No. 14-1158

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

DAVID KING, ET AL.,

Appellants,

v.

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

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA (NO. 3:13-CV-630 (JRS))

BRIEF FOR APPELLANTS

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JURISDICTIONAL STATEMENT

Plaintiffs-Appellants brought an action under the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, to vacate and declare unlawful final regulations promulgated by the Internal Revenue Service ("IRS"). The district court had subject-matter jurisdiction pursuant to 28 U.S.C. § 1331. On February 18, 2014, the district court issued an opinion granting judgment to defendants (JA291), and dismissed the case. (JA315) Appellants noticed an appeal the next day. (JA316) This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUE

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

STATEMENT OF PERTINENT AUTHORITIES

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

STATEMENT OF THE CASE

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

A. In Debating the ACA, Centrist Senators Insist That States, Not the Federal Government, Establish and Operate the Act's Health Insurance Exchanges.

The ACA regulates the individual health insurance market primarily through insurance "Exchanges." An Exchange is a mechanism for organizing the insurance marketplace to help individuals and small businesses shop for coverage and compare available plan options based on price, benefits, and services. (*See* JA292) Participation in Exchanges also facilitates federal regulation of insurers (who must comply with numerous requirements in order to participate in an Exchange) and also individuals (most of whom are required by the ACA's so-called "individual mandate" to purchase comprehensive insurance policies).

Initially, there were some proponents of having the federal government establish and operate a single, national Exchange. But Congress heard extensive testimony criticizing that approach and urging instead that the Exchanges be run by states. *E.g.*, Roundtable Discussion on Expanding Health Care Coverage: Before S. Comm. on Finance, 111th Cong. 2, 4, 6 (May 5, 2009).

The House of Representatives then enacted a bill under which the federal government would create a national Exchange, but individual states could choose to opt out and establish their own Exchanges instead. (JA205-13 (H.R. 3962, § 308, 111th Cong. (2009))) That compromise, however, was unacceptable to the Senate. Senator Ben Nelson of Nebraska, whose vote was critical to final passage, called it a "dealbreaker," expressing concern that such federal involvement would "start us down the road of … a single-payer plan." Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO (Jan. 25, 2010), http://www.politico.com/livepulse/0110/Nelson_National_exchange_a_dealbreaker.html. For Nelson and other swing Senators, it was important to keep the federal government *out* of the process. It was thus insufficient to merely allow states the *option* to establish Exchanges, as the House bill did. To secure their support, the Act had to take affirmative steps to ensure that states *would* establish their own Exchanges.

B. Congress Uses "Carrots" and "Sticks" To Encourage States To Establish Their Own Health Insurance Exchanges, with Federal Exchanges Only as a Fallback.

Under the Constitution's core federalism commands, the federal government cannot *compel* sovereign states to create Exchanges. *See Printz v. United States*, 521 U.S. 898, 935 (1997). Congress knew that, and so it knew that, to satisfy the demands of crucial moderate Senators that states operate the Exchanges, the ACA had to provide robust incentives to encourage states to voluntarily play that role.

Ultimately, then, Congress enacted a bill calling for states to establish the Exchanges and providing incentives for them to do so. The ACA provides: "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State." ACA § 1311(b)(1), *codified at* 42 U.S.C. § 18031(b)(1). It also recognizes that some states may not be "electing State[s]," because they may choose not "to apply the requirements" for an Exchange or otherwise "fai[l] to establish [an] Exchange." ACA § 1321(b)-(c), *codified at* 42 U.S.C. § 18041(b)-(c). To address that scenario, the Act authorizes the Department of Health and Human Services ("HHS") to establish fallback Exchanges in states that do not establish their own. If a state is "not an electing State" or if HHS determines that a state "will not have any required Exchange operational by January 1, 2014," the Secretary "shall … establish and operate such Exchange within the State." ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). Thus, if a state declines the role that the ACA urges it to accept, that responsibility falls upon the federal government instead.

Again, however, because crucial swing Senators sought to keep the federal government out of the Exchange system as much as possible, Congress utilized a variety of tools to encourage states to establish them voluntarily. For example, the Act authorizes federal grants to states for "activities (including planning activities) related to establishing an [Exchange]." ACA § 1311(a), *codified at* 42 U.S.C.

§ 18031(a). It also penalizes states that do not create their own Exchanges, such as by prohibiting them from tightening their Medicaid eligibility standards until they do. *See* ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg) (requiring maintenance of eligibility standards until HHS "determines that an Exchange established by the State under section 1311 of the [ACA] is fully operational").

Most importantly, the Act authorizes premium assistance subsidies for individual health coverage purchased through *state*-established Exchanges. These subsidies take the form of refundable tax credits, paid by the federal treasury to the taxpayer's insurer as an offset against the taxpayer's premiums. ACA § 1401(a), *codified at* 26 U.S.C. § 36B; ACA § 1412, *codified at* 42 U.S.C. § 18082.

Critically, the subsidy is available only for coverage through an Exchange *established by a state*. The Act provides that a tax credit "shall be allowed" in a particular "amount," 26 U.S.C. § 36B(a), with that amount calculated based on the number of "coverage months of the taxpayer occurring during the taxable year," *id.* § 36B(b)(1). The Act then defines a "coverage month" as a month for which, "as of the first day of such month the taxpayer … is covered by a qualified health plan … that was enrolled in through an Exchange *established by the State under section 1311* of the [ACA]." *Id.* § 36B(c)(2)(A)(i) (emphasis added). Unless the citizen buys coverage through a state-established Exchange, there are no "coverage months" and therefore no subsidy. Confirming that, the value of the subsidy for

any particular "coverage month" is based on the monthly premium for a "qualified health pla[n] … which cover[s] the taxpayer … and which w[as] enrolled in through an Exchange established by the State under [§] 1311 of the [ACA]," *id.* § 36B(b)(2)(A); *see also id.* § 36B(b)(3)(B)(i) (referring back to "same Exchange … [as] under paragraph (2)(A)" for purpose of calculating another value affecting the subsidy). Again, the subsidy is thus available only for coverage purchased through a state-created Exchange established under § 1311 of the ACA.

Evidently believing this offer to be so irresistible that "every state would set up its own Exchange" (JA311), Congress did not appropriate any funds in the ACA for HHS to establish Exchanges, even as it appropriated funds to help states establish theirs. "[L]awmakers assumed that every state would set up its own exchange." Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, Aug. 4, 2012, at A17; *see also* Elise Viebeck, *Obama Faces Huge Challenge in Setting up Health Insurance Exchanges*, THE HILL, Nov. 25, 2012 ("The law assumed states would create and operate their own exchanges …."). Indeed, ACA proponents emphasized that "[a]ll the health insurance exchanges … are run by states," thereby downplaying charges that the Act would be a federal "takeover" of the health care industry. SENATE DEMOCRATIC POLICY COMM., *Fact Check: Responding to Opponents of Health Insurance Reform* (Sept. 21, 2009), *available at* http://dpc.senate.gov/reform/reform-factcheck-092109.pdf.

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

Notwithstanding the ACA's text, the IRS in 2011 proposed, and in 2012 promulgated, regulations requiring the federal treasury to disburse subsidies for coverage purchases through *all* Exchanges—not only those established by states under § 1311 of the Act, but also those established by HHS under § 1321. *See* 76 Fed. Reg. 50931, 50934 (Aug. 17, 2011); 77 Fed. Reg. 30,377, 30,378, 30,387 (May 23, 2012). Appellants refer to these regulations as "the IRS Rule."

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

Facing comments pointing out this facial inconsistency with the statute, the IRS offered only the following in defense of the Rule:

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

77 Fed. Reg. at 30,378.

D. 34 States Decline To Establish Their Own Exchanges.

After the IRS announced that taxpayers would be eligible for subsidies whether or not their states established Exchanges, 34 states—including Virginia—declined to establish their own Exchanges. (JA293)[1] Two states also could not establish their Exchanges in time, for a total of 36 states without state-established Exchanges for 2014.[2] Pursuant to § 1321 of the ACA, *codified at* 42 U.S.C. § 18041, HHS therefore established federal Exchanges (on HealthCare.Gov) to serve those states.

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[1] The states are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. *See State Decisions For Creating Health Insurance Exchanges*, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/.

