No. 14-114

IN THE

Supreme Court of the United States

DAVID KING; DOUGLAS HURST;
BRENDA LEVY; and ROSE LUCK,
Petitioners,

v.

SYLVIA MATHEWS BURWELL, as U.S. Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; JACOB LEW, as U.S. Secretary of the Treasury; UNITED STATES DEPARTMENT OF THE TREASURY; INTERNAL REVENUE SERVICE; and JOHN KOSKINEN, as Commissioner of Internal Revenue,
Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

BRIEF FOR PETITIONERS

MICHAEL A. CARVIN
Counsel of Record
YAAKOV M. ROTH
JONATHAN BERRY
JONES DAY
51 Louisiana Ave., NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Petitioners

QUESTION PRESENTED

Section 36B of the Internal Revenue Code, which was enacted as part of the Patient Protection and Affordable Care Act ("ACA"), authorizes federal tax-credit subsidies for health insurance coverage that is purchased through an "Exchange established by the State under section 1311" of the ACA.

The question presented is whether the Internal Revenue Service ("IRS") may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under section 1321 of the ACA.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Petitioners, who were Plaintiffs-Appellants in the court below, are four individuals: David King, Douglas Hurst, Brenda Levy, and Rose Luck.

Respondents, who were Defendants-Appellees in the court below, are Sylvia Mathews Burwell (as U.S. Secretary of Health and Human Services); the United States Department of Health and Human Services; Jacob Lew (as U.S. Secretary of the Treasury); the United States Department of the Treasury; the Internal Revenue Service; and John Koskinen (as Commissioner of Internal Revenue).

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

TABLE OF AUTHORITIES

Page(s)

CASES

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

STATUTES

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

OPINIONS BELOW

The Fourth Circuit opinion (Pet.App.1a) is at 759 F.3d 358. The district court opinion (Pet.App.42a) is at 997 F. Supp. 2d 415.

JURISDICTION

The Fourth Circuit entered judgment on July 22, 2014. Pet.App.1a. Petitioners filed their petition for a writ of certiorari on July 31, 2014; it was granted on November 7, 2014. 28 U.S.C. § 1254(1) confers jurisdiction.

PROVISIONS INVOLVED

The Addendum reproduces the relevant statutory and regulatory provisions.

STATEMENT

This case concerns an IRS rule that purports to implement, but in fact contradicts, the provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("ACA"), authorizing tax-credit subsidies for certain individual health insurance policies.

A. To Encourage States To Establish Their Own Exchanges, the ACA Limits Its Tax-Credit Subsidies to State-Established Exchanges.

The ACA calls for the creation of insurance "Exchanges" organized along state lines. Exchanges allow one-stop shopping for health coverage, giving individuals and small businesses the opportunity to readily compare available plans. The President has accordingly described Exchanges as the equivalent of Amazon.com for health insurance. *Remarks by the President on the Affordable Care Act*, WHITE HOUSE OFFICE OF THE PRESS SEC'Y, Sept. 26, 2013.

Section 1311(b)(1) of the ACA urges states, in the strongest possible terms, to establish Exchanges. It provides: "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange … for the State." 42 U.S.C. § 18031(b)(1). Under the Constitution's core federalism constraints, however, Congress cannot *compel* sovereign states to create Exchanges. *Printz v. United States*, 521 U.S. 898, 935 (1997). Section 1321 of the Act therefore 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." 42 U.S.C. § 18041(b)-(c). To address that scenario, ACA § 1321(c) directs the Department of Health and Human Services ("HHS") to "establish and operate such Exchange within the State." 42 U.S.C. § 18041(c). Accordingly, if a state declines the role that the ACA urges it to accept and refuses to establish its own Exchange, that obligation falls instead upon the federal government, which must establish and operate a fallback Exchange in that state.

Congress used a variety of "carrots" and "sticks" to induce states to establish Exchanges voluntarily. For example, § 1311(a) of the Act authorizes federal grants to states for "activities … related to establishing an [Exchange]." 42 U.S.C. § 18031(a). The Act also penalizes states that do not create Exchanges, such as by barring them from restricting eligibility for their state Medicaid programs until "an Exchange established by the State under section 1311 of the [ACA] is fully operational." 42 U.S.C. § 1396a(gg) (ACA § 2001(b)(2)).

Most importantly, the Act authorizes subsidies, in the form of refundable tax credits, for health coverage that is purchased through *state*-established Exchanges. 26 U.S.C. § 36B (ACA § 1401(a)). These subsidies may be paid by the U.S. Treasury directly to a taxpayer's insurer, to offset premiums owed. 42 U.S.C. § 18082 (ACA § 1412).

Critically, the Act only subsidizes coverage through an Exchange *established by a state*. It provides that a credit "shall be allowed" in a certain "amount," 26 U.S.C. § 36B(a), based on the number of "coverage months of the taxpayer occurring during the taxable year," *id.* § 36B(b)(1). A "coverage month" is a month during 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]." *Id.* § 36B(c)(2)(A)(i) (emphasis added). Unless the citizen buys coverage through a state-established Exchange, he has no "coverage months" and so no subsidy. Confirming that, the subsidy for any particular "coverage month" is based on premiums for coverage that was "enrolled in through an Exchange established by the State under [§] 1311 of the [ACA]." *Id.* § 36B(b)(2)(A).

These inducements for states to establish their own Exchanges were compelled by political realities. The House of Representatives initially enacted a bill under which the *federal government* would create a national Exchange, though individual states could affirmatively choose to establish their own instead. H.R. 3962, § 308, 111th Cong. (2009). That scheme, however, was unacceptable to the Senate. *Halbig v. Sebelius*, No. 13-623, 2014 U.S. Dist. LEXIS 4853, at *61 (D.D.C. Jan. 15, 2014) ("[T]hese proposals proved

politically untenable and doomed to failure in the Senate ….”). Senator Ben Nelson of Nebraska, whose vote was critical to passage, called a national Exchange 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. For Nelson and some other Senators, it was important to keep the federal government *out* of the process, and thus insufficient to merely allow states the *option* to establish Exchanges, as the House bill did. Rather, states had to take the lead role, which, given the constitutional bar on compulsion, required serious incentives to induce such state participation.

The robust incentives provided by the ACA, and in particular, the conditioning of tax credits on state-run Exchanges, were thought sufficient to do so. As even the district court below agreed, “Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges.” Pet.App.70a. Likewise, Jonathan Gruber—a “key architect” of the Act who was paid “close to $400,000 as a consultant to [HHS] during 2009 and 2010,” Michael D. Shear, *Care Act Supporter Ignites Fury with a Word: ‘Stupid’*, N.Y. TIMES, Nov. 15, 2014, at A12, and who helped congressional staff “draft the specifics of the legislation,” Catherine Rampell*, Mr. Health Care Mandate*, N.Y. TIMES, Mar. 29, 2012, at B1—later explained: “[I]f you’re a state and you don’t set up an Exchange, that means your citizens don’t get their tax credits.… I hope that that’s a blatant enough political reality that states will get their act together and realize there are billions of dollars at stake here in setting up these Exchanges, and that

they'll do it." Jonathan Gruber at Noblis, at 32:00, Jan. 18, 2012, https://www.youtube.com/watch ?v=GtnEmPXEpr0&t=31m25s.

Perhaps in light of that "political reality" deterring states from turning down "billions" of free federal dollars, "lawmakers 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. Accordingly, they did not appropriate in the ACA any specific funds for HHS to build Exchanges. *See* Amy Goldstein & Juliet Eilperin, *Challenges Have Dogged Obama's Health Plan Since 2010*, WASH. POST, Nov. 2, 2013 (Congress "included no money for the development of a federal exchange"). And the ACA's proponents emphasized that "[a]ll the health insurance exchanges … are run by states," to rebut charges that the Act was a federal "takeover" of health care. SEN. DEMOCRATIC POLICY COMM., *Fact Check: Responding to Opponents of Health Insurance Reform*, Sept. 21, 2009, http://dpc. senate.gov/reform/reform-factcheck-092109.pdf.

B. The IRS Nonetheless Extends the ACA's Subsidies to HHS-Established Exchanges.

Contrary to Congress's expectation, the ACA remained highly controversial in the years following its enactment. Perhaps concerned that some states would refuse to establish Exchanges even at the cost of subsidies, the IRS in 2011 proposed, and in 2012 promulgated, regulations extending subsidies to *all* Exchanges—not only those established by *states* under § *1311*, but also by *HHS* under § *1321*. 76 Fed. Reg. 50,931, 50,934 (Aug. 17, 2011); 77 Fed. Reg. 30,377, 30,378, 30,387 (May 23, 2012).

These regulations ("the IRS Rule") contradict the statutory text restricting subsidies to Exchanges "established by the State under section 1311." Specifically, the 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 (emphasis added); 45 C.F.R. § 155.20 (emphasis added). Under the IRS Rule, subsidies are thus available in *all* states, even those states that failed to establish Exchanges. Put another way, the IRS Rule allows subsidies for coverage purchased through the federal Exchange, known as HealthCare.Gov, rather than just for coverage purchased through state-run Exchanges.

Commenters, including at least 25 Members of Congress, pointed out this facial inconsistency with the statute. *See* H. Comm. on Oversight & Gov't Reform and H. Comm. on Ways & Means, *Administration Conducted Inadequate Review of Key Issues Prior to Expanding Health Law's Taxes and Subsidies* at 4, 113th Cong., Feb. 5, 2014. The IRS responded with only the following explanation:

> 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.

