "individual market") generally did not receive favorable federal tax treatment, so the purchasers had to bear the full costs of premium payments. *Key Issues* 9. Moreover, federal law generally did not prevent insurers in the non-group market from increasing premiums, or denying coverage altogether, based on an individual's medical condition or history. Without such rules, insurers denied coverage to or charged higher premiums for individuals with conditions as common as high blood pressure, asthma, ear infections, and pregnancy. *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong., 2d Sess. 52 (2008) (Statement of Prof. Mark Hall); Ed Neuschler, *Policy Brief on Tax Credits for the Uninsured and Maternity Care* 3 (2004). A 2010 survey found that 35% of non-elderly adults who tried to purchase health insurance in the non-group market in the previous three years (about 9 million people) were denied coverage, charged a higher premium, or offered restricted coverage because of their medical condition or history. Sara R. Collins *et al.*, *Help on the Horizon, Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010* xi & Exh. ES-2.

Because of the high cost of policies sold in the non-group insurance market and restrictions on coverage, participation in that market was low even among those who lacked other health coverage options. *Key Issues* at 46. Of the 45 million individuals who lacked access to an employer-sponsored group plan or

government health benefits program in 2009, only about 20% were covered by a policy purchased in the non-group insurance market. *Ibid*. The remaining 80% were uninsured. *Ibid*.

B. The Affordable Care Act's Reforms of the Non-group Market

In Title I of the Affordable Care Act, Congress enacted a set of provisions that work in tandem to reform the non-group health insurance market. As discussed above, before the Act's passage, that market was characterized by high premiums, restrictive insurance industry practices, and low participation.

Premium tax credits. To provide "Affordable Coverage Choices for All Americans," ACA Title I, Subtitle E, Congress provided favorable federal tax treatment for certain health insurance obtained in the non-group market. The Act establishes federal tax credits that assist eligible individuals with household income between 100% and 400% of the federal poverty level to pay premiums for non-group insurance policies on the health insurance Exchanges created pursuant to the Act. *See* ACA § 1401, *codified at* 26 U.S.C. § 36B ("Section 36B").[3] These premium tax credits help to make health insurance affordable by reducing a taxpayer's net cost of insurance. For eligible individuals with income between 100% and 250% of the federal poverty level, the Act also authorizes federal

[3] The federal poverty level for an individual is currently $11,670, except in Alaska and Hawaii. *See* 79 Fed. Reg. 3593 (Jan. 22, 2014).

payments to insurers to help cover those individuals' cost-sharing expenses (such as co-payments or deductibles) for certain insurance obtained through an Exchange. ACA § 1402, *codified at* 42 U.S.C. § 18071(c)(2).

CBO projected in 2009 that 78% of people who would buy non-group insurance policies through Exchanges (18 million of 23 million) would receive premium tax credits, and that those credits, on average, would cover nearly two-thirds of the premium. *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 24 (Nov. 30, 2009) (JA 144). More recent CBO projections indicate that the average tax subsidy will be $5,290 per person in 2014, rising to $7,900 in 2023, and that, by 2018, 80% of people who buy non-group policies through the Exchanges (20 million of 25 million) will receive premium tax credits. CBO, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act: May 2013 Baseline*, tables 1 & 3 (May 14, 2013) (JA 116, 118). CBO projected that federal subsidies for insurance purchased on the Exchanges will total $33 billion in 2014, rising to $153 billion by 2023. *Id*., table 3 (JA 118).

Guaranteed-issue and community-rating requirements. To eliminate restrictive insurance industry practices that prevented people from obtaining affordable coverage in the non-group market, Congress prohibited insurers, starting in 2014, from denying new coverage to any person because of medical condition or

history (the guaranteed-issue requirement, *codified at* 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a)) and from charging higher premiums for such coverage because of a person's medical condition or history (the community-rating requirement, *codified at* 42 U.S.C. §§ 300gg(a)(1), 300gg-4(b)). *See* ACA § 1201. Congress thereby extended to the non-group market norms of non-discrimination parallel to those already applicable to group health plans.

Minimum coverage provision. To ensure that individuals who can afford coverage do not delay the purchase of insurance until they are sick or injured, Congress provided that non-exempted individuals must maintain a minimum level of health coverage for themselves and their dependents or pay a tax penalty. *See* ACA § 1501, *codified at* 26 U.S.C. § 5000A. Congress exempted from this tax penalty individuals who cannot afford coverage, including individuals who cannot afford coverage even with the benefit of the premium tax credits provided under Section 36B. *See* 26 U.S.C. § 5000A(e)(1).

Exchanges. Congress provided for the creation of health insurance Exchanges to serve "as an organized and transparent marketplace for the purchase of health insurance where individuals . . . can shop and compare health insurance options." H.R. Rep. No. 111-443, pt. II, at 976 (2010) (quotation marks and citation omitted). Section 1311 of the Act provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange

(referred to in this title as an 'Exchange')" that "facilitates the purchase of qualified health plans." ACA § 1311(b)(1), *codified at* 42 U.S.C. § 18031(b)(1)). If, however, a State elects not to establish an Exchange, or if the Secretary of Health and Human Services ("HHS") determines that the State will not establish an Exchange that is consistent with federal standards, Section 1321 of the Act provides that the Secretary of HHS "shall . . . establish and operate such Exchange within the State[.]" ACA § 1321(c)(1), *codified at* 42 U.S.C. § 18041(c)(1).

* * *

When Congress enacted the ACA Title I provisions discussed above, Congress understood that the extension of nondiscrimination norms—*i.e.*, the guaranteed-issue and community-rating requirements—to the non-group market would undermine that market unless these new regulations of the insurance industry were coupled with the premium tax credits and the minimum coverage provision. CBO advised Congress that, by themselves, the guaranteed-issue and community-rating requirements would result in "adverse selection" that would "increase premiums in the exchanges relative to nongroup premiums under current law." *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 19 (Nov. 30, 2009) (JA 139).

CBO also concluded, however, that "several other provisions of the proposal would tend to mitigate that adverse selection." *Ibid*. Most notably, CBO

determined that there would be "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed." *Id*. at 6 (JA 126). CBO advised Congress that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people." *Id*. at 19-20 (JA 139-140) (explaining that, for people whose income was below 200% of the federal poverty level, those subsidies would average about 80% of the premium payments). Furthermore, CBO concluded that the structure of the federal tax credits for premium payments would mitigate the impact of adverse selection. Under the Act, "[t]he premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees[.]" *Id*. at 20 (JA 140). Instead, "federal subsidy payments would have to rise to make up the difference." *Ibid*. CBO informed Congress that the premium tax credits "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." *Ibid*. Taking the premium tax credits, minimum coverage provision, and other mitigating influences into account, CBO concluded that the extent of adverse selection in the non-group market "is likely to be limited[.]" *Ibid*.[4]

[4] The other mitigating influences noted by CBO were an annual open

Continued on next page.

State insurance regulators likewise advised Congress that the premium tax credits and minimum coverage provision were necessary to protect insurance markets operating under guaranteed-issue and community-rating rules. The National Association of Insurance Commissioners ("NAIC") offered "the experience and expertise of the states to Congress as it attempt[ed] to improve the health insurance marketplace." *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-503 (2009) (statement of Sandy Praeger, Kansas Commissioner of Insurance, on behalf of the NAIC). "Based on that experience and expertise," the NAIC emphasized the need to avoid adverse selection. *Id*. at 503, 504. The NAIC explained that proposals for "guaranteed issue and elimination of preexisting condition exclusions for individuals" could "result in severe adverse selection," and the NAIC advised Congress that "State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Id*. at 504.

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enrollment period that would limit opportunities for people to wait until a health problem arose before enrolling in non-group market coverage, and a temporary reinsurance program that would limit the impact of adverse selection on premiums during the transitional 2014-2016 period.

Accordingly, Congress coupled the Act's guaranteed-issue and community-rating requirements with the minimum coverage provision and billions of dollars of federal tax credits that will pay the lion's share of the premium for most individuals who buy coverage on an Exchange. Congress found that the premium tax credits "are *key* to ensuring people affordable health coverage." H.R. Rep. No. 111-443, vol. 1, at 250 (March 17, 2010) (JA 69) (emphasis added).

II. Factual Background and District Court Proceedings

Plaintiffs are four individuals, joined by a group of affiliated Texas restaurants and two other employers. *See* JA 332 n.3 (district court opinion). They contend that the Affordable Care Act authorizes federal premium tax credits only for insurance purchased on state-run Exchanges and not for insurance purchased on federally-run Exchanges, which would mean that federal premium tax credits would be unavailable in more than half of the States. "While sixteen states and the District of Columbia have elected to set up their own Exchanges, thirty-four states rely on federally-facilitated Exchanges." JA 328. "Seven of these thirty-four states have chosen to assist the federal government with its operation of federally-run Exchanges, while twenty-seven states have declined to undertake any aspect of Exchange implementation." *Ibid.*

The government moved to dismiss the complaint on various threshold grounds, including standing, the availability of an adequate statutory review

proceeding within the meaning of the Administrative Procedure Act ("APA"), and, with respect to the employer plaintiffs, the Anti-Injunction Act bar. *See* R.23.

One of the four individual plaintiffs, David Klemencic, submitted declarations attempting to show he would be injured by premium tax credits. *See* R.24-1; R.24-2. Mr. Klemencic was a plaintiff in *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012), *see* JA 30, where he argued that Congress lacked the power to require him to choose between maintaining a minimum level of health coverage or paying a tax penalty. The Supreme Court rejected that contention and upheld Section 5000A as a proper exercise of Congress's taxing power. *See NFIB*, 132 S. Ct. at 2593-2600.