[2] Jennifer Corbett Dooren, *Two States Seek Help With Health Exchanges*, WALL ST. J. (May 22, 2013), http://online.wsj.com/news/articles/SB10001424127887323336104578499444065609364.

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

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

For individuals, the availability of the subsidy triggers the Act's individual mandate penalty for many who would otherwise be exempt. That mandate requires all "applicable" individuals to obtain "minimum essential coverage." 26 U.S.C. § 5000A(a). Failure to comply triggers a penalty. *Id.* § 5000A(b). But that penalty does not apply to those "who cannot afford coverage" or who would suffer "hardship" if forced to buy it. *Id.* § 5000A(e)(1), (5). Under HHS regulations implementing these exemptions, an individual may obtain an advance exemption from the individual mandate penalty, called a "certificate of exemption," if the annual cost of health coverage exceeds eight percent of his projected household income. *See* 45 C.F.R. § 155.605(g)(2); *see also* 26 U.S.C. § 5000A(e)(1)(A). For individuals only able to purchase coverage in the individual market, that cost is calculated as the annual premium for the cheapest insurance plan available in the Exchange in that person's state, minus "the credit allowable under section 36B." 26 U.S.C. § 5000A(e)(1)(B)(ii). Thus, by purporting to make a credit "allowable" in states served by HealthCare.Gov, the IRS Rule reduces the number of people in those states exempt from the individual mandate's penalty. Now ineligible for

certificates of exemption, those individuals are no longer free to forgo coverage, or to buy less expensive "catastrophic" coverage (otherwise restricted to those under age 30, ACA § 1302(e)(1)(A), (2), *codified at* 42 U.S.C. § 18022(e)(1)(A), (2)).

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

F. Injured Virginia Residents Challenge the IRS Rule.

Appellants in this case are individuals residing in Virginia, which has declined to establish its own Exchanges and therefore is served by HealthCare.Gov. The four individual plaintiffs do not want to comply with the individual mandate in 2014, and, given their low incomes, would not be subject to penalties for failing to do so—but for the IRS Rule, which renders them eligible for subsidies that would

reduce the net cost of their coverage to below 8% of projected income and so disqualify them from the mandate's hardship exemption. (JA295-96) In other words, the IRS Rule brings each of the Appellants "within the ambit of the Minimum Coverage Provision [*i.e.*, the individual mandate]." (JA295-96) Thus, "as a result of the IRS Rule, they will incur some financial cost because they will be forced to buy insurance or pay the [individual mandate] penalty." (JA298)

G. The District Court Rejects the Government's Jurisdictional Arguments, but Upholds the IRS Rule on the Merits.

Below, Appellants moved for a preliminary injunction against the IRS Rule. The district court denied that motion, reasoning that it would expedite the merits briefing and dispose of the case before any irreparable harm resulted. (JA289) The parties then filed cross-motions, with the Government raising jurisdictional objections to the Complaint and both sides debating the validity of the IRS Rule.

On February 18, 2014, the district court rejected the Government's standing and ripeness arguments, but upheld the IRS Rule. On the jurisdictional issues, the court found that Appellants had Article III standing because "their economic injury is real and traceable to the IRS Rule." (JA299) Appellants also clearly satisfied the prudential standing test, since they are "directly regulated" by the Act. (JA300) The court also recognized that Appellants could challenge the IRS Rule under the APA, and that such a challenge was ripe given the purely legal nature of the suit and the hardship that Appellants would suffer from delay. (JA300-04)

On the merits, the district court recognized that Appellants' "plain meaning interpretation of section 36B has a certain common sense appeal." (JA311) The court, nonetheless, concluded that Congress unambiguously intended just the contrary of that "plain meaning." The court inferred that counter-textual intent from (i) Congress's policy goal "to ensure broad access to affordable health care for all" (JA311); (ii) the absence of "direct support in the legislative history" confirming the plain text (JA311); and (iii) supposed "anomalous results" under some of the Act's other provisions, were the text given its plain meaning (JA307).

SUMMARY OF ARGUMENT

I. No legitimate method of statutory construction would interpret the phrase "Exchange established by the State under section 1311" in the ACA's subsidy provision to mean "Exchange established by the State *or by HHS* under section 1311 *or section 1321*." The Act contemplates both state-established Exchanges (the default) and HHS-established Exchanges (in states that refuse to establish their own); where it specifically refers to one or the other, courts must give effect to that language. It is fundamentally incompatible with the plain text to treat an HHS-established Exchange as "established by the State," particularly because it is a state's *failure* to establish an Exchange that triggers HHS's authority in the first place; because Congress elsewhere in *the same provision* referred expressly to HHS Exchanges as distinct from state Exchanges; and because

Congress demonstrably knew how to deem other Exchanges to be state-established when it wanted, as it did with Exchanges established by U.S. territories. The district court, however, all but ignored the actual statutory language.

Because the plain text of the subsidy provision creates no absurdity, either in that provision itself or any other part of the ACA, that text would be conclusive even if legislative history and purpose undermined it. But they do not. Indeed, the ACA's restriction of subsidies to state-established Exchanges is neither novel nor surprising. Congress has often evaded the constitutional bar on commandeering states by offering them "deals" they could not refuse, conditioning federal benefits for the state or its residents on state compliance with federal directives. Indeed, Congress indisputably did so *in the ACA* itself, conditioning all future Medicaid funds on the state's agreement to expand the eligibility criteria for that program. The ACA's subsidy provision offered an analogous "deal" to entice states to establish Exchanges—because Congress (wisely, in hindsight) knew it had to offer huge incentives for the states to assume responsibility for that logistically nightmarish and politically toxic task. Just as there is no indication in the legislative record that anyone worried about states rejecting the Medicaid "deal," there is no indication that anyone worried about rejection of the Exchanges "deal."

If a state nonetheless *had rejected* the Medicaid "deal," that would plainly have required cutting off its Medicaid funds, notwithstanding Congress's obvious

purpose of *expanding* Medicaid. Similarly, while denying subsidies to states rejecting the Exchanges "deal" creates the (far-fetched) potential for fewer subsidies than Congress optimally desired, that is the inevitable risk created by Congress' need to offer states inducements to undertake the desired action (since it could not require such action). Of course, it is quite likely (if not certain) that Congress would have accomplished *both* its policy goals—state-run Exchanges *and* universal subsidies—had the IRS not preemptively eliminated the irresistible incentive of subsidies, replacing a deal too good to refuse with a "deal" that offered states nothing (and which 34 states unsurprisingly declined).

II. *Chevron* deference cannot save the IRS Rule. *First*, deference is triggered only if a statute is *ambiguous*, yet the ACA directly answers the question at issue. *Second*, it is simply implausible that Congress would have left it to the IRS to decide whether to trigger *billions* of dollars of annual federal spending; there was no implicit delegation here. *Third*, any deference would be displaced by the venerable canon requiring all tax credits to be provided *unambiguously*. *Fourth*, the *IRS* is entitled to no deference in construing the statutory language on which the Government bases its defense of the Rule, which is found in Title 42 of the U.S. Code, *not* the Internal Revenue Code. *Finally*, rendering express statutory text nugatory is the epitome of an *unreasonable* construction.

STANDARD OF REVIEW

In APA challenges to agency action, this Court reviews the district court's findings *de novo*. *Ohio Valley Envt'l Coal. v. Aracoma Coal Co.*, 556 F.3d 177, 189 (4th Cir. 2009). *Accord Holland v. Nat'l Mining Ass'n*, 309 F.3d 808, 814 (D.C. Cir. 2002) ("[W]e review the administrative action directly, according no particular deference to the judgment of the District Court.").

ARGUMENT

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

"If the statute is clear and unambiguous 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *Bd. of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 368 (1986) (quoting *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984)); *see also Sigmon Coal Co. v. Apfel*, 226 F.3d 291, 304 (4th Cir. 2000) (finding agency interpretation irrelevant where statutory "text" was "clear and unambiguous"), *aff'd sub nom. Barnhart v. Sigmon Coal Co.*, 534 U.S. 438 (2002). Here, the relevant text of the ACA is indeed "clear and unambiguous," *Dimension Fin.*, 474 U.S. at 368, and the IRS Rule is squarely inconsistent with it. The ACA repeatedly makes perfectly clear that subsidies are available only for coverage purchased on Exchanges established "*by the State*," but the IRS Rule consciously eliminates that express prerequisite.