C. 34 States Decline To Establish Their Own Exchanges for 2014.

After the IRS announced that taxpayers would be eligible for subsidies whether or not their states established Exchanges, 34 states declined to create Exchanges for 2014. Pet.App.44a-45a. HHS established Exchanges to serve those states instead.[1]

Although HHS rules allow for states to establish Exchanges after 2014 as well, 45 C.F.R. § 155.106, no state that declined to create an Exchange in 2014 will set one up for 2015. *See* Kaiser Family Found., *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*, Aug. 28, 2014, http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/.[2]

---

[1] Two other states sought to establish Exchanges but were not able to do so in time for 2014. They therefore relied on HHS Exchanges that year. Jennifer Corbett Dooren, *Two States Seek Help With Health Exchanges*, WALL ST. J., May 22, 2013.

[2] Of these states, 7 chose to assist HHS with operation of the federal Exchanges. Kaiser Family Found., *State Decisions*, *supra*. Those so-called "partnership" Exchanges are formally established by HHS pursuant to § 1321 of the ACA, as HHS has admitted. 77 Fed. Reg. 18,310, 18,325 (Mar. 27, 2012).

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

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

For individuals, eligibility for a subsidy triggers the Act's individual mandate tax penalty for many who would otherwise be exempt. That penalty does not apply to those "who cannot afford coverage" or who would suffer hardship if forced to buy it. 26 U.S.C. § 5000A(e)(1), (5) (ACA § 1501(b)). Under regulations implementing these exemptions, an individual is exempt from the individual mandate penalty if the annual cost of coverage exceeds eight percent of his projected household income. 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 the annual premium for the cheapest plan available to that person on his Exchange, minus "the credit allowable under section 36B." 26 U.S.C. § 5000A(e)(1)(B)(ii). By purporting to make a credit "allowable" in states served by HHS Exchanges, the IRS Rule thus increases the number of people in those states subject to the tax penalty.

For employers, subsidies trigger the "assessable payments" used to enforce the Act's employer mandate. The Act provides that large employers will be subject to such payments if they do not offer full-time employees the opportunity to enroll in affordable, employer-sponsored 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

(ACA § 1513(a)). Thus, if no subsidies are available in a state because that state has not established an Exchange, employers in that state face no liability. Since the IRS Rule authorizes subsidies nationwide, however, it exposes businesses in those states to the employer mandate penalties.

E. Injured Individuals Bring Suit To Challenge the IRS Rule.

Petitioners reside in Virginia, which has declined to establish its own Exchange. They do not want to comply with the individual mandate, and, given their low incomes, would not be subject to penalties for failing to, but for the IRS Rule. That Rule renders them eligible for subsidies that would reduce the net cost of their coverage to below 8% of their projected incomes, disqualifying them from the exemption. *See* JA29-38. Therefore, "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." Pet.App.52a-53a.

F. The Courts Below Uphold the IRS Rule on the Merits, While Other Courts Find the Rule Illegal and Order Its Vacatur.

The district court ruled for the Government on February 18, 2014. It concluded that Petitioners had standing and could sue under the APA. Pet.App.53a-60a. On the merits, the district court recognized that Petitioners' "plain meaning interpretation of section 36B has a certain common sense appeal." Pet.App.71a. The court, nonetheless, concluded that Congress *unambiguously* intended just the contrary of that "plain meaning." The court inferred that countertextual intent from (i) Congress's policy goal "to ensure broad access to affordable health coverage

for all" (Pet.App.71a); (ii) the absence of "direct support in the legislative history" confirming the text (Pet.App.70a); and (iii) supposed "anomalous results" under some of the Act's other provisions were the text of § 36B given its plain meaning (Pet.App.64a).

On July 22, 2014, the Fourth Circuit affirmed on alternative grounds. It conceded the "common-sense appeal of the plaintiffs' argument," but ultimately held the ACA to be ambiguous as to whether an HHS Exchange is "established by the State." Pet.App.18a. Judge Gregory wrote the opinion, joined by Judges Davis and Thacker. Pet.App.2a. Judge Davis also wrote a concurrence defending the district court's reasoning. Pet.App.34a.

Two hours before the Fourth Circuit issued its opinion, the D.C. Circuit decided another challenge to the same IRS Rule. *Halbig v. Burwell*, 758 F.3d 390 (D.C. Cir. 2014). In *Halbig*, Judge Griffith wrote a majority opinion joined by Judge Randolph, over a dissent by Judge Edwards. The panel found the IRS Rule directly contrary to the text of the ACA. *Id.* at 394. On the Government's request, the D.C. Circuit later ordered en banc rehearing. *See* 2014 U.S. App. LEXIS 17099 (D.C. Cir. Sept. 4, 2014).

Another court, after reviewing the opinion below and *Halbig*, declared the latter "more persuasive" and condemned the Government's defense of the IRS Rule as "lead[ing] us down a path toward Alice's Wonderland, where up is down and down is up, and words mean anything." *Oklahoma v. Burwell*, No. 11-cv-30, 2014 U.S. Dist. LEXIS 139501, at *14, 16 (E.D. Okla. Sept. 30, 2014). Faced with this division in authority, this Court granted certiorari. The D.C. Circuit then ordered *Halbig* held in abeyance.

SUMMARY OF ARGUMENT

I. As statutory construction cases go, this one is extraordinarily straightforward. There is no legitimate way to construe the phrase "an Exchange established by the State under section 1311" to include one "established by *HHS* under section *1321*." Congress expressly contemplated both state-established Exchanges (in the first instance) and HHS-established Exchanges (if states refused to establish their own); because it specifically singled out for subsidies one type, and only one type, courts must give effect to that plain language.

A. Three ACA provisions dispose of this case. First, § 1311 instructs that all states "shall" establish Exchanges. 42 U.S.C. § 18031(b). Second, § 1321 provides that, in case of a state's "failure to establish [an] Exchange," HHS "shall … establish and operate such Exchange within the State." *Id.* § 18041(c). And third, the Act then grants subsidies for coverage that is "enrolled in through an Exchange *established by the State under section 1311*." 26 U.S.C. § 36B(c)(2)(A) & (b)(2)(B) (emphasis added). Any English speaker would immediately understand that no subsidies are available for coverage obtained on an Exchange established by HHS under § 1321. If Congress had wanted subsidies to be available in *both* Exchanges, there is simply no explanation for why it would have gone out of its way to specify that only coverage through Exchanges "established by the State under section 1311" may be subsidized. Why would Congress add unnecessary words that, on any reading, say precisely the *opposite* of what it supposedly meant?

B. In the face of this unambiguous text, the Government and courts below have argued that § 1321's authorization for HHS to create Exchanges (if and only if states fail to do so) somehow means that HHS-established Exchanges under this section *are themselves* state-established Exchanges under § 1311. But that obviously does not follow; every iteration of this argument is facially meritless.

First, the fact that the Act *authorizes* HHS to establish Exchanges plainly does not imply that those Exchanges are "established by the State." Just the opposite: Because the Act contemplated that two different entities could establish Exchanges, § 36B's words are a clear *exclusion* of HHS Exchanges.

Second, the instruction to HHS to establish "such" Exchange if the state defaults simply means that HHS is to establish the same *type* of Exchange. But § 36B makes subsidies turn not on the *type* of Exchange, but on *who* established it, and the word "such" does not somehow require HHS to, impossibly, establish a state-established Exchange.

Third, the notion that HHS acts *on behalf of* a defaulting state is both false and irrelevant. The Act directs HHS to establish an Exchange "within" the defaulting state, not on its behalf. Indeed, HHS's authority is only triggered by a state's *refusal*, so it cannot possibly be acting on the state's behalf. And either way, the Exchange is still established *by* HHS.

Fourth, the Act's definition of "Exchange" as one established "under § 1311" does not advance the ball: If anything, potential confusion over whether HHS acts under § 1321 or indirectly under § 1311 explains why § 36B further clarifies that only Exchanges "established *by the State*" trigger subsidies.

Fifth, the Government's new theory that HHS Exchanges are "established by the State" purportedly "as a matter of law" is pure *ipse dixit*; the Act says nothing of the sort. Congress *could have* deemed HHS Exchanges to be "established by the State" for subsidy purposes, but it never did so—in contrast to other equivalences established in the U.S. Code, an early ACA draft, and elsewhere in the final Act itself.

C. Even if § 36B's language is clear, the Government complains, one cannot read that single provision out of context. But § 36B is the *only* ACA provision that defines the subsidy's scope and value. And, in any case, statutory context only *confirms* its plain text. Context shows that Congress elsewhere used broader phrases that clearly encompass HHS Exchanges, but chose not to do so in § 36B. Context shows that Congress expressly deemed other non-state entities to be "states," but again, chose not to do so for HHS. Context shows that Congress did not treat state and HHS Exchanges as indistinguishable; it referred distinctly to both types of Exchanges in another subsection of § 36B itself. Finally, context shows that § 36B's formula for computing the value of the subsidy, far from being a "mousehole" in which Congress would not have naturally limited subsidies, is the provision that sets the substantive parameters of the subsidy in all relevant respects.

D. As this Court has so often repeated, if statutory text is clear, that is the end of the inquiry, so long as the text does not produce an absurd result. Here, there is no question that it does not, either in § 36B itself or elsewhere in the Act. There is thus no warrant—for courts *or* agencies—to flout that text.

1. To be sure, subsidies are important to the statutory scheme, and Congress wanted them nationwide. But *conditioning* subsidies on state creation of Exchanges is not contrary to that desire, any more than conditioning Medicaid funds on state expansion of Medicaid eligibility is contrary to Congress's obvious desire to extend those funds to all states. There is no inconsistency (much less irrational conflict) between desiring subsidies and conditioning their availability on certain state action, because such conditions serve a valuable purpose of the Act that is lost if subsidies are unconditional—namely, inducing states to take the desired action of establishing Exchanges. As such, there is no basis for rewriting the condition embodied in § 36B's plain text, because it is clearly not absurd. Rather, it produces the valuable benefit of inducing the state action strongly encouraged—indeed, purportedly mandated—by § 1311 of the Act, *i.e.*, having states establish Exchanges.