In this suit, Mr. Klemencic contends that he should not have to make that choice because he would qualify for the "unaffordability exemption" in Section 5000A if he were not eligible for the premium tax credits that make health coverage affordable. JA 334. Because Mr. Klemencic expects to receive such tax credits, his choice is to "purchase subsidized health insurance, estimated at approximately $20 per year" or "$1.70 per month," or else "pay some higher amount per year as a Section 5000A tax penalty," JA 335, estimated to be about $12 per month, *see* R.46 at 45-46; R.29 at 15-16.

The district court concluded that Mr. Klemencic's submissions were sufficient to establish standing, *see* R.46 at 17, but denied a preliminary injunction because Mr. Klemencic failed to demonstrate irreparable harm. *See id*. at 45-46.

On cross-motions for summary judgment, the district court reaffirmed its holding that Mr. Klemencic has standing. *See* JA 334-335. The court also concluded that his claim is ripe, and that he has a cause of action under the APA notwithstanding the availability of a tax refund suit. *See* JA 335-340.[5]

Rejecting the claim on the merits, the district court explained that plaintiffs rely on subsection (b) of Section 36B, which sets the formula for calculating the amount of the premium tax credit. That subsection provides that the tax credit is calculated by adding up the "premium assistance amounts" for all "coverage months" in a given year; that the "premium assistance amount" is based in part on the cost of the monthly premium for the health plan that the taxpayer purchased "through an Exchange established by the State under [42 U.S.C. § 18031]"; and that a "coverage month" is defined as a month during which the taxpayer (or dependent) is enrolled in and pays the premium for a qualified health plan "that was enrolled in through an Exchange established by the State under [42 U.S.C. § 18031]." JA 349-350 (quoting 26 U.S.C. § 36B(b)(1)-(2) & 36B(c)(2)(A)(i)). In

[5] The court held that the employer-plaintiffs' claims are barred by the Anti-Injunction Act. *See* JA 340-346.

plaintiffs' view, the phrase "established by the State under [42 U.S.C. § 18031]" demonstrates that Congress did not make federal tax credits for payments of premiums for health insurance policies bought on federally-run Exchanges.

The district court explained that the relevant provisions, read together, preclude this interpretation. Subsection (b) of Section 36B refers to an Exchange "established by the State under [42 U.S.C. § 18031]." The cross-referenced provision—42 U.S.C. § 18031—in turn provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')." The court explained that all parties, including plaintiffs, agree that 42 U.S.C. § 18031 "does not mean what it literally says; states are not actually required to 'establish' their own Exchanges." JA 352 (quoting R.57 at 14 ("'*All* agree that states are free *not* to establish Exchanges.'")) (plaintiffs' emphasis). The Act provides, instead, "that a state may 'elect' to establish an Exchange and implement federal requirements for that Exchange," *ibid*. (quoting ACA § 1321, *codified at* 42 U.S.C. § 18041), and that, if a State does not elect to do so, "'the Secretary shall . . . establish and operate *such Exchange* within the State and the Secretary shall take such actions as are necessary to implement such other requirements.'" *Ibid*. (quoting 42 U.S.C. § 18041(c)) (court's emphasis). "In other words, even where a state does not actually establish an Exchange, the federal government can create 'an Exchange established by the

State under [42 U.S.C. § 18031]' *on behalf of* that state." JA 352-353 (court's emphasis).

Other provisions, the district court observed, confirm that premium tax credits are available on federally-run Exchanges. For example, subsection (f) of Section 36B—titled "Reconciliation of credit and advance credit"—requires federally-run Exchanges to report information that enables the Internal Revenue Service to reduce a taxpayer's end-of-year premium tax credit by the amount of any advance payment of such a tax credit. *See* JA 354-355. "Section 36B(f) would serve no purpose with respect to federally-facilitated Exchanges . . . if federal Exchanges were not authorized to deliver tax credits." JA 355.

Similarly, the court observed that plaintiffs' position cannot be reconciled with "Section 1312 of the ACA, codified at 42 U.S.C. § 18032, [which] sets forth provisions regarding which individuals may purchase insurance from the Exchanges." JA 355. "This section provides that only 'qualified individuals' may purchase health plans in the individual markets offered through the Exchanges, and requires that a 'qualified individual' be a person who 'resides in the State that established the Exchange.'" *Ibid*. (quoting 42 U.S.C. § 18032(f)(1)(A)(ii)). The court explained that, "[i]f this provision were read literally, no 'qualified individuals' would exist in the thirty-four states with federally-facilitated Exchanges, as none of these states is a 'State that established [an] Exchange,'" and

the "federal Exchanges would have no customers, and no purpose." *Ibid*. The court found no need to adopt "this absurd construction[.]" JA 356. It explained that 42 U.S.C. § 18041—the provision that directs the Secretary to establish and operate an Exchange when a state declines to do so—"authoriz[es] the federal government to stand[] in the shoes of the state for purposes of Section 18032's residency requirement." JA 356.

The district court further explained that plaintiffs' proposed reading of the statute would undermine the "central purpose of the ACA: to provide affordable health care to virtually all Americans." JA 357. The court rejected plaintiffs' assertion that "Congress had another, equally pressing goal when it passed the ACA: convincing each state to set up its own health insurance Exchange." JA 358. The court explained that "a state-run Exchange is not an end in and of itself, but rather a mechanism intended to facilitate the purchase of affordable health insurance." *Ibid*. "It makes little sense to assume that Congress sacrificed nationwide availability of the tax credit—which plaintiff David Klemencic previously described" in his Supreme Court briefing "as critical to the operation of the Exchanges"—"in an attempt to promote state-run Exchanges." JA 358-359

(citing Brief for Private Petitioners on Severability, *NFIB v. Sebelius*, Nos. 11-393 & 11-400 (S. Ct.), 2012 WL 72440, *51-*52 (JA 236-237)).[6]

"In sum," the district court concluded that, "while there is more than one plausible reading of the challenged phrase in Section 36B when viewed in isolation, the cross-referenced sections, the surrounding provisions, and the ACA's structure and purpose all evince Congress's intent to make premium tax credits available on both state-run and federally-facilitated Exchanges." JA 359. Accordingly, the court rejected plaintiffs' challenge to the Treasury Department's interpretative regulation that confirms that premium tax credits are available on federally-run Exchanges. *See* 26 C.F.R. § 1.36B-1(k); 77 Fed. Reg. 30,377, 30,378 (May 23, 2012). The court held that "the intent of Congress is clear at *Chevron* step one." JA 359.

The district court ruled in the alternative that, "[e]ven if the statute could be characterized as ambiguous—which it cannot—the [Treasury regulation] must be upheld at *Chevron* step two as a permissible construction of the statute." JA 362 n.14. For the reasons previously set forth in the opinion, the court concluded that "the plain text of the statute, when considered in light of the statutory structure, the statute's purpose, and the limited legislative history, establish that the Secretary's

[6] The court noted that "the scant relevant legislative history" confirms its interpretation of the statute. JA 359.

interpretation is, at minimum, a reasonable one." *Ibid*.; *see also* JA 347-348 (rejecting plaintiffs' contention that *Chevron* deference does not apply).

SUMMARY OF ARGUMENT

To provide "Affordable Coverage Choices for All Americans," ACA Title I, Subtitle E, Congress authorized billions of dollars of federal tax credits each year to help middle- and low-income individuals pay the premiums for certain insurance policies sold in the non-group market. Plaintiffs contend that these premium tax credits are available only to taxpayers who buy health insurance on an Exchange run by a state government, and not to taxpayers who buy health insurance on an Exchange run by the federal government.

Plaintiffs premise that argument on one phrase in Section 36B, read in isolation from the rest of Section 36B and divorced from the statutory provisions that it cross references, the structure of the statute, and the purpose of the Act. The Supreme Court, however, has repeatedly emphasized that "statutory construction is a holistic endeavor." *Adoptive Couple v. Baby Girl*, 133 S. Ct. 2552, 2563 (2013). "In expounding a statute, [a court] must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Maracich v. Spears*, 133 S. Ct. 2191, 2203 (2013). A statutory phrase cannot be "considered in isolation, and without reference to the structure and purpose of" the statute." *Id*. at 2199, 2200. "It is a 'fundamental canon of

statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.'" *National Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-133 (2000)).[7]

Moreover, in the context of federal taxing statutes, the Supreme Court has held that "revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. 224, 238 (1994). "State law may control only when the federal taxing act, by express language or necessary implication, makes its own operation dependent upon state law." *Burnet v. Harmel*, 287 U.S. 103, 110 (1932).

Assuming that the Court can reach the merits notwithstanding the threshold issues discussed in Point II of the Argument, the judgment of the district court should be affirmed. The district court correctly held that, "while there is more than one plausible reading of the challenged phrase in Section 36B when viewed in isolation, the cross-referenced sections, the surrounding provisions, and the ACA's structure and purpose all evince Congress's intent to make premium tax credits available on both state-run and federally-facilitated Exchanges." JA 359.

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[7] *Accord Graham County Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 290 (2010); *Zuni Pub. Sch. Dist. No. 89 v. Dep't of Educ.*, 550 U.S. 81, 98-99 (2007); *Household Credit Servs., Inc. v. Pfennig*, 541 U.S. 232, 239 (2004); *Davis v. Mich. Dep't of Treasury*, 489 U.S. 803, 809 (1989).

ARGUMENT

I. Federal Premium Tax Credits Are Available for Individuals Who Buy Insurance on Federally-Run Exchanges.

A. The Act's Text and Structure Show That Federal Premium Tax Credits Are Available on Federally-Run Exchanges.

1. *Congress defined the Exchange established by the Secretary on behalf of a State to be the Exchange that a State would have established if it had elected to establish an Exchange*.

Section 36B provides that a tax credit shall be allowed to any "applicable taxpayer," defined as "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." 26 U.S.C. § 36B(a), (c)(1)(A). Congress thus identified the taxpayers who are eligible for federal premium tax credits as those with a certain household income, regardless of whether the Exchange on which the insurance is purchased is established by the Secretary on behalf of a State, or by the State itself.