A. There Is No Remotely Plausible Reading of the ACA's Subsidy Provision That Could Support the IRS Rule, and the District Court Offered None.

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

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

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

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

3. The IRS Rule thus facially contradicts the plain and unambiguous text of the ACA. The latter expressly restricts subsidies to coverage obtained through "an Exchange established by the State under section 1311," but the former expands them to *any* Exchange, "regardless of whether [it] is established … by a State."

At the risk of belaboring the obvious: An Exchange established by HHS under the authority of § 1321 of the Act is not "an Exchange established by the State under section 1311 of the [Act]." HHS is not a "State." If there could be any doubt, the Act clarifies: "[T]he term 'State' means each of the 50 States and the District of Columbia." ACA § 1304(d), *codified at* 42 U.S.C. § 18024(d). Moreover, sections 1311 and 1321 of the Act are distinct grants of authority to distinct entities, the former directing each "State" to "establish an American Health Benefit Exchange" and the latter directing HHS to "establish and operate such Exchange" in states that fail to. As the district court acknowledged, Appellants offer a "plain language interpretation" of the statute. (JA311) And because the statutory text is clear, the "judicial inquiry is complete." *Crespo v. Holder*, 631 F.3d 130, 136 (4th Cir. 2011) (quoting *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992)). After all, the Supreme Court has "consistently stated that when a statute is plain on its face, a court's inquiry is at an end." *Rosmer v. Pfizer, Inc.*, 263 F.3d 110, 117 (4th Cir. 2001).

4. Reading the text's plain language to mean what it says is corroborated by every canon of construction. *First*, if "Exchange established by the State under section 1311" is read to include *all* Exchanges, then the modifiers "established by the State" and "under section 1311" would serve no purpose at all, violating the "cardinal principle" that "no clause … [of a statute] shall be superfluous, void, or insignificant." *Duncan v. Walker*, 533 U.S. 167, 174 (2001). Indeed, the problem with the Government's view is not merely that it renders the text "superfluous" because *redundant*, but that the modifiers state the very *opposite* of what Congress supposedly intended. The *Act says* "established by the State" and "under section 1311" even though Congress purportedly intended to convey "or established by HHS" and "or under section 1321." If Congress intended to include *both* types of Exchanges, why expressly refer to only one? The district court did not even *try* to answer this dispositive, fatal question.

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

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

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

5. Nevertheless, the district court held that "an Exchange established by the State" in § 36B means "an Exchange established by the State *or by HHS when the state fails to establish one*." Its single sentence analyzing the statutory text suggests that since the ACA provides that HHS should establish "*such* Exchange" when a state fails to do so, ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c) (emphasis added), the Act somehow required the impossible: for *HHS* to "establish" a *state-established* Exchange. (JA307)

That is untenable. "Such" simply means that HHS must establish the same Exchange that the State would have established had it elected to create one. Thus, "such Exchange" simply describes *what* the Exchange is, not *who* established it. The HHS Exchange should operate just like the Exchange that "the State would otherwise have established." *But it is established by HHS, not the state.* If Congress asked states to build certain airports, and described these airports in great detail (specifying, *e.g.*, air traffic and security procedures), but added that the Secretary of Transportation should construct "such airports" if states fail to, would anyone refer to the latter as "state-constructed airports"? Obviously not.

The district court also cited the ACA's global definition of "Exchange," but that provision adds nothing, and certainly does not support the *Government's* argument. The Act defines "Exchange" as "an American Health Benefit Exchange established under section 1311." ACA § 1563(b)(21), *codified at* 42 U.S.C.

§ 300gg-91(d)(21). If anything, that makes Appellants' argument stronger, as it suggests that § 36B's use of the term "Exchange"—even without the qualifiers "established by the State under section 1311"—could have been read as limiting subsidies to the state-run Exchanges that are established under that section. Yet, to avoid doubt, Congress clarified further. The Government has argued that, by plugging the definition of Exchange into the ACA provision directing HHS to establish "such Exchange" if the state fails to do so, the result is that HHS is directed to establish an Exchange "under section 1311." But that still cannot and does not change the dispositive fact that it is *HHS*, not the *state*, that is establishing the Exchange—and thus that HHS Exchanges are not "established by the State."[3]

6. The court below also cited a decision by a District of Columbia district court, in a case raising the same challenge to the IRS Rule. In upholding the Rule, the court there reasoned that federal Exchanges may be treated as established "by the State" because the ACA "directs the Secretary of HHS to establish such Exchange and bring it into operation if the state does not do so." *Halbig v. Sebelius*, No. 13-623, 2014 WL 129023, at *14 (D.D.C. Jan. 15, 2014).

[3] At most, the Act's definition of "Exchange" could sow doubt over the metaphysical question whether Exchanges established by HHS *pursuant to* § 1321 of the ACA are created "under" that section (as common parlance would dictate and HHS recognizes, 45 C.F.R. § 155.20) or rather "under" § 1311. But, either way, they are established *by HHS*, and only if the state *fails* to establish an Exchange. This potential confusion is presumably why § 36B further specifies that subsidies are limited to Exchanges "established *by the State* under section 1311."

That is, because a federal Exchange may be established if there is no state Exchange, this somehow means that the replacement federal Exchange is necessarily included in any reference to a state Exchange.

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

The *Halbig* court seems to have concluded that, when HHS establishes an Exchange because a state fails to do so, HHS acts "*on behalf of*" the state and thus, by some bizarre transitive property, an HHS-established Exchange is "established by the State." But it is plainly wrong to say that an Exchange established on behalf of a state by a different entity is somehow established by the state. An Exchange is

established either by a state or by HHS, not both. A "federally established state-established Exchange" is an oxymoron. An Exchange established by HHS "on behalf of" a state refusing to establish one is established *by HHS* in the refusing state, not *by* the state. Indeed, HHS's authority to create an Exchange is only *triggered* by the state's *failure* to do so, making the contrary reading particularly illogical: The ACA's *premise* is thus that an HHS Exchange is *not* an Exchange *established by the State*, because the former can be created only if the latter is not.

Thus, the only way that an HHS-established Exchange could be equated with a state-established Exchange is if the Act's plain language instructs that an HHS Exchange should be "deemed" to be established by the state. But the Act says no such thing. This is dispositive, particularly because the Act *does* contain just such express language for Exchanges established by U.S. territories. Section 1323 provides that if a territory establishes an Exchange, it "shall be treated as a State" for such purposes. ACA § 1323(a)(1), *codified at* 42 U.S.C. § 18043(a)(1). This conclusively proves that Congress knew how to create such equivalence when it wanted to, but no provision does so for federal Exchanges.

Likewise, an earlier House version of the ACA—which created one national Exchange but allowed states to "opt in" to run Exchanges themselves—also stated *expressly* that, if a state did opt in, "any references in this subtitle to the Health Insurance Exchange … shall be deemed a reference to the State-based Health

Insurance Exchange." (JA212-13 (H.R. 3962, § 308(e), 111th Cong. (2009)) No equivalent language regarding HHS Exchanges appears in the enacted ACA.

In short, that HHS may "step into the shoes" of a defaulting state and establish an Exchange in no way suggests that the HHS-established Exchange *is* "established by the State." For this reason, when Congress wants the federal government to step into the shoes of another entity *and be treated as if it were that entity*, it always says so *expressly*. For example, 28 U.S.C. § 2679(d)(1) allows the United States to "step into the shoes" of federal officers who are sued: It expressly provides that such a suit "shall be *deemed* an action against the United States." *Id.* (emphasis added). Likewise, the Bankruptcy Code allows a trustee "to stand in the shoes of an hypothetical creditor of the debtor to effect a recovery from a third party." *Zilkha Energy Co. v. Leighton*, 920 F.2d 1520, 1523 (10th Cir. 1990). That law, too, expressly provides that the trustee "shall have … the rights and powers of" such creditors. 11 U.S.C. § 544(a). And federal law allows the FDIC to "ste[p] into the shoes" of failed banks, *O'Melveny & Myers v. FDIC*, 512 U.S. 79, 86 (1994); it does so by expressly providing that the FDIC "shall … succeed to … all rights, titles, powers, and privileges" thereof. 12 U.S.C. § 1821(d)(2)(A)(i).