In fact, limiting subsidies to state-established Exchanges was the best, and perhaps the only, way Congress could accomplish *both* nationwide subsidies *and* state-run Exchanges. Congress reasonably could expect states not to reject a "deal" providing their citizens with billions of dollars of free federal money to purchase health insurance. Absent such a financial incentive, however, it was unlikely that all states would voluntarily assume this complicated and controversial responsibility. Proving the point, when the IRS eliminated the incentive of subsidies, replacing a deal too good to refuse with a "deal" that offered states nothing, most states declined the role Congress had urged upon them.

To the extent, therefore, that vacating the Rule now could have adverse policy consequences on the insurance markets—at least temporarily, until states exercise their choice to establish Exchanges going forward—those effects are the *result* of the unlawful IRS Rule. They cannot be invoked to *sustain* it.

In short, the Government's constant refrain that Congress viewed subsidies as important is entirely beside the point. As a practical matter, the same Congress imposed conditions on *Medicaid* funds, which are more important and more entrenched than the new subsidies, belying any notion that the ACA would refrain from conditioning federal funds if they were viewed as highly desirable. And as a legal matter, the perceived importance of the subsidies is irrelevant: If the condition imposed by § 36B's plain text produces an objectively non-absurd result—and even the Fourth Circuit conceded that it does—then the condition cannot be ignored, just as neither the judiciary nor the Executive would be empowered to authorize desperately needed Medicaid funds for a state that had not satisfied the conditions thereupon.

Finally, for essentially the same reasons, it is irrelevant whether Congress *stated* its desire to induce the states to establish Exchanges in the Act's legislative history. There is no requirement that Congress expressly articulate an objectively non-absurd purpose in the legislative history to make unequivocal statutory text enforceable. To the contrary, even *express* legislative history cannot overcome plain text. Its *absence* is thus certainly irrelevant, and especially unsurprising for a statute negotiated largely behind closed doors.

In any case, there is ample evidence that Congress meant exactly what it said. A pre-debate proposal by an influential expert suggested that Congress tie subsidies to state cooperation. A draft Senate bill undeniably did just that, further belying the notion that any such condition would have been unthinkable to Congress. Meanwhile, a House bill that gave states *no* incentives to create Exchanges was a non-starter in the Senate for this reason, as everyone concedes, and the House had no capacity to push back against the Senate bill after supporters of the Act lost their filibuster-proof majority. If that were not enough, one of the Act's principal architects later explained that the point of linking subsidies to state Exchanges was precisely to politically pressure states by offering the incentive of federal funds for state residents.

2. In yet another argument even the Fourth Circuit rejected, the Government claims that giving § 36B its plain meaning would lead to anomalous results as to *other* provisions in the Act. But mere "anomalies," as this Court recently warned, never override plain text. And even if the anomalies in the other provisions rose to the level of absurdity, that could not justify ignoring *§ 36B's* text, which is *not* absurd. In all events, the Government's contention fails on its own terms. The "anomalies" it alleges are simply contrived. All of the Act's other provisions are just as compatible with the plain meaning of § 36B as with the Government's unlawful revision of it, as the court below admitted. These provisions obviously do not come anywhere close to absurdity, on any terms, and they certainly do not justify "exporting" the absurdity to revise the statutory text wholesale, throughout the Act.

II. *Chevron* deference cannot save the IRS Rule. *First*, the ACA's subsidy provision unambiguously answers the precise question presented, which is unsurprising: Congress would never have delegated a decision of such economic and political significance to the IRS. *Second*, any deference is displaced here by the venerable canon requiring tax credits to be unambiguous. Where the expenditure of Treasury funds is at stake, the Constitution itself demands that congressional authorization be plain. Here it is not, and executive say-so cannot fill that hole. *Third*, the *IRS* is afforded no deference in construing the language critical to the theory offered by the Government and the courts below, which is found in Title 42 of the U.S. Code, *not* the Internal Revenue Code. There is no dispute that the language of § 36B standing alone is unambiguous, and the IRS has no power to construe other, non-tax parts of the statute. Conversely, HHS has no power to interpret the tax laws. Congress did not delegate § 36B's meaning to *any* agency, but rather intended it as a clear, direct answer to the question presented.

* * *

If the rule of law means anything, it is that text is not infinitely malleable, and that agencies must follow the law as written—not revise it to "better" achieve what they assume to have been Congress's purposes. This case may be socially consequential and politically sensitive, but that only heightens the importance of judicial fidelity to the rule of law and well-established interpretive principles. Under those principles, it is clear that the IRS Rule must fall.

ARGUMENT

I. PLAIN TEXT SQUARELY FORECLOSES THE IRS RULE, AND THERE IS NO LEGAL BASIS TO REJECT THAT PLAIN TEXT.

"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. NRDC, Inc.*, 467 U.S. 837, 842-43 (1984)). That principle resolves this case. The ACA plainly limits subsidies to coverage purchased on *state-established* Exchanges. No absurdity arises from that limitation, which is consistent with the Act's structure, history, and purposes. The IRS Rule therefore cannot stand.

A. The IRS Rule Contradicts the Plain Meaning of the ACA's Subsidy Provision.

On its face, the IRS Rule directly contradicts the plain text of the ACA's subsidy provision.

1. The ACA grants a tax credit "equal to the premium assistance credit amount," which is the sum of monthly assistance amounts for "all coverage months of the taxpayer" during the year. 26 U.S.C. § 36B(a), (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*, 42 U.S.C. § 18031]." *Id.* § 36B(c)(2)(A)(i) (emphasis added). These provisions are thus perfectly clear: Unless a taxpayer enrolls in coverage "through an Exchange established by the State under section 1311 of the [ACA]," he has no "coverage months" and therefore no "premium assistance amounts."

Reinforcing that point, the Act specifies that the subsidy for any "coverage month" is the lesser of two values: *First*, monthly premiums for a plan "which cover[s] the taxpayer" and "w[as] enrolled in through an Exchange established by the State under [§] 1311 [of the ACA, 42 U.S.C. § 18031]." *Id.* § 36B(b)(2)(A). *Second*, the excess, over a specified percentage of the taxpayer's average monthly income, of the "adjusted monthly premium for such month for the applicable second lowest cost silver plan" that is "offered through the same Exchange [as] … under paragraph (2)(A)"—namely, one "established by the State under [section] 1311 [of the ACA, 42 U.S.C. § 18031]." *Id.* § 36B(b)(2)(B), (3)(B). Consistent with the definition of "coverage month," these sums presuppose that the taxpayer has obtained coverage from "an Exchange established by the State under section 1311."

2. In stark contrast, the IRS Rule provides that a taxpayer is eligible for a subsidy so long as he "[i]s enrolled in one or more qualified health plans through *an Exchange*," without regard to what entity established the Exchange. 26 C.F.R. § 1.36B-2(a)(1) (emphasis added). The regulations then adopt by cross-reference an HHS definition of "Exchange" that expressly includes *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 (emphasis added). Under these regulations, therefore, an individual who enrolls in coverage through an HHS-established Exchange is eligible for a subsidy. Again in contrast to the ACA, the regulations also apply that broader definition of Exchange to the definition of "coverage month." 26 C.F.R. § 1.36B-3(c)(1)(i).

3. The IRS Rule thus contradicts the plain and unambiguous text of the ACA. The statute expressly allows subsidies only for coverage obtained through "an Exchange established by the State under section 1311" of the Act, but the regulation then expands those subsidies to coverage obtained through *any* Exchange, "regardless of whether [it] is established and operated by a State … or by HHS." That is, the Act says subsidies *if* A; the IRS Rule says subsidies *regardless* of A. It is hard to imagine a starker, more lawless departure from statutory text.

At the risk of belaboring the obvious, HHS is not a "State." If there could be any doubt on that, the Act clarifies: "'State' means each of the 50 States and the District of Columbia." 42 U.S.C. § 18024(d) (ACA § 1304(d)). Moreover, §§ 1311 and 1321 of the ACA are distinct grants of authority to distinct entities.

The IRS Rule therefore renders Congress's choice of language utterly inexplicable. To begin, the modifiers "established by the State" and "under section 1311" would serve no purpose if Congress actually wanted subsidies available in all Exchanges. *See Duncan v. Walker*, 533 U.S. 167, 174 (2001). Far worse, they say precisely the *opposite*. Why on earth would Congress add clauses that are not just unnecessary but also directly misleading?

In short, Congress could not have chosen clearer language to express its intent to limit subsidies to state Exchanges, and no one has been able to explain why it would have used this language *absent* such intent. As such, the text is "plain and unambiguous," and so "[o]ur inquiry must cease." *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340 (1997). This should be the "end of the matter." *Chevron*, 467 U.S. at 842.

B. The Fourth Circuit's Textual "Hook" for the IRS Rule Does Not Withstand Scrutiny.

The Fourth Circuit nevertheless reasoned that, although § 36B plainly limits subsidies to coverage through Exchanges "established by the State," that phrase could somehow be read to include Exchanges established by HHS. Pet.App.17a-18a. No English speaker would ever so understand the phrase, and no Congress trying to extend subsidies to all Exchanges would ever have gone out of its way to use it.

1. Judge Davis's concurrence offered the most aggressive argument for treating HHS Exchanges as "established by the State." Section 1321 of the ACA, he reasoned, creates a "contingency provision" under which HHS "establishes and operates the Exchange in place of the state." Pet.App.36a. For Judge Davis, that alone "disposes" of Petitioners' claim. *Id.* Since HHS Exchanges may *replace* state Exchanges, they somehow *become* state Exchanges. Or, in his words, "'established by the State' indeed means established by the state—except when it does not." *Id.*

Respectfully, that makes no sense. That the Act *envisions* HHS-established Exchanges when states default obviously cannot mean that § 36B's reference to "Exchange established by the State" also connotes HHS Exchanges. To the contrary, it reinforces that the Act's reference to state Exchanges *excludes* HHS Exchanges. Precisely because the Act directs two distinct entities to establish Exchanges, "Exchange established by the State" cannot be read to include an Exchange established by HHS. Congress knew it was authorizing both state- and HHS-established Exchanges; its subsequent reference to *one* cannot be construed to include *both* simply because both exist.