Plaintiffs attempt to significantly limit the availability of federal premium tax credits, however, by reliance on a phrase in subsection (b) of Section 36B, which sets the formula for calculating the amount of the premium tax credit. That subsection provides that the premium tax credit is calculated by adding up the "premium assistance amounts" for all "coverage months" in a given year; that the "premium assistance amount" is based in part on the cost of the monthly premium

for the health plan that the taxpayer purchased "through an Exchange established by the State under [42 U.S.C. § 18031]"; and that a "coverage month" is defined as a month during which the taxpayer (or dependent) is enrolled in and pays the premium for a qualified health plan "that was enrolled in through an Exchange established by the State under [42 U.S.C. § 18031]." 26 U.S.C. § 36B(b)(1)-(2) & 36B(c)(2)(A)(i). Plaintiffs contend the phrase "established by the State under [42 U.S.C. § 18031]" in this provision about how to calculate the amount of the credit means that Congress intended not to make federal premium tax credits available on federally-run Exchanges.

The district court correctly rejected that argument and held that the relevant statutory provisions, read together, preclude this interpretation. Subsection (b) of Section 36B refers to an Exchange "established by the State under [42 U.S.C. § 18031]," and 42 U.S.C. § 18031(a), in turn, provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')." The district court explained that all parties—including plaintiffs—agree that § 18031 "does not mean what it literally says; states are not actually required to 'establish' their own Exchanges." JA 352 (quoting R.57 at 14 ("'*All* agree that states are free *not* to establish Exchanges.'")) (plaintiffs' emphasis). Instead, the Act provides that a State may "elect[]" to establish an Exchange and, if a State does not elect to do so or fails to do so

consistent with federal standards, the Act requires the Secretary of Health and Human Services to establish the Exchange on the State's behalf. The relevant provisions are in Section 1321 of the Act, *codified at* 42 U.SC. § 18041, which provides for "State Flexibility" with respect to an Exchange. "Each State that elects" to establish an Exchange meeting federal standards shall have the Exchange operational by January 1, 2014. *Id*. § 18041(b). If, however, "a State is not an electing State," or if "the Secretary determines, on or before January 1, 2013, that an electing State . . . will not have any required Exchange operational by January 1, 2014," the Act provides that "the Secretary shall . . . establish and operate *such Exchange* within the State[.]" *Id*. § 18041(c) (emphasis added).

"In other words, even where a state does not actually establish an Exchange, the federal government can create 'an Exchange established by the State under [42 U.S.C. § 18031]' *on behalf of* that state." JA 352-353 (court's emphasis). Furthermore, Congress made clear that an Exchange established by the Secretary *is* the Exchange that the State would otherwise have established. The Act provides that, if a State will not have the "*required Exchange*" operational by January 1, 2014, the Secretary shall establish "*such Exchange*" on the State's behalf. 42 U.S.C. § 18041(c) (emphasis added). Congress thus defined the Exchange established by the Secretary to be the Exchange that the State would otherwise have established if it had elected to create an Exchange. *See*, *e.g.*, Black's Law

Dictionary 1570 (9th ed. 2009) ("such" means "[t]hat or those; having just been mentioned"). "Read in context," the federally-run Exchange "must be the same ['Exchange'] mentioned at the beginning of [the provision] . . . . Indeed, because there are no other ['Exchanges'] mentioned in the section, there is no other antecedent to which the word 'such' could refer." *Miller v. Clinton*, 687 F.3d 1332, 1344 (D.C. Cir. 2012).

If there were any doubt on this score, it is removed by the ACA's definitional provisions. For each use of the term "Exchange" in Title I of the ACA (which includes 42 U.S.C. § 18041), that term "means an American Health Benefit Exchange established under [42 U.S.C. § 18031]." 42 U.S.C. § 300gg-91(d)(21) (defining term for purpose of Public Health Service Act); *see* 42 U.S.C. § 18111 (incorporating this definition for Title I of ACA); *see also id*. § 18031(d)(1). Because "Exchange" is a defined term in the ACA, Section 18041(c)(1) effectively reads, "the Secretary shall . . . establish and operate such [American Health Benefit Exchange established under 42 U.S.C. § 18031]." Thus, for purposes of the statute, an Exchange established by the Secretary *is*, by definition, the required State Exchange established under Section 18031.

Plaintiffs conceded as much below: "The term 'such,' and the definition of 'Exchange,' confirm that the federal government should establish *the same Exchange* as the state was supposed to have established." R.57 at 5 (plaintiffs'

emphasis). Although plaintiffs now declare this statutory equivalency to be an "oxymoron," Pl. Br. 23, Congress is free to define statutory terms in any way that it chooses. Indeed, plaintiffs recognize that, "if a territory establishes an Exchange, it 'shall be treated as a State' for such purposes." Pl. Br. 24 (quoting ACA § 1323(a)(1), *codified at* 42 U.S.C. § 18043(a)(1)). Plaintiffs assert that this provision "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." *Ibid*. But that is exactly what Congress did in the statutory provisions quoted above: Congress created an equivalence between an Exchange established by a State and an Exchange established by the Secretary on the State's behalf. And it is that statutory text that controls here, rather than short-hand references in the calculation formula subsection on which plaintiff relies.[8]

Plaintiffs also recite the canon against superfluity, *see* Pl. Br. 20, but their own argument fails to give meaning to the statutory phrase "such Exchange" and also renders superfluous other provisions of the Act. *See* JA 353 n.11 (district court opinion). The "canon against surplusage assists only where a competing

[8] Congress addressed the territories separately because territorial residents generally do not pay federal income tax, 26 U.S.C. §§ 931-33, and Congress needed a different mechanism other than federal premium tax credits to effectuate the goals of the Act in the territories.

interpretation gives effect to every clause and word of a statute," *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013), which is not the case for plaintiffs' position here. In any event, "instances of surplusage are not unknown" in federal statutes, *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 299 n.1 (2006), and the canon cannot override Congress's decision to treat an Exchange established by the Secretary on a State's behalf as the Exchange the State would otherwise have established.

Moreover, the district court correctly noted that "the statutory formula for calculating the tax credit seems an odd place to insert a condition that the states establish their own Exchanges if they wish to secure tax credits for their citizens." JA 359 n.12 (citing *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001) ("[Congress] does not, one might say, hide elephants in mouseholes.")). "One would expect that if Congress had intended to condition availability of the tax credits on state participation in the Exchange regime, this condition would be laid out clearly in subsection (a), the provision authorizing the credit, or some other provision outside of the calculation formula." *Ibid*. "This is particularly so because courts presume that 'Congress when it enacts a statute is not making the application of the federal act dependent on state law.'" *Ibid*. (quoting *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 43 (1989)). That principle has particular force in the area of taxation, where the Supreme Court has emphasized

that "'the revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application.'" *Ibid.* (quoting *United States v. Irvine*, 511 U.S. 224, 238 (1994)).[9]

2. *The reporting requirements in Section 36B confirm that premium tax credits are available on federally-run Exchanges.*

The reporting requirements in Section 36B confirm that premium tax credits are available on federally-run Exchanges. *See* JA 354-355. Section 36B(f)—titled "Reconciliation of credit and advance credit"—requires the Internal Revenue Service to reduce the amount of a taxpayer's end-of-year premium tax credit by the amount of any advance payment of such a tax credit. *See* 26 U.S.C. § 36B(f)(1) ("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[.]").

To enable the IRS to perform this reconciliation of end-of-year and advance premium tax credits, Section 36B(f) requires "each Exchange" to report specified information to the Department of the Treasury. There is no dispute that these

[9] Plaintiffs incorrectly suggest (Pl. Br. 41 & n.6) that an earlier statute, the Trade Adjustment Assistance Act, conditioned tax credits for individuals on state action. *See* Pl. Br. 41 & n.6 (citing 26 U.S.C. § 35(a), (e)(2)). That statute provided a tax credit for certain workers displaced by foreign competition, which could be used to offset the costs of several different kinds of qualifying health insurance. The statute made some forms of qualifying insurance available nationwide, and permitted States to designate additional kinds of insurance that would meet certain minimum standards. *See* 26 U.S.C. § 35(e).

reporting requirements apply regardless of whether an Exchange was established by the State under 42 U.S.C. § 18031 (ACA § 1311) or by the Secretary of HHS under 42 U.S.C. § 18041 (ACA § 1321). Section 36B(f) provides in relevant part:

> (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 [42 U.S.C. § 18031(f)(3) or 42 U.S.C. § 18041(c)]) shall provide the following information to the Secretary [of the Treasury] 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.

The italicized text above makes clear that these reporting requirements apply to an Exchange established by the Secretary of HHS under ACA § 1321(c), 42

U.S.C. § 18041(c). The district court correctly reasoned that these reporting requirements would be nonsensical if premium tax credits were not available on federally-run Exchanges. JA 354-355. The purpose of requiring these reports to Treasury is to enable the IRS to reconcile end-of-year premium tax credits with advance premium tax credits. *See* 26 U.S.C. 36B(f) ("Reconciliation of credit and advance credit"). To that end, the Act directs federally-run Exchanges (as well as state-run Exchanges) to report a taxpayer's "advance payment of such credit"; information needed to determine the taxpayer's "eligibility for, and the amount of, such credit"; and "[i]nformation necessary to determine whether a taxpayer has received excess advance payments." 26 U.S.C. § 36B(f)(3)(C), (E), (F). These reporting requirements leave no doubt that Congress intended taxpayers to receive tax credits for payments of premiums for insurance purchased on federally-run Exchanges.