In all of the U.S. Code, there is not a single example of a situation in which Congress "deems" one entity to be another *without saying so*. Yet not only does the ACA not use any such express language; it does not even say that HHS should

establish an Exchange "for" or "on behalf of" the state. Instead, it says only that HHS shall establish an Exchange "within" the refusing state, ACA § 1321(c)(1), *codified at* 42 U.S.C. § 18041(c)(1), which has no "deeming" connotation at all. It simply designates the geography where the federal Exchange will operate, without suggesting that it is established *on behalf of* the defaulting state, much less that it is *equivalent* to an Exchange established by the state.

6. Even the Government does not actually believe that HHS Exchanges are, in fact, state-established. HHS regulations concede that federal Exchanges are "established … *by the Secretary* under *section 1321(c)(1)*" of the ACA. 45 C.F.R. § 155.20 (emphases added). Further, the very HHS definition of "Exchange" adopted by the IRS Rule provides that it covers any Exchange, "regardless of whether [it] is *established* and operated *by a State* … or *by HHS*." *Id.* (emphases added). HHS, at least, is under no illusions about who establishes state- and HHS-established Exchanges. And, quite sensibly, HHS refers to the two as distinct in its own regulations. *E.g.*, 78 Fed. Reg. 65046, 65048 (Oct. 30, 2013) ("In this final rule, we use the terms 'State Exchange' or 'FFE' [federally facilitated Exchange] when we are referring to a particular type of Exchange."). HHS thus recognizes that it would make no sense to refer to "State" Exchanges in *regulations* intended to capture *all* Exchanges, yet the Government's implausible argument here is that Congress irrationally did so in the *statute*.

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

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

Because the subsidy provision itself is plain and unambiguous, this Court's analysis should end there—with the text. "The general rule is that unless there is some ambiguity in the language of a statute, a court's analysis must end with the statute's plain language." *Hillman v. IRS*, 263 F.3d 338, 342 (4th Cir. 2001); *see also Blitz v. Napolitano*, 700 F.3d 733, 740 (4th Cir. 2012) ("[W]e have no reason to look beyond the plain text of the statute, in which Congress clearly expressed its intention … ."); *Allen v. United States*, 173 F.3d 533, 536 (4th Cir. 1999).

The only permissible basis for departing from plain text is the "rare and narrow" situation in which it creates an *absurd* result. *Md. Dep't of Educ. v. Dep't of Veterans Affairs*, 98 F.3d 165, 169 (4th Cir. 1996). "[W]hen the statute's

language is plain, the sole function of the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms." *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). Only if plain meaning "results in an outcome that can truly be characterized as absurd, *i.e.*, that is 'so gross as to shock the general moral or common sense,'" may the court "look beyond" the text. *Sigmon Coal*, 226 F.3d at 304. And, given the risk of substituting judges' policy views for those of Congress, "such instances are, and should be, exceptionally rare." *Id.* Thus, "the issue is not whether the result would be 'unreasonable,' or even 'quite unreasonable,' but whether the result would be *absurd*." *In re Sunterra Corp.*, 361 F.3d 257, 268 (4th Cir. 2004). This Court is thus properly "more than a little hesitant to abandon the presumption that Congress meant what it said, or did not say, when the words of a statute are plain." *Sigmon Coal*, 226 F.3d at 304.

1. Construing the ACA to provide subsidies only for coverage purchased on state-established Exchanges is plainly not absurd. Given the plausible concern that states would be reluctant to undertake the thankless job of establishing and operating Exchanges, offering them a seemingly irresistible incentive—billions of dollars in federal subsidies to their citizens—is extraordinarily sensible. Indeed, so conditioning subsidies was perhaps the only—and certainly the best—way to have states run the Exchanges: Congress could not *force* them to do so and thus needed a *very strong* incentive. Billions in subsidies are obviously the strongest incentive

and have a direct nexus to the Exchanges. Congress could quite reasonably have believed that elected state officials would not want to explain to their voters that they had deprived them of billions of dollars by failing to establish an Exchange.

Viewed another way, it is eminently sensible not to treat states that reject the invitation to establish an Exchange just as well as those who agree to shoulder that load. Indeed, treating participating and defaulting states the *same* is obviously *not* sensible because it eliminates any incentive to establish Exchanges. The decision to eschew federal subsidies in HHS Exchanges is thus hardly irrational. It is *undisputed* that it does not come *anywhere close* to "shock[ing] the general moral or common sense." *Sigmon Coal*, 226 F.3d at 304.

Indeed, Congress in the ACA imposed an analogous condition on states' receipt of Medicaid funds: Unless the states expanded their eligibility criteria for Medicaid benefits, they would lose all of their Medicaid funds. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012) ("*NFIB*") ("Congress is coercing the States to adopt the changes it wants by threatening to withhold all of a State's Medicaid grants, unless the State accepts the new expanded funding and complies with the conditions that come with it."). To be sure, Congress wanted and expected all states to comply with those new conditions, and in that sense intended for all states to continue to receive Medicaid grants. Yet, quite obviously, if a state had nonetheless refused to comply with the new rules, it could not have

asked a court to ignore the ACA's plain text on the ground that it would be "absurd" to deprive it of all of its Medicaid funds, given the Act's strong "purpose" of expanding, not contracting, Medicaid.

The district court claimed that there was "no direct support in the legislative history of the ACA for Plaintiffs' theory that Congress intended to condition federal funds on state participation." (JA311) That is not true (*see infra* Part I.C.2)—but the more basic point is that the legislative history (and certainly its *absence*) is *irrelevant*; the court fundamentally misconceived the inquiry. When text is plain, the only question is whether its meaning is absurd. *Lamie*, 540 U.S. at 534. Put another way, the absurdity inquiry asks whether the Act's plain text is *objectively* absurd—not whether Congress *subjectively* intended its *non-absurd* result. *Sigmon Coal*, 226 F.3d at 308 (since explanation for anomalous text is "plausible," it is not absurd, even though plausible explanation "is not indisputably evident from extra-textual sources"). Indeed, to require "direct" legislative history proving that Congress intended the text's *clearly reasonable* result eviscerates the absurdity rule. "[T]here would be no need for a rule … that there should be no resort to legislative history when language is plain and does not lead to an absurd result, if the rule did not apply precisely when plain language and legislative history may seem to point in opposite directions." *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488, 494-95 (D.C. Cir. 2004) (Roberts, J.).

Indeed, given the Act's plain text, even legislative history explicitly stating that subsidies are *not* limited to state Exchanges would not suffice to overcome it. *United States v. Morison*, 844 F.2d 1057, 1064 (4th Cir. 1988) ("[W]hen the terms of a statute are clear, its language is conclusive and courts are not free to replace that clear language with an unenacted legislative intent."). Obviously, then, the purported absence of legislative history *echoing* the statute is utterly meaningless.

2. The district court claimed that certain "anomalous results" flow from the law's plain meaning. (JA307) But those supposed anomalies either do not result from Appellants' interpretation of § 36B, or are not anomalous. Certainly none rises anywhere close to absurdity. As this Court has ruled, even if "the literal text … produces a result that is, arguably, somewhat anomalous," the court is "not simply free to ignore unambiguous language." *Sigmon Coal*, 226 F.3d at 308.

a. *First*, an ACA provision defines "qualified individuals" as persons who, *inter alia*, "resid[e] in the State that established the Exchange." ACA § 1312(f)(1)(A), *codified at* 42 U.S.C. § 18032(f)(1)(A). In states that did not establish Exchanges, the district court reasoned, there would thus be no "qualified individuals," and nobody could enroll in Exchanges established by HHS—which would be absurd. (JA307) To avoid that absurdity, the court apparently adopted the semantically nonsensical notion that HHS somehow establishes an Exchange "established by the State" when it steps in after the state fails to establish one.

This reasoning fails on multiple levels. At the outset, any absurdity in *this provision* cannot justify rewriting the plain, concededly non-absurd text of *§ 36B*. If it is absurd to interpret "[r]eside in the State that established the Exchange" to be a prerequisite for enrollment on federal Exchanges, the solution is to excise the words causing the absurdity, to read "reside in the State." The solution is not to interpret "state-established Exchange" to mean "HHS-established Exchange" and then *transport* that atextual definition *throughout the* Act, even where, as in § 36B, it produces no absurdity. That is, the absurdity principle obviously does not authorize courts to rewrite plain, non-absurd language in the Internal Revenue Code because of its similarity to language in another Title of the U.S. Code that purportedly creates an absurd result. *See Green v. Bock Laundry Mach. Co.*, 490 U.S. 504, 529 (1989) (Scalia, J., concurring) (courts should adopt non-absurd interpretation that "does least violence to the text").