2. Given that § 1321's mere authorization of HHS Exchanges cannot possibly create any confusion between Exchanges "established by the State" versus those established by HHS, the full panel's opinion instead emphasized one particular word in that provision: It directs HHS to establish "*such* Exchange," 42 U.S.C. § 18041(c) (emphasis added), referring back to the Exchange that the state was asked to establish but failed to. Pet.App.18a. On the panel's theory, then, the Act required the impossible: for *HHS* to establish a *state-established* Exchange.

The word "such" cannot bear this weight. "Such" simply requires HHS to establish the same Exchange that the State would have established had it chosen to establish one. If § 1321 had said "*an* Exchange," HHS could have created *any* sort of Exchange; the word "such" eliminates that discretion. Thus, "such Exchange" describes *what the Exchange is*, not *who established it*. The HHS Exchange should operate just like the Exchange the state would otherwise have established. *But it is established by HHS, not by the state*. And that is the critical fact for subsidy purposes. As the *Halbig* panel explained, the term "such" creates an equivalence between the two types of Exchanges "in terms of what they are," but subsidies turn on another attribute of Exchanges—"who established them." 758 F.3d at 400.

The contrary view fails because an Exchange is established either by a state or by HHS; it cannot be both simultaneously. A "federally established state-established Exchange" is an oxymoron. If Congress asked states to build certain airports, and described the airports in great detail, specifying, *e.g.*, security procedures and infrastructure requirements, but

then added that the U.S. Secretary of Transportation should construct "such airports" if states fail to do so, nobody would ever think to refer to the latter as "state-constructed airports."

3. In a subtle variant of this same argument, the panel below suggested that, when a state fails to establish an Exchange, HHS does so "on behalf of" the state and thus, by some bizarre transitivity, the HHS Exchange is itself "established by the state." Pet.App.18a. That premise is wrong, however, and the conclusion does not follow in any event.

At the outset, the ACA does not say that HHS should establish an Exchange "for" or "on behalf of" the state. Rather, § 1321 tells HHS to establish an Exchange "within" a declining state. 42 U.S.C. § 18041(c). That is language signifying *geography*, not *agency*. Moreover, the crucial premise allowing HHS to act under § 1321 is the state's *failure* to act, making it particularly illogical to describe HHS as acting on the state's behalf. HHS is doing something the state has rejected doing, so it cannot be acting *on behalf of* the state—only *instead of* the state.

In any event, even if the Act expressly stated that HHS is establishing the Exchange "on behalf of the State," that HHS-established Exchange would still not be eligible for subsidies. Section 36B authorizes subsidies for an "Exchange established by the State," not for one established by HHS on the State's behalf. When, by contrast, Congress wants the federal government to act on behalf of another entity *and be treated as that entity*, it says so expressly. *See, e.g.*, 28 U.S.C. § 2679(d)(1) (allowing United States to "step into the shoes" of federal officers who are sued, and such suit "shall be deemed

an action against the United States"); 11 U.S.C. § 544(a) (granting bankruptcy trustee all "rights and powers of" creditors owed money by third parties); 12 U.S.C. § 1821(d)(2)(A)(i) (allowing FDIC to step into shoes of failed banks and FDIC "shall … succeed to … all [their] rights, titles, powers, and privileges").

4. The Fourth Circuit also cited the Act's global definition of "Exchange" as "an American Health Benefit Exchange established under section 1311." 42 U.S.C. § 300gg-91(d)(21) (ACA § 1563(b)). Since that definition refers to § 1311—which tells states to establish Exchanges—all Exchanges are "established by the State" definitionally, it thought. Pet.App.17a.

If anything, however, that definition of Exchange makes *Petitioners'* argument stronger, since it suggests that any use of the term "Exchange"—even *without* the qualifier "established by the State under section 1311"—could fairly be read as limited to the state-run Exchanges established under that section. Yet, to avoid doubt, Congress clarified this further in § 36B. Conversely, the definition does not advance the Government's argument, as it merely confirms what "such" already makes clear, *i.e.*, that the HHS Exchange should be the same as the Exchange the state would have established under § 1311.

At most, as the *Halbig* panel noted, plugging this definition into § 1321 of the ACA could sow doubt over the metaphysical, immaterial question whether Exchanges established by HHS pursuant to § 1321 are established "under" that section (as HHS recognizes, 45 C.F.R. § 155.20) or rather, indirectly, "under" § 1311. *Halbig*, 758 F.3d at 399-400. Either way, this metaphysical ambiguity over whether the HHS-established Exchange is a "§ 1311" or "§ 1321"

Exchange leaves no uncertainty on the only relevant question: whether it is "established by the *State*." Thus, however an HHS Exchange is characterized, the dispositive point is that it is established *by HHS*.

Indeed, this potential ambiguity over whether HHS Exchanges are "§ 1311" or "§ 1321" Exchanges may be why Congress used the language it did in § 36B. A careful draftsman told to limit subsidies to state-established Exchanges, noting the potential ambiguity created by the definition of "Exchange," would allow subsidies only on an "Exchange established *by the State* under section 1311," rather than just one "established under section 1311." Needless to say, since § 36B's language is the best one could use to *eliminate* any ambiguity created by the Act's definitional section as to whether HHS Exchanges are eligible for subsidies, it cannot be argued that § 36B *contains* ambiguity on that point.

The panel also pointed to the specification in § 1311 that an Exchange must be "a governmental agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(d)(1). The panel thought that this "narrow[s] the definition of 'Exchange' to encompass only state-created Exchanges," and that a narrow focus on "state-created Exchanges" somehow *supports* inclusion of HHS-created Exchanges in § 36B. Pet.App.17a. Even the Government has not pressed that argument—and for good reason: Section 1311 is the provision directing *states* to establish Exchanges. Section 1311(d)(1) simply provides that they may do so through either a state-created agency or nonprofit. That "Exchange established by the State" denotes a *state* agency or non-profit obviously cannot imply that it denotes an *HHS* Exchange.

5. Apparently recognizing the insufficiency of all the above, the Government argued in opposing certiorari that "Exchange established by the State" includes HHS Exchanges "as a matter of law," on some type of legal fiction. That is pure *ipse dixit*.

The Government seems to reason that § 1321 furnishes "alternative means" for states to *satisfy* the obligation under § 1311 to establish Exchanges, such that an HHS Exchange under § 1321 is "established by the State under section 1311" since it represents one way for a state to meet its statutory obligation to establish one. (BIO 14.) But the Act says just the opposite: Section 1321 authorizes an HHS Exchange only on a state's "*failure* to establish [an] Exchange." 42 U.S.C. § 18041(c) (emphasis added). "*Failure*" to meet a requirement is obviously not a way to *fulfill* that requirement. Rather, an HHS Exchange is a *fallback* if the state *fails* to fulfill the requirement.

Congress may give words a "different meaning" than they naturally suggest, "[b]ut before we will assume it has done so, there must be *some* indication [it] intended such a result." *Mohamad v. Palestinian Auth.*, 132 S. Ct. 1702, 1707 (2012). Congress could have used any number of formulations to equate HHS Exchanges with those established by states—but did not. It did not stipulate, for example, that HHS "shall be treated as a State" for some purposes. That omission "is particularly significant since Congress knew how to provide that a non-state entity should be treated as if it were a state when it sets up an Exchange." *Halbig*, 758 F.3d at 400. Specifically, § 1323 provides that if a U.S. territory establishes an Exchange, it "shall be treated as a State" for certain purposes. 42 U.S.C. § 18043(a)(1).

Nor does the Act provide that an HHS Exchange is "deemed" to be "established by the State." Again, that is notable because a House version of the ACA, which created one national Exchange but allowed states to "opt-in" to run Exchanges themselves, said *expressly* that, if a state opted in, "references … to the Health Insurance Exchange … shall be deemed a reference to the State-based Health Insurance Exchange." H.R. 3962, § 308(e), 111th Cong. (2009).

In short, since no language in § 1321 suggests that an HHS Exchange should be deemed or treated as a state Exchange, and since Congress used such language when it meant to convey such equivalence, the Government's argument is an exercise in "distortion, not interpretation." *Halbig*, 758 F.3d at 412 (Randolph, J., concurring).

C. The Act's Structure and Context Confirm the Plain Text of the Subsidy Provision.

Both the Fourth Circuit panel opinion and Judge Davis's concurrence contended that, although § 36B may limit subsidies to Exchanges "established by the State," overall statutory "context" somehow suggests otherwise. Pet.App.17a, 36a. Not so. Section 36B is the *only* provision of the ACA that speaks directly to the availability of subsidies. And statutory context only confirms the limit in its plain language.

1. As a matter of statutory context, it is notable that Congress did not use the phrase "Exchange established by the State under section 1311" by rote, every time it sought to refer to the Exchanges under the Act. Rather, it often referred to "an Exchange" standing alone, or used broader language that clearly encompasses HHS Exchanges. For example, the Act elsewhere refers to an "Exchange established under

this Act," 42 U.S.C. § 18032(d)(3)(D)(i)(II) (ACA § 1312(d)(3)(D)(i)(II)). Under the IRS Rule, however, the narrower phrase "Exchange established *by the State*" would have the same meaning as "established *under this Act*," violating the canon of construction 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).

Thus, as the court below admitted, "[i]f Congress did in fact intend to make the tax credits available to consumers on both state and federal Exchanges, it would have been easy to write in broader language, as it did in other places in the statute." Pet.App.16a-17a. But Congress did *not* do so—strong contextual evidence that it meant exactly what it said.