Plaintiffs do not dispute that, on their theory, the information that Congress required federally-run Exchanges to report to Treasury and the taxpayer would never exist. If, as they propose, there were no premium tax credits on federally-run Exchanges, there would be no "advance payment of such credit"; there would be no information needed to determine the taxpayer's "eligibility for, and the amount of, such credit"; and there would be no "[i]nformation necessary to determine

whether a taxpayer has received excess advance payments." 26 U.S.C. § 36B(f)(3)(C), (E), (F).

Plaintiffs ignore these categories of information. *See* Pl. Br. 30-31. "That plaintiffs interpret [these reporting requirements] to be an empty gesture is yet another indication that their submission is erroneous." *Fund for Animals, Inc. v. Kempthorne*, 472 F.3d 872, 878 (D.C. Cir. 2006).

Moreover, plaintiffs incorrectly assert that Treasury needs other categories of information set out in Section 36B(f)(3) for purposes that are unrelated to premium tax credits, rather than for Congress's stated purpose of allowing the reconciliation of premium tax credits and advance credits. For example, plaintiffs declare that "Treasury needs enrollment information to enforce the Act's individual mandate to buy insurance." Pl. Br. 31 (referring to ACA § 1501, *codified at* 26 U.S.C. § 5000A). However, in Section 1502 of the Act, Congress separately required "[e]very person who provides minimum essential coverage to an individual during a calendar year" to report specified information that enables Treasury to determine whether the individual is in compliance with Section 1501, the minimum coverage provision. *See* ACA § 1502, *codified at* 26 U.S.C. § 6055.

Similarly, plaintiffs declare that the government needs "enrollment and premium data, even with respect to individuals who do not obtain subsidies," so that the Comptroller General can conduct a "study on affordable coverage" that is

required under ACA § 1401(c). Pl. Br. 31. But Section 36B(f) requires reports to Treasury to reconcile premium tax credits; it does not require reports to the Comptroller to conduct a study. In any event, the provision that requires a study on affordable coverage directs the Comptroller to consider "the impact of the tax credit for qualified health insurance coverage of individuals under section 36B[.]" ACA § 1401(c)(1)(A)(i), 124 Stat. at 220. Congress understood that premium tax credits are essential to make coverage affordable on the Exchanges.

3. *Other Affordable Care Act provisions confirm that references to State-established Exchanges include Exchanges established by the Secretary on a State's behalf.*

Various other Affordable Care Act provisions confirm that, when Congress referred to a state-established exchange, it included an Exchange established by the Secretary on a State's behalf. The provisions discussed below are illustrative.

The definition of a "qualified individual." Section 1312 of the Act provides that a "qualified individual" may buy insurance on an Exchange. *See* ACA § 1312(a)(1), *codified at* 42 U.S.C. § 18032(a)(1) ("A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible."). Congress provided that "[t]he term 'qualified individual' means, with respect to an Exchange, an individual who—(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) *resides in the State that established the Exchange*." 42 U.S.C.

§ 18032(f)(1)(A) (emphasis added). Individuals who are incarcerated, and individuals who are not U.S. citizens, nationals, or lawfully present aliens, are not qualified individuals. *See id.* § 18032(f)(1)(B), (f)(3).

The district court explained that "[t]here is no separate provision defining 'qualified individual' for purposes of the federally-facilitated Exchanges." JA 355. "If [the italicized] provision were read literally, no 'qualified individuals' would exist in the thirty-four states with federally-facilitated Exchanges, as none of these states is a 'State that established [an] Exchange.'" *Ibid.* "The federal Exchanges would have no customers, and no purpose." *Ibid.*

The district court properly declined to adopt "this absurd construction." JA 356. Instead, the court explained that 42 U.S.C. § 18041—the provision that directs the Secretary to establish and operate an Exchange when a State elects not to do so—"authoriz[es] the federal government to stand[] in the shoes of the state for purposes of Section 18032's residency requirement." JA 356.

"Plaintiffs concede that the federally-run Exchanges *must* be able to offer insurance, and suggest that the Court should not interpret the residency requirement literally." JA 356 (court's emphasis). According to plaintiffs, "[t]hat definition *assumes* a state-created Exchange; it thus can readily be construed as not prohibiting eligibility where that assumption proves false." Pl. Br. 33 (plaintiffs' emphasis). "But plaintiffs' concession only proves the [government's] point."

JA 356. The definition of "qualified individual" makes sense "when construed consistently with [the government's] interpretation of the Act—*i.e.*, viewing 42 U.S.C. § 18041 as authorizing the federal government to create 'an Exchange established by the State under [42 U.S.C. § 18031] on behalf of a state that declines to establish its own Exchange." JA 356-357.

In a variant on the same argument, plaintiffs suggest that, in the 34 States with federally-run Exchanges, the residency requirement should be ignored and "an applicant should still be understood to satisfy [the 'qualified individual' definition] based solely on its *other* prong." Pl. Br. 33 (plaintiffs' emphasis). Congress, however, specified that both clause (i) *and* clause (ii) of the definition must be met for a person to be a "qualified individual." If an applicant resides in a State where the Secretary established an Exchange on the State's behalf, the residency requirement in clause (ii) is satisfied because the reference to "the State that established the Exchange" includes a State in which the Secretary established the Exchange on the State's behalf.

Plaintiffs also assert that Section 1312 is a "nondiscrimination provision" that does not restrict who may shop on an Exchange. Pl. Br. 32-33. On this theory, undocumented aliens and incarcerated individuals could shop on Exchanges, which is clearly not what Congress provided. Section 1312 is not a nondiscrimination provision; it indicates who is "qualified" to shop on an

Exchange. Other provisions of the Act address nondiscrimination. *See, e.g.*, ACA § 1201 (prohibiting "Discrimination Based on Health Status" and "Discriminatory Premium Rates" in certain plans); ACA § 1557 (requiring "Nondiscrimination" on specified bases in certain programs).

The Medicaid maintenance-of-effort requirement. The Affordable Care Act provides, as a condition of receiving Medicaid funds, that a State may not tighten its Medicaid eligibility standards for adults until "the date on which the Secretary determines that an Exchange established by the State under [42 U.S.C. § 18031] is fully operational." ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg)(1). This transitional measure was intended to protect Medicaid recipients from a loss of coverage until January 1, 2014, when those Medicaid recipients who would lose Medicaid eligibility would be able to obtain subsidized health insurance on an Exchange. Accordingly, HHS advised Maine, which has a federally-run Exchange, that its maintenance-of-effort obligation would nonetheless expire on January 1, 2014.[10]

[10] *See* Letter of January 7, 2013 from the Acting Administrator of HHS's Centers for Medicare & Medicaid Services to the Maine Commissioner of Health & Human Services (reproduced in the addendum to this brief); *see also* CMS, FAQs on Exchanges, Market Reforms, and Medicaid (Dec. 10, 2012), *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf (deadline for States to submit a blueprint for operating their own Exchange was December 14, 2012).

By contrast, under plaintiffs' theory, a State with a federally-run Exchange would *never* be relieved of the maintenance-of-effort requirement. *See* Pl. Br. 35. Although plaintiffs declare that such a perpetual obligation "makes perfect sense," *ibid*., the point of the maintenance-of-effort requirement was to serve as an interim measure until affected Medicaid recipients could transition to health insurance obtained on the Exchanges.

By plaintiffs' account, their proposed interpretation of the maintenance-of-effort requirement would present constitutional problems. In district court, plaintiffs argued that this requirement would be unconstitutional if—as they proposed—the requirement were interpreted as a "stick" intended "to coerce the states to act." R.57 at 13 n.4 (urging that "[p]rospectively, this 'stick' may have been invalidated by the Supreme Court's decision on Medicaid" in *NFIB*). But, as plaintiffs recognize, *see* Pl. Br. 50, courts "have a duty to construe a statute to save it, if fairly possible." *NFIB*, 132 S. Ct. at 2600; *see also id*. at 2594 ("every reasonable construction must be resorted to, in order to save a statute from unconstitutionality"). Here, the maintenance-of-effort requirement is readily construed to expire when the Secretary establishes the required State Exchange on behalf of the State. Congress provided that, if a State will not have the "required Exchange" operational by January 1, 2014, the Secretary shall establish "such Exchange" for the State. 42 U.S.C. § 18041(c). The maintenance-of-effort

requirement confirms that statutory references to "an Exchange established by the State" include an Exchange established by the Secretary on the State's behalf.

* * *

The district court aptly concluded that these and other Affordable Care Act provisions "reflect an assumption that a state-established Exchange exists in each state." JA 356.[11] "If construed literally, these provisions would be nullified when applied to states without state-run Exchanges, leading to strange or absurd results." *Ibid*. "These provisions make far more sense when construed consistently with [the government's] interpretation of the Act—*i.e.*, viewing 42 U.S.C. § 18041 as authorizing the federal government to create 'an Exchange established by the State under [42 U.S.C. § 18031]'" on behalf of the State that elects not to establish the required Exchange. JA 356-357.

B. Plaintiffs' Position Would Undermine Congress's Objective To Make Affordable Insurance Available in the Non-Group Health Insurance Market.

1. *Congress understood that federal premium tax credits are essential to protect insurance markets operating under guaranteed-issue and community-rating rules.*

The purpose of the Affordable Care Act is "to increase the number of Americans covered by health insurance and decrease the cost of health care."

[11] *See, e.g.* 42 U.S.C. § 1397ee(d)(3)(B-C) (requiring adequate coverage for low-income children in an "Exchange established by the State under [§ 18031]").

NFIB, 132 S. Ct. at 2580. In combination, the Act's provisions are designed to achieve "near-universal coverage" for all Americans. ACA § 1501(a)(2)(D), *codified at* 42 U.S.C. § 18091(2)(D). To that end, Congress included a set of interrelated provisions in ACA Title I that, working in tandem, have reformed what was the dysfunctional non-group health insurance market.