Anyway, while it would be absurd to interpret § 18032(a)(1) as a *ban* precluding enrollment on *HHS* Exchanges, there are three perfectly sensible ways to read it, consistent with its text, to not apply to *HHS* Exchanges and/or to not *ban* enrollment. First, under this provision's plain language, it applies only to *state-established* Exchanges, not Exchanges established by *HHS*. The statute says that a "qualified individual"—"*with respect to an Exchange*"—is one who "resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A) (emphasis

added). And the ACA elsewhere defines "Exchange" as "Exchange established under *section 1311*." ACA § 1563(b)(21), *codified at* 42 U.S.C. § 300gg-91(d)(21) (emphasis added). Since § 1311 is the provision directing *states* to establish Exchanges, the definition of "qualified individual" only applies to state-established Exchanges; it does not, therefore, limit enrollment on federal Exchanges.

Second, contrary to the district court, the provision does not establish a *minimum eligibility* requirement, limited to "qualified individuals" and excluding all others. Entitled "Consumer Choice," the provision says only that a qualified individual "may enroll in any qualified health plan available to such individual and for which such individual is eligible." ACA § 1312(a)(1), *codified at* 42 U.S.C. § 18032(a)(1). It therefore *authorizes* enrollment by "qualified individuals," but does not *prohibit* enrollment by others. In other words, this is a *non-exclusion* provision—to ensure that "qualified individuals" are allowed to "enroll in any qualified health plan" they choose. It does not *restrict* enrollment. Proving the point, the Act states that illegal aliens are not "qualified individuals" *and also* "may not be covered under a qualified health plan … through an Exchange," ACA § 1312(f)(3), *codified at* 42 U.S.C. § 18032(f)(3), which would be unnecessary if the Act automatically excluded those who are merely not "qualified individuals." Thus, even if nobody in the states served by HealthCare.Gov is "qualified," that does *not* mean that they are barred from enrolling, and so no absurdity arises.

Relatedly, even if the "qualified individual" definition is generally read as a limit on enrollment (and as applicable to federal Exchanges), an applicant should still be understood to satisfy it based solely on its *other* prong. Even assuming this provision generally excludes individuals that are not "qualified," it surely does not exclude individuals who have *not failed to qualify*, but are purportedly "ineligible" because there is *no qualification to satisfy*. One who seeks to enroll through a federal Exchange does not *fail* the requirement that he "resid[e] in the State that established the Exchange." That definition *assumes* a state-created Exchange; it thus can readily be construed as not prohibiting eligibility where that assumption proves false. (By contrast, the subsidy provision does not assume a state-created Exchange; it simply limits subsidies to such.)

Contrary to the district court, Appellants are not asking the Court to "read [this provision] out of the ACA" or render it "superfluous." (JA307-08) Rather, they are urging entirely plausible *interpretations* of this language that do not render it superfluous, but do avoid absurdity. The district court, in stark contrast, *eschews* these interpretations of the Act's plain language and, consequently, does render superfluous the words "that established the Exchange" as leading to an absurd result. Even with respect to § 18032 in isolation, it is far preferable to plausibly interpret it to not apply to *HHS* Exchanges and/or to not bar otherwise qualified state residents than to gratuitously interpret it as an exclusion provision for HHS

Exchanges, and then eviscerate that provision on absurdity grounds. More important, as noted, this judicial evisceration of § 18032 on absurdity grounds cannot possibly justify rewriting the non-absurd § 36B. The district court cannot *leverage* its rewriting of § 18032 to *also* rewrite the subsidy provision's similar but non-absurd plain language.[4]

b. *Second*, the court claimed that a provision calling for both state- and HHS-run Exchanges to report certain data, 26 U.S.C. § 36B(f), would be "superfluous" if HHS Exchanges could not offer subsidies. (JA309) Not so.

The provision requires reporting of six different categories of information. Some of those, which address subsidies, are irrelevant for HHS Exchanges (which offer no subsidies). But those categories *are* relevant to state-run Exchanges, and so none of the categories of reportable data is superfluous. Nor was it superfluous for the Act to apply the same reporting provision to HHS Exchanges, because the *other* categories of reportable information (*i.e.*, the "level of coverage" purchased, "total premium" paid, and "name, address, and TIN" of each enrollee, 26 U.S.C. § 36B(f)(3)(A), (B), (D)) are equally relevant to the HHS Exchanges.

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

Indeed, Treasury has obvious, good reasons to want this data reported even for individuals who do not receive subsidies. Most obviously, Treasury needs enrollment information to enforce the Act's individual mandate to buy insurance. 26 U.S.C. § 5000A; *NFIB*, 132 S. Ct. at 2584 (IRS enforces mandate). Moreover, the very same section of the ACA calls for a comprehensive "study on affordable coverage," ACA § 1401(c); to conduct it, the Government obviously needs broad enrollment and premium data, even with respect to individuals who do not obtain subsidies. This is why the reporting requirement indisputably extends to "*any* health plan provided through the Exchange," even plans purchased without subsidies. 26 U.S.C. § 36B(f)(3) (emphasis added).

As Appellants explained below, the only alternative way for Congress to have written the statute would have been to enact two separate *redundant* reporting requirements—one for HHS Exchanges listing items (A), (B), and (D) on § 36B's list of reportable information, and another for state Exchanges repeating those items and adding items (C), (E), and (F). Avoiding such redundancies is hardly anomalous, and certainly not absurd. In sum, it is hardly odd—and not remotely absurd—for Congress to have subjected HHS Exchanges to the same reporting requirements as state-established Exchanges, even though coverage obtained therefrom is not subsidized, and even though HHS Exchanges will not have to report *as much* data as Exchanges established by states that disburse subsidies.

If anything, the reporting rule *confirms* § 36B's plain meaning, because it is expressly directed at any "Exchange under section 1311(f)(3) or 1321(c)," 26 U.S.C. § 36B(f)(3), thus proving that Congress knew how to refer to both when it wanted to and that Congress did not believe they were the same.

c. *Third*, the district court cited a provision that precludes states from tightening their Medicaid "eligibility standards" until "the date on which the Secretary determines that an Exchange established by the State under section 1311 of [the ACA, *codified at* 42 U.S.C. § 18031] is fully operational." ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg)(1). (JA309) The plain language of this "maintenance of effort" provision prevents a state from restricting Medicaid eligibility in that state unless it first establishes its own Exchange.

But this makes perfect sense. Again, Congress wanted to induce states to run Exchanges, and the maintenance-of-effort proviso creates a substantial "stick" if they fail to. Further, it is perfectly rational for Congress to want to preserve Medicaid benefits for the most impoverished in states where low-income people were already doing without § 36B subsidies. Indeed, the point of the maintenance-of-effort provision is to protect Medicaid beneficiaries until they are able to obtain subsidized coverage on an Exchange. In states that do not establish their own Exchanges, no subsidized coverage would be available, and so there remains a need for such protection against state Medicaid cutbacks.

The district court theorized that this provision would be unconstitutional if construed in accord with its plain language, because it would purportedly fail to give states sufficient notice of the "condition" on its continued receipt of Medicaid funds. (JA310) That is both irrelevant and wrong. Irrelevant, as the question is whether interpreting the law to mean what it says creates an *absurd* result that *Congress* could not have *intended*, not whether a non-absurd intended result would be viewed as constitutionally problematic by a court. And wrong, because there is no basis for the district court's concern. The maintenance-of-effort provision is perfectly clear on its face. Indeed, nobody disputes that it was clear enough to bind all states at least until January 2014, *i.e.*, before *any* Exchanges were established. There is no reason why it would somehow cease to be clear (or become unconstitutional) thereafter, in states where no "Exchange established by the State" is operational. In any event, the remedy for an "unclear" condition is *invalidating* the *condition*—not rewriting the provision, much less *other* provisions.

d. In a footnote, the district court also cited (without discussion) several other ACA provisions that supposedly would be anomalous on Appellants' view of § 36B. (JA310 n.8) None is anomalous, much less absurd.