2. Moreover, in another subpart of the subsidy provision itself, Congress referred expressly—and distinctly—to state *and* HHS Exchanges, confirming its understanding that one does not encompass the other. Specifically, a subsection of § 36B requiring all Exchanges to report information to the Treasury clarifies that it applies to anyone carrying out the responsibilities of an "Exchange under Section 1311(f)(3) or 1321(c)." 26 U.S.C. § 36B(f)(3).[3] This shows, again, that when Congress wanted to refer to

---

[3] Sections 1311(f) and 1321(c) allow states and HHS, respectively, to contract out some Exchange duties. 42 U.S.C. §§ 18031(f), 18041(c). Section 1311(f), in particular, provides that "[a] State may elect to authorize an Exchange established by the State under this section to enter into an agreement" to contract out certain Exchange duties. On the Government's theory that HHS Exchanges are "established by the State," this provision would, absurdly, allow *states* to authorize *HHS-run* Exchanges to contract out.

both state *and* HHS Exchanges, it "knew how to do so." *Custis v. United States*, 511 U.S. 485, 492 (1994). Yet, in those subsections of § 36B that define the subsidy's scope, Congress referred *only* to state Exchanges. This, too, is strong contextual evidence confirming the meaning of the plain text.

3. Concurring, Judge Davis tried to cast doubt on § 36B's plain text by suggesting (Pet.App.39a) that "the formula in a subprovision governing how to calculate the amount of the credit" was an odd place for Congress to insert a condition on eligibility—like hiding an elephant in a mousehole. *Cf. Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001).

But the technical formula that defines the "premium assistance credit amount" is the *only* provision that specifies which purchases are eligible for subsidies. It is therefore clearly the most natural provision in which to specify that only coverage purchased through a state-established Exchange is eligible. This is particularly obvious because it is also the only statutory provision specifying that only coverage purchased on an "Exchange" (as opposed to directly from insurers) is eligible for a subsidy. Thus, the same "formula" that Judge Davis believes too obscure to limit subsidies to state Exchanges is what limits subsidies to coverage purchased on *an Exchange*. Therefore, as the *Halbig* panel explained, "even under the government's reading of section 36B(b), the statutory formula houses an elephant: namely, the rule that subsidies are only available for plans purchased through Exchanges." 758 F.3d at 401 n.4. That formula simply also limits subsidies to coverage through Exchanges *established by states*.

Nor is it at all unusual for Congress to put conditions on receipt of a tax credit into the formula for its amount—even if the conditions require states to take action to render their citizens eligible. Indeed, as *Halbig* noted, *id.*, a neighboring health tax credit uses an analogous structure, first broadly providing a credit for any "individual" based on the cost of coverage "for eligible coverage months," then defining "eligible coverage month" as one during which the individual is covered by certain types of insurance—but only if the state "elected" to impose certain regulations on insurers. 26 U.S.C. § 35(a), (b), (e). That is, taxpayers are entitled to credits for "coverage months," but cannot qualify unless their state has agreed to take certain action. Section 35 was thus very likely the model for § 36B, particularly because a materially identical version of the former was sponsored by Sen. Max Baucus, who chaired the Finance Committee that developed the latter. *See* S. 2737, § 601, 107th Cong. (2002).

D. The Plain Text Does Not Render § 36B or Any Other Provision of the Act Absurd, As Even the Fourth Circuit Conceded.

Because § 36B's text is plain, the only question is whether that text creates such an unthinkable result as to trigger the absurdity doctrine. *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004) ("[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."). Indeed, absurdity is the *only* basis for the "extraordinary" step of departing from plain text. *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488, 494 (D.C. Cir. 2004) (Roberts, J.). And the

test is a rigorous, objective one: The absurdity must be "so clear as to be obvious to most anyone," such that it is "quite *impossible* that Congress could have intended the result." *Pub. Citizen v. Dep't of Justice*, 491 U.S. 440, 471 (1989) (Kennedy, J., concurring in judgment) (emphasis added).

No absurdity exists here. As the Fourth Circuit conceded, it is certainly "plausible" that Congress meant exactly what it said, and was conditioning the subsidies on state establishment of Exchanges, to induce states to establish them. Pet.App.25a. That is the end of the matter. Because the plain language does not produce an objectively absurd result, it must be followed, regardless of what Congress (purportedly) subjectively intended. *See Republic of Argentina v. Weltover, Inc.*, 504 U.S. 607, 618 (1992) (question is "not what Congress 'would have wanted' but what Congress enacted"); *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992) (Congress "says in a statute what it means and means in a statute what it says there"). In any event, here there is *no* expression of "intent" that differs from that plainly stated in the enacted text. Indeed, although it is irrelevant, there is ample evidence supporting the (ought-to-be-indisputable) proposition that Congress meant what it said.

Moreover, giving a plain-text meaning to the phrase "Exchange established by the State" does not create any absurd anomalies *elsewhere* in the Act. Again, even the Fourth Circuit was "unpersuaded" by the Government's contrary claims. Pet.App.22a. Nor, in any event, would such anomalies justify rewriting the plain and non-absurd text of § 36B.

1. *Using subsidies as an incentive for states to create Exchanges is perfectly sensible and consistent with Congress's purposes.*

a. Construing the ACA to provide subsidies only for coverage through state-established Exchanges is plainly not absurd. Given the plausible concern that at least some states would be reluctant to undertake the thankless job of establishing and operating Exchanges, offering them an irresistible incentive—billions of dollars in "free" federal subsidies to their citizens—is a most sensible tactic. Indeed, Congress in the ACA indisputably imposed an analogous condition on states' receipt of Medicaid funds: Unless the states expanded their eligibility criteria for Medicaid benefits, they would lose *all* Medicaid funds. *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 …."). As with Medicaid, Congress could quite reasonably believe that elected state officials would not want to explain to voters that they had deprived them of billions of dollars by failing to establish an Exchange. Stated differently, it makes good sense not to treat states that reject the request to establish Exchanges just as favorably as those who agree to bear that burden. Indeed, treating them equally is plainly *not* sensible, as it eliminates any incentive to establish Exchanges and thus would lead (as the IRS Rule did) to most states declining to do so. Thus, as even the Fourth Circuit agreed, "it is at least plausible that Congress would have wanted to ensure state involvement in the creation and operation of the Exchanges," which would "comport with a literal reading of [§ 36B]." Pet.App.24a-25a.

Accordingly, because § 36B's subsidy condition serves the non-absurd (indeed, eminently sensible) purpose of inducing states to create Exchanges, that is the "end of the matter," *Chevron*, 467 U.S. at 842, because it eliminates the only potential basis for departing from the statute's plain text.

b. Nonetheless, the Government argues that courts must rewrite the plain statutory text, even though it clearly advances a reasonable purpose, because it is allegedly contrary to another purported "purpose" of the ACA—making subsidies universally available so that health coverage will be "affordable." Govt.C.A.Br.31-36. But invoking this amorphous "purpose" to "construe" § 36B to mean the opposite of what it says would not be legitimate interpretation, but wholly lawless revision.

At the threshold, the Government's argument is based on an impermissible approach to statutory construction, because "vague notions of a statute's 'basic purpose' are … inadequate to overcome the words of its text." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261 (1993); *see also Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam) ("[I]t frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law."). In any event, there is no conflict between § 36B's plain language and Congress's desire for subsidies. The Government is thus not seeking to implement any *congressional* "purpose," but to create a new "subsidies-everywhere" purpose and, in doing so, defeat the Act's clearly enunciated purpose of encouraging state-established Exchanges.

The Government's constant refrain is that subsidies are important to making health coverage affordable (and consequently to increasing demand on the Exchanges). While Congress surely wanted subsidies, § 36B's plain text is not at all inconsistent with this desire because it does not *eliminate* such subsidies; it merely *conditions* them on states creating Exchanges. While it is certainly true that "[*w*]*ithout* the federal subsidies," the Exchanges "would not operate as Congress intended," *NFIB*, 132 S. Ct. at 2674 (joint dissent) (emphasis added), *conditioning* such subsidies on state establishment of Exchanges would operate precisely as Congress intended, because such a condition is the best (and probably only) way to accomplish *both* the Act's goals of widely available subsidies *and* state-established Exchanges.

The Government's contrary argument ignores, on the one hand, Congress's textually stated purpose to induce states to establish Exchanges and invents, on the other, a congressional purpose to extend subsidies outside state Exchanges. The ACA's plain text clearly establishes the congressional purpose to have states establish their own Exchanges. Indeed, state-established Exchanges were so important that the Act purports to *mandate* them, directing that each state "shall" establish an Exchange. 42 U.S.C. § 18031(b)(1). But, under the Constitution, Congress could not directly enforce this mandate, so the only mechanism for accomplishing this goal was that used in Medicaid (and many other statutes)—conditioning federal funds on the states' agreement to engage in the desired action.

Conversely, nothing in the ACA's text, or even its *legislative history*, evinces a purpose to extend subsidies outside state Exchanges. Section 36B expressly limits subsidies to state Exchanges, and the Act constantly cross-references § 36B when it mentions those subsidies elsewhere. *E.g.*, 42 U.S.C. § 18054(c)(3) (ACA § 1334(c)(3)); *id.* §§ 18081-18083 (ACA §§ 1411-1413); 26 U.S.C. § 6055(b)(1)(B) (ACA § 1502(a)). And the legislative history nowhere states that subsidies are available on HHS Exchanges. *See* Part I.D.1.c, *infra*. Thus, nobody in Congress anywhere articulated a purpose to extend subsidies outside state-established Exchanges.