As discussed above (pp. 2-4, *supra*), before the Affordable Care Act was enacted, the non-group health insurance market was characterized by high premiums, restrictive insurance industry practices, and low participation. Health insurance obtained in the non-group market did not receive federal tax subsidies, so purchasers had to bear the full cost of premiums. Federal law did not prevent insurers from denying coverage or charging higher premiums based on an individual's health status, and, without such rules, millions of individuals were denied coverage or offered premiums that they could not afford. As a result, participation in the non-group market was low even among those who lacked other health coverage options. Of the 45 million individuals who did not have access to an employment-based group health plan or government health benefits program in 2009, only 20% were covered by a policy purchased in the non-group insurance market. The remaining 80% were uninsured.

To reform the non-group health insurance market, Congress: (1) extended federal tax subsidies to the non-group market (the premium tax credits and cost-

sharing subsidies); (2) barred insurers from denying coverage to or charging higher premiums because of an individual's health status (the guaranteed-issue and community-rating requirements); and (3) required that non-exempted individuals maintain minimum essential health coverage or else pay a tax penalty (the minimum coverage provision, which plaintiffs refer to as the "individual mandate"). *See* pp. 4-6, *supra*.

Congress understood that the guaranteed-issue and community-rating requirements would undermine—rather than reform—the non-group health insurance market unless those requirements were paired with the minimum coverage provision and premium tax credits that make minimum coverage affordable. As discussed above (pp. 7-8, *supra*), the Congressional Budget Office ("CBO") and state insurance regulators warned Congress that, by themselves, the guaranteed-issue and community-rating requirements would create adverse selection that would lead to a cycle of rising premiums and declining enrollment in the non-group market. CBO explained that the premium tax credits and minimum coverage provision were needed to mitigate such adverse selection. CBO informed Congress that there would be "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed," JA 126; that "[t]he substantial premium subsidies available in the exchanges would encourage the

enrollment of a broad range of people," JA 139; and that the structure of the premium tax credits (under which federal subsidies increase if premiums rise) "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." JA 140.

The National Association of Insurance Commissioners ("NAIC"), which offered Congress "the experience and expertise of the states to Congress as it attempt[ed] to improve the health insurance marketplace," likewise warned Congress that proposals for "guaranteed issue and elimination of preexisting condition exclusions for individuals" could "result in severe adverse selection." The NAIC advised Congress that "State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-503, 504 (2009).

Accordingly, Congress coupled the Act's guaranteed-issue and community-rating requirements with the minimum coverage provision and premium tax credits designed to provide "Affordable Coverage Choices for All Americans." ACA Title I, Subtitle E. Congress understood when it enacted the legislation that the vast majority of people who bought non-group health insurance on the Exchanges would receive premium tax credits, and that, on average, the tax credits would

cover the lion's share of the premiums. In response to Congress's request that CBO analyze how health care reform proposals would affect premiums in various markets, CBO advised Congress that, under the proposed legislation, 78% of the people (18 million of 23 million) who bought insurance through the Exchanges in 2016 would receive premium tax credits, and that those credits, on average, would cover nearly two-thirds of the premium. *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* i, 24 (Nov. 30, 2009) (JA 120, 144). Congress found that the premium tax credits "are *key* to ensuring people affordable health coverage." H.R. Rep. No. 111-443, vol. 1, at 250 (March 17, 2010) (JA 69) (emphasis added).

Given this background, it is untenable to suggest that Congress withheld premium tax credits from individuals who live in States with federally-run Exchanges. Congress sought to *reform* the non-group market, not to *destroy* it. "Plaintiffs' proposed construction in this case—that tax credits are available only for those purchasing insurance from state-run Exchanges—runs counter to this central purpose of the ACA: to provide affordable health care to virtually all Americans." JA 357. Insurers in States with federally-run Exchanges would still be required to comply with guaranteed-issue and community-rating rules, but, without premium tax subsidies to encourage broad participation, insurers would be deprived of the broad policy-holder base required to make those reforms viable.

Adverse selection would cause premiums to rise, further discouraging market participation, and the ultimate result would be an adverse-selection death spiral in the individual insurance markets in States with federally-run Exchanges.[12]

Plaintiff Klemencic himself urged the Supreme Court in *NFIB* that the Exchanges could not operate without the premium tax credits. There, he argued (through the same counsel) that, "[w]ithout the subsidies driving demand within the exchanges, insurance companies would have absolutely no reason to offer their products through exchanges, where they are subject to far greater restrictions." Brief for Private Petitioners on Severability, *NFIB v. Sebelius*, Nos. 11-393 & 11-400 (S. Ct.), 2012 WL 72440, *51-*52 (JA 236-237). The four Justices who considered the issue of severability agreed: "Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges, and some insurers may be unwilling to offer insurance inside of exchanges. With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all." *NFIB*, 132 S. Ct. at 2674 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).

Now, plaintiffs ascribe to Congress the intent to render the non-group insurance markets in States with federally-run Exchanges dysfunctional. Their

[12] *See, e.g.*, Jonathan Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act* (Aug. 2010) (JA 195-200).

argument is, at bottom, a *post hoc* account designed to dismantle the health care reform legislation that they have steadfastly opposed. In the words of the Oklahoma Attorney General, who appears as plaintiffs' *amicus* here, if plaintiffs' position is adopted, "the structure of the ACA will crumble." Scott Pruitt, *ObamaCare's Next Legal Challenge*, The Wall Street Journal (Dec. 1, 2013). "While much time has been devoted in Washington to the issue of 'defunding' the Affordable Care Act, the success of these lawsuits would have much the same effect." *Ibid*.[13]

2. *Exchanges are not an end in and of themselves, but a means to provide affordable health insurance, and Congress did not "coerce" States into establishing Exchanges.*

"Plaintiffs try to explain away the inconsistency between their proposed construction and the statute's underlying purpose by proposing that Congress had another, equally pressing goal when it passed the ACA: convincing each state to set up its own health insurance Exchange." JA 357. On this theory, Congress threatened to withhold premium tax credits from people who need them in order to

[13] Although Georgia also appears here as plaintiffs' *amicus*, the Georgia Health Insurance Exchange Advisory Committee advised the Governor that the Affordable Care Act "provides HHS subsidies and IRS refundable tax credits to individuals meeting federal eligibility requirements and an income between 100-400% of Federal Poverty Level" and that "*Georgians will be eligible for these subsidies whether the [American Health Benefits Exchange] in Georgia is established by the state or federal government*." Georgia Health Insurance Exchange Advisory Committee, *Report to the Governor* 13 (Dec 15, 2011) (emphasis added).

"coerce state action," Pl. Br. 41, by making a threat to state residents so dire that a State "could not refuse" to set up an Exchange. Pl. Br. 14.

That makes no sense. "A state-run Exchange is not an end in and of itself, but rather a mechanism intended to facilitate the purchase of affordable health insurance." JA 358. "It makes little sense to assume that Congress sacrificed nationwide availability of the tax credit—which plaintiff David Klemencic previously described as critical to the operation of the Exchanges,"—"in an attempt to promote state-run Exchanges." JA 358-359.

Plaintiffs' "coercion" theory disregards the plain language of the Act, which provides that the Secretary of HHS will establish an Exchange if a State elects not to do so. 42 U.S.C. § 18041(c)(1). Congress did not "coerce" States to establish Exchanges. Instead, Congress authorized federal grants to assist States in establishing Exchanges. *See id*. § 18031(a); *see also id*. § 18031(d)(5)(A) (continuing Exchange operations may be financed through user fees). Congress also vested the Exchanges with certain regulatory power with respect to health insurers seeking to offer plans on the Exchanges. *See id*. § 18031(e) (power to certify qualified health plans and to review insurers' proposed premium rates); *id*. § 18021(a)(1)(C)(iv) (power to impose additional requirements for qualified health plans). Congress thus gave States the option of accepting that regulatory power by

operating the Exchange or forgoing it and having its Exchange run by the federal government instead.

Contrary to plaintiffs' premise (Pl. Br. 14), "there can be no suggestion that the Act commandeers the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program." *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981). "The most that can be said is that the [Act] establishes a program of cooperative federalism that allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." *Id*. at 289.

Although plaintiffs seek to analogize the Exchange provisions with the Medicaid eligibility expansion that was at issue in *NFIB*, *see* Pl. Br. 14, 28, 37-41, the twenty-six plaintiff States in *NFIB* repeatedly contrasted the Medicaid eligibility expansion with "the real choice that the ACA offers States to create exchanges or have the federal government do so." Brief of State Petitioners on Medicaid, *Florida v. HHS*, No. 11-400, 2012 WL 105551, *51. Medicaid is jointly funded by the federal and state governments and administered by the States. If a State does not participate, the Secretary of HHS has no authority to administer the program in its place. By contrast, if a State declines to establish the required State

Exchange, the Affordable Care Act directs the Secretary to do so on the State's behalf.

Thus, the plaintiff States in *NFIB* explained: "Because States were given a meaningful choice whether to operate the health benefit exchanges created by the Act, there is a plan B. The federal government will step in if States decline." *Id*. at *22. The "lack of any contingency plan" in the Medicaid eligibility expansion "stands in stark contrast to other provisions of the Act in which Congress gave States a meaningful option and expressly accounted for the possibility that States might decline the federal blandishments." *Id*. at *35. "Most prominently, in providing for the creation of 'health benefit exchanges' in each State, Congress authorized the federal government to establish and operate those exchanges in any State that chooses to forgo federal funding to do so itself." *Id*. at *35.

In short, plaintiffs' "coercion" theory is baseless. Premium tax credits are not grants to States. They are federal subsidies that Congress provided directly to federal taxpayers so that they can afford health insurance. Like other federal tax benefits, the premium tax credits that Congress authorized for middle- and low-income Americans in Section 36B are available nationwide.[14]

[14] Because plaintiffs' "coercion" theory is foreclosed by the statutory text, there is no need to consult the legislative history. In any event, the district court correctly found that the legislative history is entirely consistent with the statutory

Continued on next page.