First, two subsections of 42 U.S.C. § 1397ee(d)(3) concern the Children's Health Insurance Program ("CHIP"). They say that if state "funding shortfalls" prevent all eligible children in a state from being covered by CHIP, "the State shall

establish procedures to ensure that the children are enrolled in a qualified health plan" that (i) is "certified" by HHS as including sufficient benefits for children; and (ii) "is offered through an Exchange established by the State under section 1311 of the [ACA]." Children who so enroll are exempted from the general prohibition on CHIP-eligible children receiving subsidies.

Again, there is nothing troubling about this provision if "established by the State" is given its plain-text meaning. For states served by federal Exchanges, it would make no sense to require "the *State*" to adopt procedures for enrolling children affected by CHIP funding shortfalls. *HHS* is operating these Exchanges, so *HHS itself* should enroll these children in whatever plans *HHS* believes are sufficient. Moreover, this provision prevents these children's CHIP eligibility from disqualifying them for *subsidies* that they could otherwise receive. It is thus of no use on *federal* Exchanges, since there are no subsidies to be disqualified from.

Second, the district court cited 42 U.S.C. § 18031(d)(4), which—among the eleven functions that the ACA directs *all* Exchanges to perform—says that all Exchanges should "make available by electronic means a calculator to determine the actual cost of coverage" net of "any" subsidy, and provide to the IRS a list of "each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit." *Id.* § 18031(d)(4)(G), (I). Obviously, these

two specific functions will be easy for HHS Exchanges. But, just as with the reporting requirements, Congress included these functions on the list because the same list principally governs the state Exchanges, for which these tasks will be more involved. And Congress subjected HHS Exchanges to the same list because the nine other functions—*e.g.*, certifying health plans, creating a website, granting exemptions, etc., *id.* § 18031(d)(4)(A), (B), (C), (D), (H), (K)—are equally relevant to HHS Exchanges. Again, there is neither superfluity nor redundancy here, and the only alternative would have been for Congress to create *two* lists of functions—one for state Exchanges listing all eleven functions, and another for HHS Exchanges repeating all but two.

Finally, the district court cited 42 U.S.C. § 18083(b)(1)(A), which requires HHS to "develop and provide to each State a single, streamlined form" that "may be used to apply for all applicable State health subsidy programs within the State." It is not clear why the district court believed this provision would be "redundant or useless" (JA310 n.8) if § 36B subsidies were not "applicable" in certain states.

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

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

1. The district court simplistically reasoned that the ACA's goal was to "ensure broad access to affordable health coverage for all," and blocking subsidies in federal Exchanges would hinder that goal. (JA311) Yet particularly with a law as complex as the ACA, "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam); *see also Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261 (1993) ("[V]ague notions of a statute's 'basic purpose' are … inadequate to overcome the words of its text …."); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 217 (2002) ("It is … not [the Court's] job to find reasons for what Congress has plainly done."); *Sigmon Coal*, 226 F.3d at 294 (declining "invitation to rewrite" law based on "general congressional purpose and various snippets of legislative history").

Again, adopting the court's amorphous "purpose" analysis would mean that if a state had rejected the Medicaid "deal," agencies could nonetheless send it billions of federal Medicaid dollars in the face of the Act's plain language foreclosing expenditures to states that do not expand their Medicaid eligibility criteria. After all, just as is purportedly the case with § 36B, no "direct" legislative history echoes the plain Medicaid statutory language, and Congress clearly "wanted" *all* states to have Medicaid. But that would be a clearly improper rewriting of the Act's Medicaid condition, just as the district court rewrote § 36B.

Granted, Congress wanted subsidies to be uniformly available—but it also wanted states to establish Exchanges. By conditioning subsidies on state creation of Exchanges—giving the states an offer "too good to refuse"—Congress expected to achieve *both* of those goals. As the district court acknowledged, "Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges. Instead, Congress assumed that tax credits would be available nationwide because every state would set up its own Exchange." (JA311) That is quite right, and is exactly why the plain meaning of § 36B is perfectly consistent with Congress's evident goal of nationwide subsidies. Without incentives like § 36B, Congress could not have expected most states, let alone all, to establish Exchanges. Indeed, this seems to be the *only* constitutional way to achieve both state-run Exchanges and nationwide subsidies.

In the end, Congress's assumption about universal state establishment of Exchanges proved false only because the IRS failed to faithfully transmit to the states Congress's condition on the receipt of the subsidies. Rather, the IRS in the challenged Rule promised states the "quid" of subsidies without demanding the "quo" of Exchanges, thereby eliminating any incentive for states to establish their own Exchanges. Congress's bargain did not "backfir[e] … to the surprise of all" (JA306), but as a predictable reaction to the IRS Rule. Sustaining that Rule on the basis of the policy effects *that it caused* is therefore especially perverse.

2. The district court found "no direct support in the legislative history of the ACA for the … theory that Congress intended to condition federal [subsidy] funds on state participation." (JA311) Of course, the statutory *text* is proof of congressional intent; the best evidence of what Congress "means in a statute [is] what it says there." *Conn. Nat'l Bank*, 503 U.S. at 254. Requiring *confirmation* of the plain meaning through "direct" legislative history, as the district court did, is plainly improper. *See Carbon Fuel Co. v. USX Corp.*, 100 F.3d 1124, 1133 (4th Cir. 1996) ("Absent *explicit* legislative intent *to the contrary*, the statute should be construed according to its plain and ordinary meaning." (emphasis added)); *Sigmon Coal*, 226 F.3d at 305 (allowing resort to legislative history only for "pellucid expression[s] of legislative intent"); *Md. Dep't of Educ.*, 98 F.3d at 171 (ignoring legislative history that does not "clearly express" intent about precise issue).

3. Anyway, the limited legislative history firmly supports the proposition that Congress conditioned the subsidies on state creation of Exchanges as a means to induce states to act. To be sure, Congress barely discussed federal Exchanges during legislative debate, apparently because the overwhelming consensus was that states would submit to the Act's pressures and establish Exchanges. *See* Pear, *U.S. Officials Brace for Huge Task*, *supra* ("Mr. Obama and lawmakers assumed that every state would set up its own exchange."); Viebeck, *Obama Faces Huge Challenge*, *supra* ("It's a situation no one anticipated when the [ACA] was written.

The law assumed states would create and operate their own exchanges ….”). But what little history does exist shows that conditioning subsidies on state Exchanges was proposed early on, adopted by the Senate, and forced onto the House when ACA supporters lost their filibuster-proof Senate majority.

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

That was hardly a novel suggestion; Congress, after all, used—*in the very same Act*—the same “too good to turn down” offer of huge federal grants to induce states to expand Medicaid. *NFIB*, 132 S. Ct. at 2601. And Congress previously conditioned *other* tax credits on state compliance with federal wishes as to health coverage. *E.g.*, 26 U.S.C. § 35(a), (e)(2) (tax credit for individuals enrolled in certain state-sponsored coverage, if state coverage satisfied federal criteria). More generally, using federal grants to induce state action is a common congressional tool, forming the basis for Medicaid and CHIP, among other programs.

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

The Finance Committee simply conditioned subsidies on state establishment of Exchanges, rather than on states' adoption of insurance reforms. Its chair, Senator Max Baucus, used the conditional nature of the subsidies to justify his jurisdiction over the Exchanges and related regulations of health coverage in the draft ACA; that is, the *Finance* Committee had jurisdiction over *health* issues only because the bill *conditioned* "tax credit" subsidies, within its bailiwick, on states creating Exchanges subject to regulation. (JA285-87)[5] *See* Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule To Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX 119, 156 (2013).

[5] The official transcript erroneously quotes Senator Baucus as saying that taxes "aren't" the jurisdiction of the Finance Committee. (JA287) As is very clear from context, he actually said that taxes "are in" the Committee's jurisdiction.

The House had little choice but to accede to the Senate bill after the election of Senator Scott Brown deprived ACA supporters of a filibuster-proof majority. *See* Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, N.Y. TIMES, Jan. 19, 2010, at A1. To be sure, limited changes to the Senate bill could still be approved during reconciliation, but measures that would have increased the deficit, like expanding subsidies, would (absent offsetting revenues) have been extraneous under the "Byrd Rule" and so could not have been implemented. 2 U.S.C. § 644; *see also* Dkt. 39-1, Exh. A (Decl. of Douglas Holtz-Eakin).

