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ABSTRACT

The Patient Protection and Affordable Care Act (PPACA) provides tax credits and subsidies for the purchase of qualifying health insurance plans on state-run insurance exchanges. Contrary to expectations, many states are refusing or otherwise failing to create such exchanges. An Internal Revenue Service (IRS) rule purports to extend these tax credits and subsidies to the purchase of health insurance in federal exchanges created in states without exchanges of their own. This rule lacks statutory authority. The text, structure, and history of the Act show that tax credits and subsidies are not available in federally run exchanges. The IRS rule is contrary to congressional intent and cannot be justified on other legal grounds. Because tax credit eligibility can trigger penalties on employers and individuals, affected parties are likely to have standing to challenge the IRS rule in court.

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INTRODUCTION

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA or "the Act") into law.[1] The PPACA creates a complex scheme of new government regulations, mandates, subsidies, and agencies in an effort to achieve near-universal health insurance coverage. Immediately after passage, a majority of state attorneys general and numerous business and public interest groups filed suit challenging various portions of the new law—most notably the so-called "individual mandate" and Medicaid expansion. This litigation wound its way to the US Supreme Court, which produced a divided ruling upholding the constitutionality of the mandate but limiting the Medicaid expansion.[2] Yet this decision did not end the controversy surrounding the PPACA.[3] Additional litigation has already ensued and is likely to continue in the years to come.[4]

1. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified in scattered sections of the U.S. Code).

2. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (upholding the constitutionality of the individual mandate as a tax but invalidating conditioning of federal Medicaid funds on state acceptance of Medicaid expansion).

3. News reports suggesting Chief Justice John Roberts may have switched his vote after oral argument have only fueled the controversy. *See* Jan Crawford, *Roberts Switched Views to Uphold Health Care Law*, CBS NEWS (July 1, 2012, 1:29 PM), http://www.cbsnews.com/8301-3460_162-57464549/roberts-switched-views-to-uphold-health-care-law/.

4. *See* Rob Field, *Legal Challenges to Obamacare Live On*, THE FIELD CLINIC (Dec. 7, 2012, 12:31 PM), http://www.philly.com/philly/

in his office in the US Capitol, where they merged the two committee-reported bills into the Patient Protection and Affordable Care Act.[15]

Although Senate Democrats held a sixty-seat majority—the minimum necessary to break a Republican filibuster—Senator Reid had difficulty collecting yea votes from every member of his caucus.[16] Once he had corralled all sixty votes, Senate Democrats broke the Republican filibuster. The new Patient Protection and Affordable Care Act cleared the US Senate before sunrise on December 24, 2009, without a vote to spare.[17]

Congressional Democrats had intended to have a conference committee merge the PPACA with the "Affordable Health Care for America Act" (H.R. 3962) that had passed the House of Representatives in November.[18] Had this occurred, the PPACA might look quite different than it does today. But in January 2010, Republican Scott Brown won a special election to fill the seat vacated by the death of Sen. Edward Kennedy (D-MA). Brown's victory shifted the political terrain. It gave Senate Republicans the forty-first vote necessary to filibuster a conference report on the House and Senate bills.

As a result, House and Senate Democrats abandoned a conference committee in favor of a novel strategy. House Democrats agreed to pass the PPACA exactly as it had passed in the Senate, but only upon receiving assurances that after the House amended the PPACA through the "budget reconciliation" process, the Senate would immediately approve those amendments. Because Senate rules protect reconciliation bills from a filibuster, the PPACA's supporters needed only fifty-one votes to pass the House's "reconciliation" amendments. The downside of this strategy was that the rules governing budget reconciliation limited the amendments House Democrats could make.[19] Supporters opted for an

15. David M. Herszenhorn & Robert Pear, *White House Team Joins Talks on Health Care Bill*, N.Y. TIMES, Oct. 15, 2009, at A24 (quoting Senate Majority Leader Harry Reid: "This is legislating at its best.").

16. *See* Brian Montopoli, *Tallying the Health Care Bill's Giveaways*, CBS NEWS (Dec. 21, 2009, 3:56 PM), http://www.cbsnews.com/8301-503544_162-6006838-503544.html.

17. *See Vote Summary: On Passage of the Bill (H.R. 3590 as Amended)*, U.S. SENATE, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396 (last visited Jan. 25, 2013).

18. *Bill Summary & Status, 111th Congress, H.R. 3962, CRS Summary*, THOMAS, LIBRARY OF CONGRESS, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03962:@@@D&summ2=1& (last visited Jan. 25, 2012); Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009).

19. *See* John Carney, *How Does Reconciliation Work in Congress?*, BUS. INSIDER (Jan. 17, 2010) http://articles.businessinsider.com/2010-01-17/news/29990286_1_41st-vote-filibuster-vote-republican-filibuster; Alan Greenblatt, *Senate Faces Slog Over Health Bill Amendments*, NPR (Mar.

imperfect bill—that is, a bill that did not accomplish all they may have set out to do, but for which they had the votes—over no bill at all.

The Act signed into law by President Obama and the law that the IRS rule purports to implement—the PPACA—is thus a hybrid of the two Senate-committee-reported bills, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA).[20] This history, and the need to resort to the reconciliation process to pass the final law, helps explain why the final legislation looks as it does and why the Act does not conform with the hopes or expectations of some of its supporters.[21]

II. THE PPACA'S REGULATORY STRUCTURE

The PPACA attempts to achieve near-universal health insurance coverage through an interdependent system of government price controls, mandates, and subsidies. To understand the significance of the IRS rule, it is important to understand the role of health insurance Exchanges and how they were intended to complement the other controls enacted by the PPACA.

A. A Three-Legged Stool

Among the central features of the PPACA are new regulatory controls limiting medical underwriting by health insurance companies.[22] Specifically, the Act requires carriers to charge individuals of a given age the same premium, regardless of their health status.[23] This type of

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21, 2010), http://www.npr.org/templates/story/story.php?storyId=124993274.

20. Congress has further amended PPACA through subsequent legislation. Those amendments do not affect the matter at hand.

21. For example, in January 2010, eleven House Democrats raised objections to relying upon the Senate's state-based health insurance Exchanges as opposed to a single federal Exchange because of the potential for "obstruction." *See U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans*, MY HARLINGEN NEWS (Jan. 11, 2010), http://www.myharlingennews.com/?p=6426. Despite these concerns, all eleven voted in favor of the PPACA.

22. Mark A. Hall, *The Factual Bases for Constitutional Challenges to the Constitutionality of Federal Health Insurance Reform*, 38 N. KY. L. REV. 457, 464 (2011) (noting that "prohibiting medical underwriting" is among the PPACA's "core provisions.").

23. The Act prohibits carriers from adjusting premiums for any reason other than age (allowable variation: a 3 to 1 ratio for adults only); family size (two categories: individual or family); smoking status (carriers may charge smokers up to 50 percent more than nonsmokers); or by geographic "rating areas." Carriers may not adjust premiums according to an applicant's health status or sex. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 155 (2010).