The Government's contrary contention is simply a transparent device to rewrite § 36B's plain text to elevate the *Executive's* policy preference (subsidies everywhere) to the detriment of *Congress's* policy of encouraging states to establish Exchanges. Under this lawless reasoning, the IRS could grant § 36B subsidies to those who buy coverage directly from insurers, instead of through an Exchange, in light of Congress's "purpose" to make all coverage affordable through federal subsidies. (Indeed, HHS temporarily did just that in 2014.)[4] Similarly, if a state had rejected the Medicaid "deal" by refusing to accept the Act's new eligibility requirements, the Executive could nonetheless provide the state with Medicaid funds because failing to do so would contradict the Act's purpose of expanding Medicaid.

---

[4] CMS Bulletin, Feb. 27, 2014, http://cms.hhs.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf (deeming persons who bought coverage from insurers as having enrolled through Exchange, due to technical problems with the Exchanges).

Both such "interpretations" would be contrary to the ACA for the same reason the IRS Rule is here. If the text creates a condition for dispensing federal funds, they cannot be dispensed absent satisfaction of the condition, no matter how much Congress wanted the funds to go to the beneficiaries. Indeed, under the Government's free-floating "purpose" analysis, an IRS with a different agenda could have *denied* subsidies on HHS Exchanges even if § 36B's plain text *expressly authorized* them, on the grounds that such unconditional subsidies would undermine the congressional purpose—stated in § 1311—of encouraging state-established Exchanges.

In short, the Government's "purpose" argument reduces to the notion that § 36B subsidies are just too important to be conditioned, because Congress never would have run even the theoretical risk that states would reject the "deal." This assertion is both factually baseless and legally irrelevant. Congress's imposition of conditions on *Medicaid*—an iconic, 50-year-old program providing essential services to citizens markedly poorer than those receiving § 36B credits—proves that it was willing to condition even very important subsidies on state action. As to both, Congress evidently believed it was offering states a deal they would not refuse, since no state official wants to explain to its citizens that they are being deprived of federal funds available in other states.

If anything, the Medicaid "deal" was even *more* risky for Congress than the subsidy condition. As to Medicaid, Congress provided no fallback if states refused, meaning that the federal policy would in such a case be *entirely* thwarted—eliminating *any* Medicaid in the state. By contrast, Congress at least

provided for HHS Exchanges if states declined to establish their own, thus allowing the federal policy to be partially implemented. State residents would still have access to an Exchange, and, contrary to the Government's suggestions below, Exchanges serve a valuable purpose even without subsidies—both for those whose incomes are too high to qualify as well as those who reside in states where subsidies are not available. Specifically, as the Administration has repeatedly emphasized, they allow consumers to engage in efficient one-stop shopping in the formerly maze-like health insurance market. *See Remarks by the President on the Affordable Care Act*, WHITE HOUSE OFFICE OF THE PRESS SEC'Y, Sept. 26, 2013 (describing Exchanges as allowing consumers to buy insurance "the same way you shop for a plane ticket on Kayak" or "for a TV on Amazon"). Indeed, for that reason, the Government represented to this Court in *NFIB* that subsidies and Exchanges were "stand-alone provision[s] that independently advanc[e] in distinct ways Congress's core goal of expanded affordable coverage," and that either could survive on its own. Br. for Resps. on Severability at 33, *NFIB*, 132 S. Ct. 2566, 2012 WL 273133.

Anyway, it ultimately does not matter why Congress imposed the condition it did, or whether its expectation of state acquiescence was prescient; the only relevant point is that the statute imposes the condition. If, in hindsight, Congress was unduly optimistic about the states' willingness to cooperate, that obviously provides no warrant for the judiciary or bureaucracy to eliminate the condition. As this Court emphasized just last Term, neither courts nor agencies may "revise clear statutory terms that turn out not to work in practice." *Util. Air Regulatory*

Grp. v. EPA, 134 S. Ct. 2427, 2446 (2014); *see also United States v. Locke*, 471 U.S. 84, 95 (1985) ("[T]hat Congress might have acted with greater clarity or foresight does not give courts a *carte blanche* to redraft statutes in an effort to achieve that which Congress is perceived to have failed to do."); *Nixon v. Mo. Mun. League*, 541 U.S. 125, 141 (2004) (Scalia, J., concurring in judgment) ("I do not think … that the avoidance of unhappy consequences is adequate basis for interpreting a text.").[5]

This principle has special force here because there is no reason to believe that the § 36B incentive would not have worked if the IRS had not eliminated that incentive through bureaucratic fiat. Because the IRS Rule promised states the *quid* of subsidies without demanding the *quo* of state-run Exchanges, 34 states predictably declined to assume the difficult responsibility of establishing Exchanges. So, to the extent that enforcing the Act's plain text *now* would

---

[5] Another illustration arises from Congress's mistaken belief that all states would expand Medicaid to include everyone below the poverty line, as the ACA sought. Based on that belief, Congress limited § 36B subsidies to those with incomes *above* the line. 26 U.S.C. § 36B(c)(1)(A). As a result, millions of people are too *wealthy* for Medicaid yet too *poor* for subsidies under § 36B. Christopher Weaver, *Millions Trapped in Health-Law Coverage Gap*, WALL ST. J., Feb 18, 2014. Congress clearly did not intend for that result. *See NFIB*, 132 S. Ct. at 2665 (joint dissent) ("If Congress had contemplated that some of these citizens [below the poverty line] would be left without Medicaid coverage …, Congress surely would have made them eligible for the tax subsidies ….). Yet obviously that does not create an "absurdity" sufficient to allow the IRS to expand subsidies to those with incomes below the cutoff. Similarly, the IRS cannot expand subsidies to HHS Exchanges just because Congress wrongly predicted that all states would establish Exchanges.

temporarily deprive people of subsidies, that result is caused *by* the IRS's departure from the law—it cannot be used to *justify* the departure. And, indeed, if the original "deal" is restored by this Court, states may well establish Exchanges going forward. Louise Radnofsky, *States Try To Protect Health Exchanges from Court Ruling*, WALL ST. J., July 25, 2014.

c. There is no legislative history supporting the Government's countertextual assertion that § 36B's subsidies are available outside state-established Exchanges. The Government is thus reduced to the near-comical assertion that the legislative history supports the IRS's rewriting of § 36B's plain text because it does not *echo* that text.

At the outset, the legislative history is irrelevant. When text is plain, the only question is whether it causes an *objective absurdity*, not whether Congress *subjectively* intended its *rational* result. *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 460 (2002) ("Where the statutory language is clear and unambiguous, we need neither accept nor reject a particular 'plausible' explanation for why Congress would have written a statute …."). "[C]lear text speaks for itself and requires no 'amen' in the historical record," *Halbig*, 758 F.3d at 407, as "it would be a strange canon of statutory construction that would require Congress to state in committee reports or elsewhere in its deliberations that which is obvious on the face of a statute," *Harrison v. PPG Indus., Inc.*, 446 U.S. 578, 592 (1980). As the Government advised the Court this Term, "Congress was not required to confirm its intention in the legislative history." Br. for the U.S. at 27, *Elonis v. United States*, No. 13-983 (U.S. 2014). Indeed, even if legislative history *contradicts*

the unambiguous text, that is of no moment. *Davis v. Mich. Dep't of Treasury*, 489 U.S. 803, 808 n.3 (1989) ("Legislative history is irrelevant to the interpretation of an unambiguous statute," and so "inconsistency with the legislative history need not detain us."). So the Government's notion that it may flout a law's text because it is not *repeated* in the legislative history is wholly lawless.

Indeed, the Government concedes that subsidies are limited to coverage purchased on an Exchange and Medicaid funds are limited to states that expand eligibility. Yet nowhere does the legislative history reject subsidies for coverage purchased directly from insurers, or Medicaid funds for states that decline to expand eligibility. This reinforces the legal point that such legislative history "amens" are irrelevant, and the practical point that the ACA's legislative history does not discuss all important issues.

In any event, the "scant legislative history" that exists for the ACA, *Halbig*, 758 F.3d at 407, supports the proposition that Congress conditioned subsidies on state creation of Exchanges to induce states to act. To be sure, only sparse legislative history exists for the ACA in general because, at important stages, "negotiations were held behind closed doors," leaving "no record aside from what was reported in the press." John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBRARY J. 131, 159 (2013). *Accord* Pet.App.23a ("[T]he legislative history of the Act is somewhat lacking, particularly for a bill of this size."). And, specifically, Congress barely discussed HHS Exchanges, likely because the consensus was that states would establish their own.

See Pear, *U.S. Officials Brace for Huge Task*, *supra* ("[L]awmakers assumed that every state would set up its own exchange."). So the legislative history is "not particularly illuminating." Pet.App.22a. But what history does exist shows that using subsidies to induce state action was consciously adopted by the Senate and clearly understood by ACA architects.

First, when the Senate began to consider state-based Exchanges, a prominent expert—so influential he was later 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 Inst., Georgetown Univ. Legal Ctr., no. 23 at 7, Apr. 27, 2009.

Second, the Senate committees working on ACA legislation took up that suggestion. The Health, Education, Labor, and Pensions ("HELP") Committee proposed a bill that would have conditioned subsidies for a state's residents on the state's adoption of certain "insurance reform provisions" and agreement to sponsor coverage for state and local employees. S. 1679, § 3104(a), (d), 111th Cong. (2009). If a state did not take those steps, "the residents of such State shall not be eligible for credits." *Id.* § 3104(d)(2). That alone is ample evidence that "Congress at least considered the notion of using subsidies as an incentive to gain states' cooperation." *Halbig*, 758 F.3d at 408. The Finance Committee, whose version of the bill in this respect became law, simply conditioned subsidies on state creation of Exchanges, as opposed to their adoption of insurance reforms.