In the face of this evidence, the district court speculated that Congress did not intend to entice states to establish Exchanges at all, but merely authorized them to run Exchanges as an "option" offered out of comity. (JA311) That is nonsense. That Act says that states "shall" establish Exchanges and authorizes funding only for state-run Exchanges. ACA § 1311(a), (b), *codified at* 42 U.S.C. § 18031(a), (b). And the whole point of state-run Exchanges was precisely to keep the federal government out: As critical swing vote Senator Ben Nelson put it, a federal Exchange "would start us down the road of federal regulation of insurance and a single-payer plan." Brown, *Nelson: National Exchange a Dealbreaker*, *supra*. That is why the House bill was soundly rejected in the Senate (*see supra* at pp.2-3), and why the final bill had to include strong incentives "to encourage State participation," 156 Cong. Rec. H2423-24 (Mar. 25, 2010) (Rep. Waxman).

4. There is no legislative history *contradicting* the subsidy provision's text. The district court noted a Congressional Budget Office ("CBO") report, which, in forecasting the cost of premiums, assumed (like Congress) that subsidies would be available everywhere. (JA311) Of course, that analysis was conducted in March 2010, before any state had opted out of establishing an Exchange, so there would have been no principled basis to assume that any of them would.

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

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

For five independent reasons, the analysis above is unaffected by the principle of *Chevron* deference. *First*, the relevant ACA text is unambiguous, and so there is no room for agency interpretation. *Second*, it is not plausible that Congress intended to delegate to the IRS the hugely important fiscal decision to trigger tens or hundreds of *billions* of dollars in annual federal spending. *Third*, any deference principle is trumped here by the "clear statement" rule for tax exemptions and credits. *Fourth*, even if there were some ambiguity, it would only be in provisions of Title 42 of the U.S. Code, not the Internal Revenue Code—yet the IRS may construe only the latter. *Fifth*, the IRS Rule is in any case not a reasonable construction of any ambiguity that may exist.

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

Where, as here, Congress has "unambiguously expressed [its] intent" in the statute, "that is the end of the matter," and no deference is afforded the agency. *Chevron*, 467 U.S. at 842-43. Notably, judges "owe the agency no deference on the existence of ambiguity." *Am. Bar Ass'n v. FTC*, 430 F.3d 457, 468 (D.C. Cir. 2005) ("*ABA*"). For all of the reasons articulated above, there is no ambiguity in § 36B concerning the availability of subsidies on HHS Exchanges. To the contrary, Congress "has directly spoken to the precise question" of subsidy availability, and "that is the end of the matter." *Chevron*, 467 U.S. at 842.

B. Congress Did Not Intend the IRS To Make the Major Economic Decision To Spend Tens of Billions of Dollars Annually.

Deference is appropriate only if Congress intended an "implicit delegation of authority to the agency." *Sea-Land Serv., Inc. v. Dep't of Transp.*, 137 F.3d 640, 645 (D.C. Cir. 1998). Thus, "ambiguity is not enough per se to warrant deference to the agency's interpretation. The ambiguity must be such as to make it appear that Congress either explicitly or implicitly delegated authority to cure that ambiguity." *ABA*, 430 F.3d at 469. In this regard, the D.C. Circuit has recently reiterated that "courts should not lightly presume congressional intent to implicitly delegate decisions of major economic or political significance to agencies." *Loving v. IRS*, No. 13-5061, 2014 WL 519224, at *8 (D.C. Cir. Feb. 11, 2014).

Few decisions will have greater "economic or political significance" than one triggering tens or hundreds of billions of dollars per year in federal spending and expanding major components of the groundbreaking ACA (broadly affecting individuals and employers, *see supra* pp.9-10) to more than two-thirds of the states. As such, it is inherently implausible that Congress intended to implicitly direct the IRS to exercise its *discretion* on that question. The IRS Rule is a major policy in search of ambiguity as a hook to sustain it—not a mere "detail" that Congress intended the IRS to fill, which is precisely why § 36B "directly spok[e] to the precise question" at issue. *Chevron*, 467 U.S. at 842.

C. *Chevron* Deference Would Be Displaced Here by the Venerable "Clear Statement" Rule for Tax Exemptions and Credits.

The premise of *Chevron* deference is that the agency has authority to resolve statutory ambiguity and consequently may expand the statute's reach beyond what its language unambiguously compels. But, under *Chevron*, ambiguity exists only if it remains after "employing traditional tools of statutory construction." *Chevron*, 467 U.S. at 843 n.9. Thus, "[i]f an interpretive principle resolves a statutory doubt in one direction, an agency may not reasonably resolve it in the opposite direction." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722 (6th Cir. 2013) (Sutton, J., concurring). Indeed, "[a]ll manner of presumptions, substantive canons and clear-statement rules take precedence over conflicting agency views." *Id.* Thus, where established principles of statutory construction require a clear or unambiguous statement of congressional intent to infer certain results, an agency cannot construe ambiguous statutory text to achieve those results. In such circumstances, if Congress has not "directly spoken to the precise question" at issue, *Chevron*, 467 U.S. at 842, the interpretive canon forecloses one potential reading of the statutory ambiguity, for both agencies and courts.

Thus, for example, if a statute is ambiguous but one construction "would raise serious constitutional problems," there is no deference to an agency adopting it; rather, the court will adopt the contrary construction unless "plainly contrary to the intent of Congress." *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. &*

Constr. Trades Council, 485 U.S. 568, 574-75 (1988). Similarly, in *EEOC v. Arabian American Oil Co.*, 499 U.S. 244 (1991), a statute was "ambiguous" as to whether it applied overseas, but the Court held that the EEOC's view that it did could not "overcome the presumption against extraterritorial application." *Id.* at 250, 258. Justice Scalia elaborated that, in light of that presumption, the EEOC could not infer extraterritoriality from "mere implications" from ambiguous language. *Id.* at 260 (Scalia, J., concurring in part and in the judgment). Likewise, in *INS v. St. Cyr*, 533 U.S. 289 (2001), the Court held that the presumption against retroactivity means that "a statute that is ambiguous with respect to retroactive application is construed … to be unambiguously prospective," such that "there is, for *Chevron* purposes, no ambiguity in such a statute." *Id.* at 320 n.45. *See also, e.g.*, *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444-45 & n.8 (D.C. Cir. 1988) (refusing to defer because Indian law canon provides that if law "can reasonably be construed" in tribe's favor, "it *must* be construed that way").

As explained earlier, the Supreme Court has adopted a canon holding that tax credits "must be expressed in clear and unambiguous terms." *Yazoo*, 132 U.S. at 183; *accord Wells Fargo Bank*, 485 U.S. at 354. Such benefits "must rest … on more than a doubt or ambiguity." *United States v. Stewart*, 311 U.S. 60, 71 (1940); *see also Of Course, Inc. v. Comm'r*, 499 F.2d 754, 758 (4th Cir. 1974) (en banc). Only that admittedly "extremely high standard" properly respects Congress's

"exclusive authority" over taxation and spending. *Stichting*, 129 F.3d at 197-98; *see also Comm'r v. Swent*, 155 F.2d 513, 517 (4th Cir. 1946).[6]

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

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

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

1. The ACA subsidy provision is codified in the Internal Revenue Code, but even the Government does not contend that the language of *26 U.S.C. § 36B* is ambiguous. It is only the provisions establishing state and federal Exchanges that purportedly make it plausible to construe the Act as extending subsidies to the latter. (JA307) Yet those provisions are codified in a chapter of Title 42 of the U.S. Code—the domain of *HHS*, not the IRS. 42 U.S.C. §§ 18031, 18041.