C. Treasury's Reasonable Interpretation Is Entitled to Deference.

For the reasons discussed above, plaintiffs' position is not a permissible interpretation of Section 36B. Even assuming that "the statute could be characterized as ambiguous—which it cannot—[Treasury's interpretative regulation] must be upheld at *Chevron* step two as a permissible construction of the statute." JA 362 n.14.

After notice and comment rulemaking, the Treasury Department issued a regulation that (*inter alia*) confirm that premium tax credits are available on any Exchange, regardless of whether the Exchange is run by a State or by the Secretary of HHS. *See* 26 C.F.R. § 1.36B-1(k) (adopting the same definition of Exchange that the Secretary of HHS adopted in 45 C.F.R. § 155.20). Treasury explained that "[t]he 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." 77 Fed. Reg. at 30,378. "Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges." *Ibid*. "Accordingly, the final regulations maintain the rule in the proposed regulations because it is

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text: Congress gave States "the option of establishing their own Exchanges" and did not "coerce" States to do so. JA 361.

consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole." *Ibid.*

The district court correctly held that "the plain text of the statute, when considered in light of the statutory structure, the statute's purpose, and the limited legislative history, establish that the Secretary's interpretation is, at minimum, a reasonable one." JA 362 n.14. Plaintiffs' response to this holding largely reprises the contentions discussed above, *see* Pl. Br. 45-46, 53-54, and fails for the same reasons.

Plaintiffs also offer two additional arguments for why the Treasury's interpretation of Section 36B should not receive *Chevron* deference, neither of which has merit. First, they contend that the Secretary of the Treasury cannot claim deference to his interpretation of Section 36B, which is an Internal Revenue Code provision that he is charged with administering, because "neither the district court nor the Government contends that the language of *26 U.S.C. § 36B* is ambiguous." Pl. Br. 46 (plaintiffs' emphasis). Plaintiffs claim that "the court found that, standing alone, that provision favored [their] reading," and that the provisions on which the district court based its finding of ambiguity are administered in coordination by Treasury and HHS. *Ibid.*

That is a mischaracterization of the district court's decision, which did not find that Section 36B as a whole supported plaintiffs' position. The court held

that, "while there is more than one plausible reading *of the challenged phrase in Section 36B when viewed in isolation*, the cross-referenced sections, the surrounding provisions, and the ACA's structure and purpose all evince Congress's intent to make premium tax credits available on both state-run and federally-facilitated Exchanges." JA 359 (emphasis added). The court relied in part on the reporting requirements in Section 36B itself, which, it explained, show that premium tax credits are available on federally-run Exchanges. *See* JA 354-355. Congress expressly delegated authority to Treasury to resolve ambiguities in Section 36B. *See* 26 U.S.C. §§ 36B(g), 7805(a); *Mayo Found. for Med. Educ. & Research v. United States*, 131 S. Ct. 704, 715 (2011).

In any event, the fact that Treasury and HHS coordinate responsibility for administering parts of the Act is not a reason to withhold *Chevron* deference. *See* JA 347-348. When, as here, agencies issue coordinated regulations, *see* JA 347-348, *Chevron* deference applies. For example, in *National Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 664-666 (2007), the Supreme Court accorded *Chevron* deference to a regulation jointly issued by the two agencies charged with implementing the Endangered Species Act—the Departments of Commerce and the Interior—and upheld that regulation as a reasonable interpretation of the statute. *See also Coeur Alaska, Inc. v. Southeast Alaska Conservation Council*, 557 U.S. 261, 277-278 (2009) (deferring under *Chevron* to

"agencies' regulations construing" the Clean Water Act); *U.S. Postal Serv. v. Postal Regulatory Comm'n*, 599 F.3d 705, 710 (D.C. Cir. 2010).[15]

Plaintiffs also assert that "*Chevron* Deference Is Displaced Here by the Venerable 'Clear Statement' Rule for Tax Exemptions and Credits." Pl. Br. 49. There is no such principle. Although "exemptions from taxation are to be construed narrowly," *Mayo Found.*, 131 S. Ct. at 715, the Supreme Court has never suggested that this principle displaces *Chevron* deference. *Id*. at 711 (analyzing Treasury's interpretation of a tax exemption under the *Chevron* framework). A tax benefit, "even if not supported by express statutory language," can "nonetheless be recognized if it is in harmony with the statute as an organic whole." *Centex Corp. v. United States*, 395 F.3d 1283, 1295 (Fed. Cir. 2005).

The relevant canon here is not a presumption against federal tax credits—which Congress clearly authorized in Section 36B—but the principle that "revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*,

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[15] Plaintiffs rely on *American Federation of Government Employees v. Shinseki*, 709 F.3d 29 (D.C. Cir. 2013), but that case was decided at *Chevron* step 1. *See id*. at 33 ("Because we conclude that 'Congress has directly spoken to the precise question at issue' and that the text is unambiguous, our analysis also ends with the text."). The Court also stated, unremarkably, that "[w]e do not accord *Chevron* deference to the VA's interpretation of the FSLMRS because the VA does not administer that statute." *Ibid*. Here, there is no dispute that Treasury administers Section 36B, and the Treasury and HHS regulations are coordinated rather than conflicting.

511 U.S. 224, 238 (1994). "State law may control only when the federal taxing act, by express language or necessary implication, makes its own operation dependent upon state law." *Burnet v. Harmel*, 287 U.S. 103, 110 (1932). For the reasons already discussed, Congress did not allow States to block federal taxpayers from receiving the federal premium tax credits they need to purchase health insurance.[16]

II. Plaintiffs' Claims Also Fail on Threshold Grounds.

A. Mr. Klemencic's Claim

Of the four individual plaintiffs, only Mr. Klemencic attempted to show that he would be injured by premium tax credits. As noted above, Mr. Klemencic was a plaintiff in *NFIB*, where he asserted a pre-enforcement facial challenge to Section 5000A. He intervened as a plaintiff in the Supreme Court after certiorari was granted. *See* 132 S. Ct. 1133 (2012) (mem.). The purpose of that intervention was "to pretermit any standing concerns arising from a recent change in the circumstances" of the lead plaintiff, who had filed a voluntary bankruptcy petition.

[16] On February 5, the House Committee on Oversight and Government Reform, which is chaired by Representative Darrell Issa, issued a report critical of Treasury's interpretation of Section 36B (the "Issa Report"). The following day, Chairman Issa and plaintiffs' other congressional *amici* submitted an *amicus* brief that relied on the Issa Report. *See Amicus* Brief of Senator John Cornyn, *et al*, at 21. The report, which advanced plaintiffs' "coercion" theory, *see* Issa Report at 14-15, did not acknowledge the contrary district court decision in this case.

Unopposed Motion for Leave To Add Parties, *NFIB v. Sebelius*, Nos. 11-393, 11-398, 11-400 (S. Ct.) (filed Jan. 4, 2012).[17]

To establish standing in the Supreme Court, Mr. Klemencic submitted a sworn declaration that represented: "I am subject to the ACA's individual insurance mandate. I object to . . . being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance." JA 32 ¶ 8. He did not suggest that he would, in fact, be exempt from the tax penalty if the State in which he lived elected not to set up an Exchange, even though the plaintiff States in *NFIB* emphasized that the Act gives each State that choice. *See* pp. 42-43, *supra*. Moreover, he characterized his injury as economic (which is a recognized form of Article III injury) rather than ideological (which is not). *See*, *e.g.*, JA 32 ¶ 6 ("I have looked into purchasing health insurance within the past year but have determined that it is too expensive."). Based on those representations, Mr. Klemencic obtained an adjudication of the merits of his claim in the Supreme Court.

In this suit, by contrast, Mr. Klemencic submitted a sworn declaration that represented that, "absent any eligibility for federal subsidies, I would be exempt in 2014 from the individual mandate penalty and I would be entitled to obtain, before

[17] *See* "Health Law Opponents Try To Add Plaintiffs To Lawsuit, http://online.wsj.com/news/articles/SB10001424052970204331304577141072540030502 (providing a link to the *NFIB* plaintiffs' intervention motion).

January 1, 2014, a 'certificate of exemption' so certifying." JA 34-35 ¶ 6. Moreover, he described his injury as ideological rather than economic: "Even if the government would subsidize [comprehensive health coverage] or pay for it completely, I oppose government handouts and therefore do not want to buy that coverage." JA 35 ¶ 8.

The government explained below that it is unclear how these "logically inconsistent" representations could demonstrate Mr. Klemencic's standing. R.23-1 at 19. In the Supreme Court, he claimed that he *would be subject* to Section 5000A; here, he claims that he is *exempt*.

If Mr. Klemencic wishes to establish standing to challenge tax liability under Section 5000A, he has a means to do so. He can refrain from buying the subsidized health insurance estimated to cost him $20 per year ($1.70 per month), *see* JA 335; incur the tax penalty estimated to be under $150 for 2014 (about $12 per month), *see* R.46 at 45-46; R.29 at 15-16; and present his legal argument in a tax-refund action. That is the avenue Congress prescribed for challenging federal tax liability. *See* 28 U.S.C. § 1346 (district courts have jurisdiction to hear "[a]ny civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal-revenue laws").

Even apart from the issue of standing, this suit cannot proceed under the APA because a refund action is an adequate legal remedy that the APA does not displace. *See* 5 U.S.C. §§ 703, 704; *Bob Jones Univ. v. Simon*, 416 U.S. 725, 742 n.16 (1974) ("general equitable principles disfavor[] the issuance of federal injunctions against taxes, absent clear proof that available remedies at law [are] inadequate"). A tax refund action plainly would afford adequate relief—payment in full, with interest, of any overpayment of their federal tax obligations—if Mr. Klemencic were to prevail. "[T]he alternative remedy need not provide relief identical to relief under the APA, so long as it offers relief of the same genre." *Garcia v. Vilsack*, 563 F.3d 519, 522 (D.C. Cir. 2009); *see also Cohen v. United States*, 650 F.3d 717, 733 (D.C. Cir. 2011) (en banc) ("challenges to the validity of an individual tax" must be brought in a refund suit).