Third, it is clear that incentives were needed, because centrist Senators whose votes were required to pass the Act resisted plans calling for the federal government to run Exchanges. *See supra* at pp.3-5. Indeed, that is why all agree that the House version of the Act—which *allowed* states to run Exchanges but provided no *incentives* for them to do so, *see* H.R. 3962, § 308, 111th Cong. (2009), was "politically untenable and doomed to failure in the Senate." *Halbig*, 2014 U.S. Dist. LEXIS 4853, at *61. The threshold conflict between the House and Senate on *whether* states should be encouraged to establish Exchanges was expected to be resolved through the ordinary means—a "conference committee"—so it is unsurprising that there was not extensive Senate commentary on *how* to encourage states. But that conference mechanism could not be used after ACA supporters lost their filibuster-proof majority when Scott Brown won a special Senate election in January 2010. *See* Cannan, *supra*, at 159. Instead, the House had no choice but to pass the Senate bill.

Fourth, the Act's incentive function was well understood by, among others, Jonathan Gruber, a leading ACA architect and HHS consultant who helped draft the legislation. *See supra* at p.4. As he explained before the IRS had promulgated its Rule:

> [I]f you're a state and you don't set up an Exchange, that means your citizens don't get their tax credits.… I hope that that's a blatant enough political reality that states will get their act together and realize that there are billions of dollars at stake here in setting up these Exchanges, and that they'll do it.

Jonathan Gruber at Noblis, *supra*, at 32:00. *Accord Oklahoma v. Burwell*, 2014 U.S. Dist. LEXIS 139501 at *26 n.24 (E.D. Okla. Sept. 30, 2014) (citing Gruber as belying claim that § 36B's plain text is absurd).

In the face of all this, the Government points to a Congressional Budget Office ("CBO") report, which, in forecasting the cost of premiums, assumed (like Congress) that subsidies would be available everywhere. *See* Pet.App.70a. This simply reflects the natural assumption—the one Congress evidently made and that there was no reliable basis to refute—that all states would accept Congress's favorable "deal." Tellingly, CBO *also* assumed that all states would accept the Medicaid "deal." 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 does not imply that Congress thought its Medicaid grants were unconditional, the subsidy assumption does not imply that Congress thought that those were unconditional. Both conditions are obvious, and both CBO assumptions merely reflected a plausible view that all states would participate in both programs.

2. *A plain-text reading of § 36B creates no absurdities elsewhere in the Act.*

The Government argued below that giving § 36B its plain-text meaning would give rise to "anomalies" elsewhere in the Act and so the phrase "established by the State" should be ignored *throughout* the law. That contention is wrong thrice over.

For one thing, this Court made clear just last Term that apparent statutory "anomalies" are no basis to depart from plain statutory text. "[T]his Court does not revise legislation … just because the text as written creates an apparent anomaly as to some subject it does not address.… [S]uch anomalies often arise from statutes …." *Michigan v. Bay Mills Indian Cmty.*, 134 S. Ct. 2024, 2033 (2014).

Moreover, even if the anomalies rose to the level of being "patently absurd," *Pub. Citizen*, 491 U.S. at 471 (Kennedy, J., concurring in judgment)—the solution would be to address those absurdities in the provisions where they exist. It would not be to rewrite the non-absurd text of § 36B. *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"). While there is a presumption of "identical … meaning" throughout a law, it "readily yields" where "context" so demands, *e.g.*, where it produces absurdity in one section but not another. *Util. Air*, 134 S. Ct. at 2441. Thus, in *Utility Air*, because the Clean Air Act's "Act-wide" definition of "air pollutant" would have rendered the provisions at issue "unworkable," the Court held that EPA could define the term more narrowly in *those* provisions. *Id.* at 2439-42. It did *not* hold that the unworkability of some provisions required *wholesale* revision of the statutory definition throughout. *Accord Coalition for Responsible Regulation, Inc v. EPA*, No. 09-1322, 2012 U.S. App. LEXIS 25997 at *69 (D.C. Cir. Dec. 20, 2012) (Kavanaugh, J., dissenting from denial of rehearing en banc) (rejecting agency effort to invoke absurdity to "re-writ[e] other perfectly clear portions of the statute to try to make it all work out").

In any event, the supposed anomalies identified here are not anomalous, much less absurd. Even the court below was "unpersuaded" by the Government's contrary arguments. Pet.App.22a.

Reporting Requirement. The Government has argued that a reporting provision—added to § 36B by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029—would be superfluous if subsidies are unavailable through the HHS Exchanges. "Not so." *Halbig*, 758 F.3d at 403.

The reporting provision calls for all Exchanges to report to the Treasury and enrollees six pieces of information about "any health plan" they sell. 26 U.S.C. § 36B(f)(3). Three of those relate to the tax credits, *id.* § 36B(f)(3)(C), (E), (F), and so the HHS Exchanges will have nothing to report for them. (The same will be true for state Exchanges, as to plans that are unsubsidized for other reasons.) But HHS Exchanges will still have to report the plan's "level of coverage," "total premium" charged for the coverage, and "name, address, and TIN of the primary insured and the name and TIN of each other individual" covered. *Id.* § 36B(f)(3)(A), (B), (D).

Subjecting HHS Exchanges to this requirement therefore serves an obvious purpose—obtaining the latter pieces of information about plans they sell. And requiring reporting of the other information was not superfluous either, because the *same* provision governs state Exchanges, which do allow subsidies. Indeed, Congress would otherwise have had to write two *redundant* reporting requirements—one for HHS Exchanges listing items (A), (B), and (D) on the § 36B(f)(3) list of reportable information, and another rule for state Exchanges, repeating those items and

adding (C), (E), and (F). Avoiding such redundancies is hardly anomalous, much less absurd, any more than it is absurd for an answer to an inquiry on a standardized form to be "N/A."

The Government's response below was that the *only* purpose of § 36B(f)(3) reporting is for Treasury to be able to "reconcile" advance payments of the subsidy (which are sent directly to insurers during the year) with the amounts claimed on the person's tax return at year-end. Accordingly, it argued, there was no reason to want *any* of this information from HHS Exchanges unless they could grant subsidies. But the premise is "simply not true." *Halbig*, 758 F.3d at 404. Section 36B reporting extends to *all* plans obtained on Exchanges, including catastrophic plans, which are *not* subsidized, 26 U.S.C. § 36B(c)(3)(A), as well as to plans purchased by individuals ineligible for subsidies (*e.g.*, because their income is too high). And Treasury plainly has good reasons to want enrollment and premium data even for plans that are not subsidized.

Most obviously, that information is useful for "enforcing the individual mandate." *Halbig*, 758 F.3d at 403. The Government responds that § 1502 of the ACA, 26 U.S.C. § 6055, already requires *insurers* to report such information, and that § 36B(f)(3) reporting is thus not needed for that purpose. But reporting from *different sources* is not duplicative. (Nor is it unusual for the ACA; large employers are *also* required to report much the same information. 26 U.S.C. § 6056 (ACA § 1514).) This is particularly true here, because Exchanges have more comprehensive information than any single insurer, and the Act was broadly premised on distrust of

insurers. Indeed, this is why the IRS affirmatively elected to use *Exchanges'* reporting of coverage data over that from insurers, by *exempting* the insurers from § 6055 reporting where the two reports overlap. 79 Fed. Reg. 13,220, 13,221 (Mar. 10, 2014).

In addition, the very same section of the ACA that creates the reporting requirement calls for a comprehensive "study on affordable coverage" to be conducted. *See* ACA § 1401(c). To conduct it, the Government plainly needs complete enrollment and premium data. *See Halbig*, 758 F.3d at 403 n.5.

Finally, the § 36B(f)(3) reports must also be sent to *enrollees*, so they serve an additional purpose unrelated to IRS enforcement—namely, informing *consumers* about their health insurance, so they can understand what they have purchased, potentially correct mistakes, and, perhaps, lobby their state officials to establish state Exchanges so that they can reduce their premium payments through subsidies.

In sum, it is not at all absurd for Congress to have subjected HHS Exchanges to the same reporting rules as state Exchanges; it simply means that HHS Exchanges will not have to report as much information as state Exchanges.

Qualified Individuals. The ACA provision after § 1311 defines "qualified individuals" as those who "resid[e] in the State that established the Exchange," among other things. 42 U.S.C. § 18032(f)(1)(A) (ACA § 1312(f)(1)(A)). The Government has argued that under the plain language of § 1312, there would be no "qualified individuals" in states without their own Exchanges, such that nobody would be able to enroll in HHS Exchanges. It concludes that the plain text should thus be ignored both there and in § 36B.

The result the Government posits would surely be absurd—but § 36B's plain text would not cause it. Dispositively, not even the Government has claimed otherwise: It has not and will not say that, if it loses here, that ruling will somehow bleed over to the qualified-individual provision, requiring expulsion of all enrollees from HealthCare.Gov for failure to meet requisite qualifications. That exposes this as merely a tendentious litigation position, not a true conflict. In fact, there are multiple ways to construe § 1312 to allow enrollment on HHS Exchanges. HHS will surely adopt such a reading if it loses here. There is thus no basis to leverage the qualified-individual provision to distort § 36B's non-absurd text.

First, the qualified-individual definition *only* applies to *state* Exchanges, so it inherently cannot limit the individuals eligible for enrollment on HHS Exchanges. The Act defines "qualified individual" "with respect to an Exchange." 42 U.S.C. § 18032(f)(1)(A). Since "Exchange" is itself defined as an "Exchange established under section 1311," 42 U.S.C. § 300gg-91(d)(21), the definition of "qualified individual" is quite naturally construed as applying only to § 1311 state-run Exchanges. Indeed, the Government has *never disputed* that the definition of "Exchange" limits the qualified-individual provision to state-established Exchanges, and thus could not anomalously limit enrollment on HHS Exchanges.[6]

---

[6] For HHS Exchanges, HHS has broad power to "take such actions as are necessary to implement" the "other requirements" for state Exchanges. 42 U.S.C. § 18041(c). So HHS could by regulation limit HHS Exchange enrollment to state residents. And in fact, it has done just that, tying eligibility to residency in "the service area of the Exchange." 45 C.F.R. § 155.305(a)(3).