Because the IRS has no power to enforce or administer those provisions, it is entitled to no deference when it purports to construe them. *See Shanty Town Assocs. v. EPA*, 843 F.2d 782, 790 n.12 (4th Cir. 1988) (no deference to EPA as to "two statutes that EPA does not administer"); *Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.*, 250 F.3d 778, 782 (D.C. Cir. 2001) (no deference where agency interpretation rested, "in part," on "legislative enactments that are not part of its enabling statute"); *Cheney R.R. Co. v. R.R. Ret. Bd.*, 50 F.3d 1071, 1073-74 (D.C. Cir. 1995) (no deference where issue "turn[ed] on the interpretation" of laws that were "not the Board's governing statutes"). Indeed, the IRS itself recognizes that it has no authority to construe the term "Exchange" in 42 U.S.C. §§ 18031 & 18041, which is why its Rule simply adopts *HHS's* definition. 26 C.F.R. § 1.36B-1(k). Subsidy eligibility under the IRS Rule is thus wholly dependent on *HHS's* definition of "Exchange," which HHS can change at any time, without IRS input.

It does not matter that the subsidy provision in the Internal Revenue Code uses the term "Exchange" and cross-references one of the Title 42 provisions. The same dynamic was present in *American Federation of Government Employees v. Shinseki*, 709 F.3d 29 (D.C. Cir. 2013), where a law administered by the Secretary of Veterans Affairs ("VA") used the term "collective bargaining" and cross-referenced the Federal Service Labor-Management Relations Statute ("FSLMRS"). *See id.* at 33. The latter statute defined "collective bargaining," and the D.C. Circuit held that it owed no deference "to the VA's interpretation of the FSLMRS because the VA does not administer that statute." *Id.* The same is true here: The key provisions for the Government are provisions of Title 42 (§§ 18031 & 18041), but the IRS "does not administer" those, and so it is owed no deference. *See id.*

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

In short, no deference is given to the IRS because there is concededly no ambiguity to defer to in the provision it administers, and no deference is given to HHS because it does not administer the provision at issue.

2. The impropriety of deference in this case is bolstered by the rule concerning situations in which more than one agency administers the same statute.

In such cases, "a particular agency's interpretation is not entitled to *Chevron* deference," *Proffitt v. FDIC*, 200 F.3d 855, 860 (D.C. Cir. 2000), because "it cannot be said that Congress implicitly delegated to one agency authority to reconcile ambiguities or to fill gaps," *Salleh v. Christopher*, 85 F.3d 689, 692 (D.C. Cir. 1996); *accord DeNaples v. Office of Comptroller of Currency*, 706 F.3d 481, 488 (D.C. Cir. 2013) ("We have repeatedly pointed to the agencies' joint administrative authority … to justify refusing deference to their interpretations.").

The fact that deference is withheld even in the case of joint administration of the same statute establishes *a fortiori* that there is no deference here. Where two agencies enforce *one* statute, Congress could arguably have intended to delegate interpretive authority to both, but no such inference is possible where the agencies administer two *different* titles of the U.S. Code. Put another way, since the statute at issue is *26* U.S.C. § 36B, Congress's delegation to *HHS* to administer *42* U.S.C. §§ 18031 & 18041 is beside the point. HHS has authority to regulate the establishment of Exchanges. But its views are irrelevant to *tax* issues. And the courts do not need *IRS* help to construe § 36B, because it is unambiguous.[7]

[7] Thus, the district court's observation that HHS and the IRS, "[f]or the most part," have "mutually exclusive authority under the ACA" (JA313), *confirms* the impropriety of deference. The IRS does not have authority over those provisions purportedly creating the ambiguity, and the provision it *does* administer creates no ambiguity. Since Congress intended neither for the IRS to construe Title 42 nor for HHS to construe the Internal Revenue Code, *Chevron* is simply inapplicable.

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

Even if there were some ambiguity in the ACA and the IRS had been given authority to construe it, the IRS Rule would *still* fail at "Step Two" of the *Chevron* analysis, which asks whether the agency's construction is "reasonable."

"If a statute is ambiguous, an agency that administers the statute may choose a reasonable interpretation of that ambiguity—but the agency's interpretation must still stay within the boundaries of the statutory text." *EME Homer City Generation, L.P. v. EPA*, 696 F.3d 7, 23 (D.C. Cir. 2012); *see also EEOC v. Seafarers Int'l Union*, 394 F.3d 197, 205 (4th Cir. 2005) (agency interpretation must "harmoniz[e] with the plain language of the statute"). "[W]hatever ambiguity may exist cannot render nugatory restrictions that Congress has imposed." *AFL-CIO v. Chao*, 409 F.3d 377, 384 (D.C. Cir. 2005).

For reasons discussed above, the IRS Rule is not a *reasonable* construction of the ACA. It ignores the statutory text, flouts numerous canons of construction, and eliminates the incentives Congress created for states to establish Exchanges. In short, the IRS Rule "render[s] nugatory" Congress's restrictions on subsidies, and so it cannot survive. *AFL-CIO*, 409 F.3d at 384.

CONCLUSION

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

March 3, 2014

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 13,894 words, excluding the parts of the brief exempted by that Rule, as counted using the word-count function on Microsoft Word 2007 software.

March 3, 2014

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CERTIFICATE OF SERVICE

I hereby certify that, on this 3rd day of March 2014, I electronically filed the original of the foregoing document with the clerk of this Court by using the CM/ECF system. I certify that the participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system. Pursuant to this Court's Rules, I will also file eight paper copies of the foregoing document, by UPS overnight delivery, with the clerk of this Court.

March 3, 2014

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STATUTORY & REGULATORY ADDENDUM

No. 14-1158

David King, *et al.*, Appellants,
v.

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

APPELLANTS' STATUTORY & REGULATORY ADDENDUM TABLE OF CONTENTS

Reproduction of Relevant Authorities:

42 U.S.C. §18031 (ACA § 1311)

§18031. Affordable choices of health benefit plans

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

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

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

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

(4) Renewability of grant.--

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

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

(I) establishing an Exchange; and

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

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

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

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

(b) American Health Benefit Exchanges.--

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

(A) facilitates the purchase of qualified health plans;

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

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

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

(c) Responsibilities of the Secretary.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Internet portals.--

The Secretary shall-

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

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

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

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

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

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

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

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

(d) Requirements.--

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

(2) Offering of coverage.--

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

(B) Limitation.--

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

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

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

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

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

(B) States may require additional benefits.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) transfer to the Secretary of the Treasury-

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

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

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

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

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

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

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

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

(5) Funding limitations.--

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

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

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

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

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

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

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

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

(e) Certification.--

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

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

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

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

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

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

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

(3) Transparency in coverage.--

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

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

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

(vi) Data on rating practices.

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

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

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

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

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

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

(f) Flexibility.--

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

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

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

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

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

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

(3) Authority to contract.--

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

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

(i) a person-

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Quality improvement.--

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

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

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

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

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

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

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

(i) Navigators.--

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

(2) Eligibility.--

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

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

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

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

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

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

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

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

(C) facilitate enrollment in qualified health plans;

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

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

(4) Standards.--

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

(i) be a health insurance issuer; or

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

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

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

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

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

42 U.S.C. §18041 (ACA § 1321)

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

(a) Establishment of standards.--

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

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

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

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

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

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

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

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

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

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

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

(1) In general.--

If-

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

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

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

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

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

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

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

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

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

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

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

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

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

26 U.S.C. §36B (ACA § 1401(a))

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

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

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

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

(2) Premium assistance amount.--The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of-

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 1 of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of-

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

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

(A) Applicable percentage.--

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

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

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

(ii) Indexing.--

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

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

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

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

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

(ii) provides-

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

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

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

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

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

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

(D) Additional benefits.—

If-

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

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

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

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

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

(1) Applicable taxpayer.--

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

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

If-

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

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

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

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

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

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

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

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

(B) Exception for minimum essential coverage.--

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

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

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

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

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

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

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

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

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

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

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

(3) Definitions and other rules.--

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

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

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

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

(2) Household income.--

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

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

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

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

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

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

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

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

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

(3) Poverty line.--

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

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

(e) Rules for individuals not lawfully present

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

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

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

(i) A method under which-

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

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

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

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

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

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

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

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

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

(2) Excess advance payments

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

(B) Limitation on increase

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

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

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

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

(I) such dollar amount, multiplied by

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

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

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

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

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

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

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

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

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

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

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

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

26 C.F.R. § 1.36B (Excerpts)

§1.36B-1 Premium tax credit definitions.

…

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

…

§1.36B-2 Eligibility for premium tax credit.

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

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

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

…

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

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

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

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

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

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

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

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

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

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

…

45 C.F.R. 155.20 (Excerpts)

§155.20 Definitions.

The following definitions apply to this part:

…

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

…

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

…