The district court noted that there is also an administrative process by which individuals can apply for "certificates of exemption" from Section 5000A. *See* JA 337-338. Mr. Klemencic did not apply for a certificate of exemption, however, and instead represented in the Supreme Court that he would be subject to Section 5000A unless the provision were declared unconstitutional. In any event, Mr. Klemencic does not need a certificate of exemption to challenge a Section 5000A assessment. He can present the same theory that he now advances in the forum that Congress designated, a tax refund action.

B. The Restaurant Group's Claim

Among the employer plaintiffs, only the Texas-based restaurant group attempted to show that it would be injured if premium tax credits were available to individuals who buy health insurance on an Exchange. *See* JA 36-38 (Tharp Decl.). The restaurant group's theory of standing rests on the interaction between the premium tax credits authorized by Section 36B, and the Affordable Care Act provision that imposes a potential tax on large employers that fail to offer their full-time employees and their dependents adequate health coverage. *See* ACA § 1513, *codified at* 26 U.S.C. § 4980H ("Section 4980H" or the "shared responsibility provision").

As discussed above, Title I of the Affordable Care Act expands access to affordable coverage in the private health insurance markets. In addition to reforming the non-group market through the provisions already discussed, the Act also "build[s] upon and strengthen[s] the private employer-based health insurance system, which covers 176,000,000 Americans nationwide." 42 U.S.C. § 18091(2)(D). To that end, the Act provides tax credits to eligible small businesses that provide health coverage to their employees, ACA § 1421, *codified at* 26 U.S.C. § 45R, and imposes tax liability under specified circumstances on applicable large employers that do not offer adequate coverage to full-time

employees and their dependents, 26 U.S.C. § 4980H. Section 4980H will become effective in 2015. *See* 26 C.F.R. §§ 54.4980H-4(h), 54.4980H-5(g).

The Section 4980H tax will not apply unless one or more full-time employees obtain a federal premium tax credit for health insurance purchased on an Exchange. *See* 26 U.S.C. § 4980H(a)(2), (b)(1)(B). The restaurant group seeks to block its full-time employees from receiving premium tax credits under Section 36B, so that it will not be subject to the possibility of a tax under Section 4980H if it fails to offer its full-time employees and their dependents adequate health coverage. Its claim is not justiciable.

1. *The restaurant group cannot extinguish the tax-credit claims of its employees.*

First, under the terms of Section 4980H, the restaurant group's tax liability will arise as a matter of law if one or more of its full-time employees obtain premium tax credits on an Exchange because they did not have access to employer provided affordable coverage. The employees are not parties to this suit, and a judgment in this case could not extinguish their claims for premium tax credits. The employees would be free to seek such tax credits on an Exchange and, if such tax credits were denied, to sue in their local district court or in the Court of Federal Claims to compel payment of the premium tax credits.

The District Court for the Eastern District of Oklahoma made this point when it denied the same restaurant group's motion to intervene in parallel litigation

brought by the Oklahoma Attorney General, who seeks to block Oklahoma residents from receiving federal premium tax credits. *See* Order (R.59), *State of Oklahoma, ex rel. Scott Pruitt v. Sebelius*, No. 6:11-cv-00030 (E.D. Okla. Mar. 4, 2013). The *Oklahoma* court explained that "the Movants' employees are likely necessary parties to the Movants' claims, and as those employees are Texas residents, this court has no personal jurisdiction over them." *Id*. at 3-4.

In this case, plaintiffs argued below that an order setting aside the Treasury regulation would prevent the restaurant group's employees and millions of other people across the country from obtaining premium tax credits on federally-run Exchanges. Plaintiffs do not renew that argument here, and for good reason. This is not a class action, and, even assuming *arguendo* that the Court were to accept plaintiffs' position, the judgment would not extinguish the claims of non-parties, who could seek to establish their entitlement to tax credits by suing in their home Circuits. Even if Treasury's interpretive regulation did not exist, individuals who are not parties here could seek premium tax credits under the authority of Section 36B itself.

Plaintiffs asserted below that it "is extraordinarily unlikely" that the restaurant group's employees would claim Section 36B tax credits if the court were to rule in the restaurant group's favor. R.57 at 43. That assertion is inexplicable—the employees would have an obvious interest in claiming premium

tax credits that are worth, on average, more than $5,000 per person per year. *See* p. 5, *supra*.

2. *The Anti-Injunction Act bars a suit to restrain the assessment or collection of a federal tax.*

Second, the district court correctly held that Anti-Injunction Act independently bars the restaurant group's attempt to restrain the assessment and collection of the Section 4980H tax. *See* JA 340-346. The Anti-Injunction Act provides, with statutory exceptions inapplicable here, that "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." 26 U.S.C. § 7421(a). "This statute protects the Government's ability to collect a consistent stream of revenue, by barring litigation to enjoin or otherwise obstruct the collection of taxes." *NFIB*, 132 S. Ct. at 2582. "Because of the Anti-Injunction Act, taxes can ordinarily be challenged only after they are paid, by suing for a refund." *Ibid*. (citing *Enochs v. Williams Packing & Nav. Co.*, 370 U.S. 1, 7–8 (1962)); *see also Bob Jones*, 416 U.S. at 736. When the Anti-Injunction Act applies, it divests the Court of subject-matter jurisdiction. *See*

Williams Packing, 370 U.S. at 5; *Seven-Sky v. Holder*, 661 F.3d 1, 5 (D.C. Cir. 2011), cert. denied, 133 S. Ct. 63 (2012).[18]

In *NFIB*, the Supreme Court held that the Anti-Injunction Act did not bar that pre-enforcement challenge to Section 5000A, the minimum coverage provision. In so ruling, the Court relied on the "text of the pertinent statutes." *NFIB*, 132 S. Ct. at 2582. The Court stressed that the Anti-Injunction Act "applies to suits 'for the purpose of restraining the assessment or collection of any *tax*.'" *Ibid*. (quoting 26 U.S.C. § 7421(a)) (Supreme Court's emphasis). "Congress, however, chose to describe the '[s]hared responsibility payment' imposed on those who forgo health insurance not as a 'tax,' but as a 'penalty.'" *Id*. at 2583 (quoting 26 U.S.C. § 5000A(b), (g)(2)). The Court reasoned that "Congress's decision to label this exaction a 'penalty' rather than a 'tax' is significant because the Affordable Care Act describes many other exactions it creates as 'taxes.'" *Ibid*. (citation omitted). "Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally." *Ibid*. (citation omitted).

[18] The Declaratory Judgment Act also excepts from its coverage suits for declaratory relief "with respect to Federal taxes." 28 U.S.C. § 2201. This Court held that this exception is coterminous with the scope of the Anti-Injunction Act. *See Cohen v. United States*, 650 F.3d 717, 724 (D.C. Cir. 2011) (*en banc*); *cf. Bob Jones Univ. v. Simon*, 416 U.S. 725, 732 n.7 (1974) (Declaratory Judgment Act's tax exception "is at least as broad as the Anti-Injunction Act").

In contrast to the minimum coverage provision, Section 4980H repeatedly uses the term "tax" to describe the amount that a large employer will owe the IRS under the conditions described in the statute. Section 4980H(b)(2) places a cap on the "aggregate amount of tax" that an employer may owe under that provision. Section 4980H(c)(7) provides that the "tax imposed by" Section 4980H is "nondeductible." Section 4980H(c)(7) cross-references Section 275(a)(6) of the Internal Revenue Code, which provides that no tax deduction is allowed for "[t]axes imposed by chapters 41, 42, 43, 44, 45, 46, and 54." The "tax" imposed by the employer responsibility provision is nondeductible because it is one of the "[t]axes imposed by" chapter 43. *Ibid*. And the same assessment is described as a tax elsewhere in the Act. *See* 42 U.S.C. § 18081(f)(2)(A) ("The Secretary [of HHS] shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of Title 26[.]").

The district court correctly declined to follow the reasoning of the Fourth Circuit in *Liberty University v. Lew*, 733 F.3d 72, 86-89 (4th Cir. 2013), which concluded that the use of the word "tax" in Section 4980H is insufficient to implicate the Anti-Injunction Act. The Fourth Circuit read "the term 'assessable payment' as nullifying the effect of the word 'tax.'" JA 343. "[H]owever, the natural conclusion to draw from Congress's interchangeable use of the terms

'assessable payment' and 'tax' in Section 4980H is simply that Congress saw no distinction between the two terms." JA 343-344 (citing *Cohen v. United States*, 650 F.3d 717, 731 (D.C. Cir. 2011) (*en banc*) ("A baker who receives an order for 'six' donuts and another for 'half-a-dozen' does not assume the terms are requests for different quantities of donuts. . . . Different verbal formulations can, and sometimes do, mean the same thing."). The "term 'tax' as used in 26 U.S.C. § 7421(a), the Anti-Injunction statute," has "the same meaning as the term 'tax' as used elsewhere in the Internal Revenue Code, including in Section 4980H." JA 344 (citing *Powerex Corp. v. Reliant Energy Servs., Inc.*, 551 U.S. 224, 232 (2007) (recognizing the "standard principle of statutory construction . . . that identical words and phrases within the same statute should normally be given the same meaning").

Plaintiffs argue that 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." Pl. Br. 55 (quoting *Liberty University*, 733 F.3d at 88) (plaintiffs' emphasis). But plaintiffs disregard "another provision in Section 4980H" that "confirms that Congress assumed that employers would raise their challenges in post-collection suits." JA 345. "The statute provides that the Secretary of the Treasury 'shall prescribe rules . . . for the *repayment* of any assessable payment . . . if such payment is based

on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.'" *Ibid*. (quoting 26 U.S.C. § 4980H(d)(3)) (court's emphasis). No comparable provision exists in Section 5000A. *See ibid*.

Moreover, plaintiffs' description of Section 4980H as an "employer mandate" is a misnomer. There is no "mandate" in Section 4980H—there is only a tax. *See Liberty Univ.*, 733 F.3d at 98. And the Anti-Injunction Act bars an attempt to restrain the assessment or collection of that tax. Although the restaurant group asserts that it is not attempting to restrain the assessment or collection of the Section 4980H tax, *see* Pl. Br. 57, that is the only provision that even arguably could cause the restaurant group any Article III injury.

CONCLUSION

The case should be remanded with instructions to dismiss the complaint or, alternatively, the judgment of the district court should be affirmed.

Respectfully submitted,

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FEBRUARY 2014

CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(A)

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I further certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 13,754 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

/s/ Alisa B. Klein
Alisa B. Klein

CERTIFICATE OF SERVICE

I hereby certify that on February 12, 2014, I electronically filed the foregoing brief with the Clerk of this Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/ Alisa B. Klein
Alisa B. Klein

ADDENDUM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JAN - 7 2013

Ms. Mary Mayhew
Commissioner
Department of Health and Human Services
11 State House Station
221 State Street
Augusta, ME 04333-0011

Dear Ms. Mayhew:

I am responding to your request for approval of the State of Maine's Medicaid state plan amendment (SPA) #12-010, received by the Centers for Medicare & Medicaid Services (CMS) on August 1, 2012. The state subsequently split the SPA into two separate SPAs, #12-010 and #12-010A.

Today, under separate cover, we are approving #12-010A, which makes changes to eligibility for parents, caretaker relatives, and individuals who are eligible for Medicaid based on their eligibility for Medicare, whose income is above 133 percent of the federal poverty line (FPL).

In SPA #12-010, Maine proposes changes to eligibility for parents, caretaker relatives and children whose income is at or below 133 percent of the FPL. The proposal would make eligibility standards, methods, and procedures more restrictive than those in effect on March 23, 2010. For the reasons set forth below, I am unable to approve SPA #12-010 because it does not comply with the requirements of sections 1902(a)(74) and 1902(gg) of the Social Security Act (Act).

Medicaid Maintenance of Effort Requirements

Under sections 1902(a)(74) and 1902(gg) of the Act, added to the Social Security Act by the Affordable Care Act, state plans must maintain Medicaid eligibility standards, methodologies, and procedures that are no more restrictive than those in effect on March 23, 2010, (the date of enactment of the Affordable Care Act) for a limited period of time. We refer to those provisions as maintenance of effort (MOE) requirements. For adults, under 1902(gg)(1), MOE provisions apply until a health insurance Exchange is operational on January 1, 2014. To the extent that the state certifies that it has an actual or projected budget deficit, under 1902(gg)(3), there is a limited exception under which MOE provisions do not apply to non-pregnant, non-disabled adults in optional populations who have income above 133 percent of the FPL for the applicable family size.

The Affordable Care Act MOE provisions relating to adults are aimed at maintaining stability during the period between enactment of the Affordable Care Act and 2014, when the Exchanges will become operational.

Discussion

As discussed above, it is not consistent with the MOE requirements in sections 1902(a)(74) and 1902(gg) of the Act for Maine to have eligibility standards, methods, or procedures under its State plan that are more restrictive for children until September 30, 2019, and for adults until a health insurance Exchange is operational in the state (on January 1, 2014), except, based on the state's budget deficit certification, for non-pregnant, non-disabled adults whose income exceeds 133 percent of the FPL. Based on Maine's certification of a projected budget deficit, on February 10, 2012, CMS notified the state that Maine qualified for the exception to the MOE provisions pursuant to section 1902(gg)(3) of the Act for the period from July 1, 2012, through June 30, 2013. This exception applies to non-pregnant, non-disabled adults whose income exceeds 133 percent of the FPL. This provision of law allows us to approve SPA #12-010A.

The provisions of SPA 12-010 would violate the permissible limitations by reducing eligibility for children and for parents and caretaker relatives who have income below 133 percent of the FPL. As a result, we cannot approve proposed SPA 12-010 as consistent with the requirements of sections 1902(a)(74) and 1902(gg) of the Act.

Specifically, the areas of MOE violation are as follows:

1. Parents and Caretaker Relatives: Maine proposed to reduce income eligibility levels for parents and caretaker relatives, eligible under sections 1902(a)(10)(A)(i)(I) and 1931 of the Act, from 150 to 100 percent of the FPL. Since 2005, the Maine plan has covered parents and caregiver relatives with income up to 150 percent of the FPL. The proposed amendment thus would impose more restrictive eligibility standards on adults between 100 and 133 percent of the FPL, which is not consistent with the MOE requirements.

2. Children Ages 19 and 20: Maine proposed to reduce the age limit for eligibility under its state plan for individuals who meet the income and resource requirements of the AFDC state plan but would not have received AFDC benefits because of age. This proposed change would eliminate eligibility for such individuals who are ages 19 and 20. Since 1991, the Maine plan has covered 19 and 20 year olds who meet the income and resource requirements of the AFDC state plan.[1] Because the individuals were previously covered by the state based on their status as children, reduction of eligibility for these individuals is not permitted under the budget deficit certification exception, which is available only for non-pregnant, non-disabled adults. Even if these individuals were treated as adults, the budget deficit certification exception would not apply because the income level of

[1] The state would make an exception to this reduction of eligibility for 19 and 20 year olds who are independent foster care adolescents.

these individuals (based on the AFDC state plan standards) is below 133 percent of the FPL.[2]

We do not agree with your claim that *National Federation of Independent Businesses v. Sebelius*, 567 U.S. ___, 132 S. Ct. 2556 (2012) (*NFIB*), requires that SPA 12-010 be approved despite these violations of the MOE requirements. In *NFIB*, the Supreme Court did not strike down any part of the Affordable Care Act. The Court limited federal enforcement remedies with respect to states that elect not to proceed with the Medicaid adult eligibility expansion and thus have state plans that are out of compliance with the provisions of section 1902(a) of the Act. The Court did not strike down any provision of the law, nor did it authorize approval of state plan provisions that do not comply with other provisions of the law, including the MOE requirements. Accordingly, we do not agree with your assertion that the Court's reasoning in *NFIB* implies that the MOE provision in section 1902(gg) of the Act is unconstitutional or that it would be unconstitutional for the Secretary to disapprove the proposed state plan amendments due to their inconsistency with section 1902(a)(74) of the Act.

In *NFIB*, the Court likened the Medicaid adult eligibility expansion to an entirely new program because it will expand Medicaid coverage to all low-income adults, where Medicaid has previously covered only "the disabled, the blind, the elderly and needy families with dependent children." *NFIB*, 132 S. Ct. at 2605-06. The Court concluded that this shift is "a shift in kind, not merely in degree," and distinguished it from earlier eligibility expansions under the Medicaid program, which had "merely altered and not expanded the boundaries of these categories." *Id.* In concluding that the Secretary could not, constitutionally, withhold all funding for a state's existing Medicaid program if the state refused to implement the Medicaid adult eligibility expansion, the Court reasoned that, "while Congress may have styled the expansion a mere alteration of existing Medicaid, it recognized it was enlisting the States in *a new health care program*." *Id.* at 2606 (emphasis added). The Court concluded that Congress could not make existing Medicaid funding contingent upon a state's agreement to implement this new health care program. *Id.* at 2605-07.

The MOE provisions are not part of the Medicaid adult eligibility expansion. To the contrary, the MOE provisions require the state to continue providing medical assistance to populations that were previously covered by the state's Medicaid program. The populations that Maine has proposed to eliminate from the state Medicaid program are "needy families with dependent children," populations that have long been covered by the state's Medicaid program. Medicaid coverage for parents and caretaker relatives was first authorized under the original enactment of the Medicaid statute in 1965, and Maine has covered them at the current income level since 2005. Similarly, Medicaid coverage for 19 and 20 year old children was first authorized in the original enactment of the Medicaid statute in 1965, and Maine has covered them at the current income level since 1991. Thus, as relevant here, because the MOE provisions require the state plan to continue coverage of needy families with dependent children that the state has covered for many years rather than implement a new program, the analysis in *NFIB* makes it clear that the MOE provisions are well within Congress's authority.

[2] For example, the amount for a family of three with an adult in the home is approximately 28% percent of the FPL.

You also assert that the MOE requirements retroactively penalize the state for having maintained its eligibility levels during the period financial incentives for doing so were available under the American Recovery and Reinvestment Act of 2009 (ARRA), without continuing the incentives that were present under ARRA. However, as discussed above, Maine's coverage of the groups of individuals it now proposes to drop from Medicaid began long before ARRA.

To the extent that Maine now faces economic pressures, Maine still has substantial flexibility to achieve budgetary objectives consistent with the MOE requirements. The state retains flexibility to adjust benefit levels or provider payment rates and to increase the effectiveness and efficiency of service delivery consistent with many of the new opportunities afforded states under the Affordable Care Act as well as existing flexibilities in the Medicaid program.

For these reasons, and after consulting with the Secretary as required by federal regulations at 42 CFR 430.15(c), I am unable to approve this SPA. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of receipt of this letter in accordance with the procedures set forth at 42 CFR 430.18. Your request for reconsideration may be sent to Ms. Cynthia Hentz, Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP and Survey & Certification, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, MD 21244-1850.

If you have any questions or otherwise wish to discuss this determination, please contact Mr. Richard McGreal, Associate Regional Administrator, JFK Federal Building, Government Center, Room 2275, Boston, MA 02203.

Sincerely,

Marilyn Tavenner
Acting Administrator

cc:

Regional Administrator, Boston RO
Associate Regional Administrator, Boston RO