Second, the Act never actually limits enrollment on Exchanges to "qualified individuals," so even if no qualified individuals existed for HHS Exchanges, that would not preclude enrollment. This is an "obvious flaw" in the Government's claim. *Halbig*, 758 F.3d at 404. Entitled "Consumer Choice," § 1312 of the ACA says only that a qualified individual "may enroll in any qualified health plan available to such individual and for which such individual is eligible." 42 U.S.C. § 18032(a)(1). It does not say others are barred. In other words, this is a *floor guaranteeing* that qualified individuals *may* enroll, not a *ceiling precluding* all others. *See Halbig*, 758 F.3d at 405.

Indeed, the proposition that enrollment through Exchanges is not *limited* to "qualified individuals" is confirmed by other parts of § 1312 and the rest of the Act. Section 1312 provides that an illegal alien "shall not be treated as a qualified individual" *and* "may not be covered … through an Exchange," which on the Government's view would be blatantly redundant. 42 U.S.C. § 18032(f)(3). By contrast, as to incarcerated persons, it provides only that they do not constitute "qualified individual[s]," but does not further provide that they are barred from Exchanges. *Id.* § 18032(f)(1)(B).[7] Moreover, after § 1311 directs Exchanges to "make available qualified health plans to qualified individuals," it follows up with a restriction—they "may not make available any health plan that is not a qualified *health plan*." 42

[7] Prisoners are thus not categorically excluded; they are simply not guaranteed access. That makes perfect sense, since there are situations in which it would be sensible to allow prisoners to enroll (*e.g.*, if they will be released within the year).

U.S.C. § 18031(d)(2) (emphasis added). Tellingly absent is a corresponding prohibition on selling plans to anyone who is not a "qualified *individual*."

Third, in all events, someone who seeks to enroll on an HHS Exchange does not *fail* the requirement that he "resid[e] in the State that established the Exchange." That requirement facially rests on the assumption that a state-established Exchange exists; if that proves false, it has no application. (Section 36B, by contrast, does not counterfactually *presume* a state-created Exchange; it *limits* subsidies to such.)

In short, the plain-text reading of § 36B creates no absurdity in § 1312.

Medicaid Maintenance-of-Effort Rule. States are prohibited from tightening their Medicaid eligibility standards until "the Secretary determines that an Exchange established by the State under section [1311] of [the ACA] is fully operational." 42 U.S.C. § 1396a(gg)(1) (ACA § 2001(b)(2)). The Government has identified that as an absurdity, but it is actually quite "sensible." *Halbig*, 758 F.3d at 406. Since Congress wanted to induce states to run Exchanges, the maintenance-of-effort proviso creates a "stick" if they fail to. Further, the Government agreed below that this provision was meant to "protect Medicaid recipients" until "subsidized health insurance on an Exchange" became available. Govt.C.A.Br.28. If that was the provision's reasonable purpose *until* states had the *opportunity* to establish Exchanges in 2014, then why would it become absurd *after* 2014, where a state *refused to take* that opportunity and thereby deprived those beneficiaries of the subsidies? This provision, too, is thus perfectly consistent with the plain-text reading of § 36B.

II. DEFERENCE CANNOT SAVE THE IRS RULE.

The Fourth Circuit held that even if Petitioners' construction accorded more closely with the "literal" text, the law is sufficiently ambiguous that the IRS's construction was entitled to deference. Pet.App.18a, 33a. For all the reasons above, however, the text is unambiguous. And where Congress "unambiguously expressed [its] intent" in the law, "that is the end of the matter." *Chevron*, 467 U.S. at 842-43.

In any event, even if there were ambiguity, that would not justify the IRS Rule, for three reasons. *First*, it is simply implausible that Congress wanted to delegate this matter of enormous political and economic importance—worth billions of dollars of federal expenditures per year—to the IRS. As this Court recently reiterated, Congress delegates such important issues to agencies either clearly or not at all. Here, the Act itself, in § 36B, "directly spok[e] to the precise question at issue," *Chevron*, 467 U.S. at 842, so there is no basis for inferring any delegation to the IRS. *Second*, any ambiguity in § 36B would be resolved not by deference, but by the clear-statement rule for tax exemptions and credits. That canon serves to protect Congress's exclusive power over the federal purse, and is directly implicated here. Like any other canon of construction or clear-statement rule, it takes precedence over deference to agencies. And *third*, neither the Fourth Circuit nor the Government identifies any ambiguity in § 36B itself; rather, they locate ambiguity in §§ 1311 and 1321 of the ACA, which are codified in *Title 42* of the U.S. Code. But any ambiguity in that title is not within the IRS's power to resolve (and, conversely, HHS cannot dictate the meaning of the Revenue Code).

A. It Is Implausible That Congress Intended To Delegate This Critical Decision to the IRS.

As this Court reiterated last Term, "[w]e expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" *Util. Air*, 134 S. Ct. at 2444 (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000)). Few decisions will have greater economic or political significance than one triggering hundreds of billions of dollars per year in spending, deterring states from establishing Exchanges, and broadly expanding the Act's mandates. It is simply implausible that Congress intended to have the IRS resolve these broad, fundamental policy decisions.

The Fourth Circuit recognized the enormous significance of the question at issue here. However, it backwardly argued that "the importance of the tax credits" makes it *more* "reasonable to assume that Congress created the ambiguity." Pet.App.27a n.4. As this Court's cases make clear, however, the very opposite is true: It is *not* reasonable to believe that Congress wanted *the IRS* to decide whether or not to make this huge expenditure of federal funds, with all of its attendant consequences. *Accord Loving v. IRS*, 742 F.3d 1013, 1021 (D.C. Cir. 2014). Indeed, if this is a question for agency discretion, it could *change* if the agency changes its mind under a different administration. That, too, is not believable as a matter of congressional intent.

In short, the IRS Rule is a major policy in search of any ambiguity as a hook to sustain it—not a mere detail that Congress intended the IRS to fill. Indeed, that is why § 36B "directly spok[e] to the precise question" at issue. *Chevron*, 467 U.S. at 842.

B. *Chevron* Deference Is Displaced Here by the "Clear Statement" Rule for Tax Benefits.

Chevron deference allows an agency to expand a statute's reach beyond what its text unambiguously compels. But, under *Chevron*, ambiguity exists only if it remains after "employing traditional tools of statutory construction." 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, 731 (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.* Clear-statement rules thus deprive agencies of their "ordinary discretion" to resolve ambiguity. Cass Sunstein, *Nondelegation Canons*, 67 U. CHI. L. REV. 315, 316 (2000).

So, for example, if a statute is ambiguous but one construction "would raise serious constitutional problems," there is no deference to an agency adopting it. *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 574-75 (1988). A statute "ambiguous" about overseas application cannot be construed by an agency as having such application, given "the presumption against extraterritorial application." *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 250, 258 (1991). Likewise, "a statute that is ambiguous with respect to retroactive application" is controlled by the presumption against retroactivity; hence "there is, for *Chevron* purposes, no ambiguity." *INS v. St. Cyr*, 533 U.S. 289, 320 n.45 (2001). The canon—not the agency—resolves the ambiguity.

Here, a venerable canon 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). Such benefits "must rest … on more than a doubt or ambiguity," *United States v. Stewart*, 311 U.S. 60, 71 (1940); they "are not to be implied," *United States v. Wells Fargo Bank*, 485 U.S. 351, 354 (1988); *see also MedChem (P.R.), Inc. v. Comm'r*, 295 F.3d 118, 123 (1st Cir. 2002) (equating exemptions with credits for this canon). Especially as to *refundable* tax credits, which are indistinguishable from direct spending, the canon fulfills the Constitution's requirement that *Congress* exclusively control all "Money … drawn from the Treasury," such that the Executive "cannot touch moneys in the Treasury of the United States, except [as] *expressly* authorized." *Office of Personnel Mgmt. v. Richmond,* 496 U.S. 414, 424, 426 (1990) (quoting U.S. Const., Art. I, § 9, cl. 7; *Knote v. United States*, 95 U.S. 149, 154 (1877) (emphasis added)). "Any other course would give to the fiscal officers a most dangerous discretion." *Id.* at 425 (quoting *Reeside v. Walker*, 52 U.S. 272, 291 (1851)).

In light of this well-established rule for how to treat ambiguity in the tax code—namely, allowing money to be drawn from the Treasury only when the congressional custodian of the federal purse has unambiguously authorized it—*Chevron* deference is displaced here. The IRS cannot by regulation extend § 36B credits by resting on "doubt or ambiguity," *Stewart*, 311 U.S. at 71, so any ambiguity must be construed *against* the subsidy. Thus, "there is, for *Chevron* purposes, no ambiguity in [the ACA] for [the IRS] to resolve." *St. Cyr*, 533 U.S. at 320 n.45.

Indeed, it would be particularly inappropriate in *this* context to use agency discretion, rather than the interpretive canon, to resolve ambiguity. The reason for this clear-statement rule is to *block* Executive "officers" from exercising "dangerous discretion" over Treasury funds—to preclude the "control over public funds that the [Appropriations] Clause reposes in Congress [from] … be[ing] transferred to the Executive." *Richmond*, 496 U.S. at 425, 428.

The Fourth Circuit contended, based on *Mayo Foundation for Medical Education & Research v. United States*, 131 S. Ct. 704 (2011), that this canon does not displace *Chevron* deference. Pet.App.33a. Actually, *Mayo* reiterated that tax exemptions must be "construed narrowly." 131 S. Ct. at 715. Because the Government construed the exemption narrowly in that case—as it virtually always does—*Chevron* and the *Yazoo* canon reinforced each other. But here, the canon has the effect of eliminating any ambiguity, giving *Chevron* no room to expand the credit.

C. No Deference Is Owed Because the IRS Does Not Administer the ACA Provisions That Supposedly Give Rise to Ambiguity.

The ACA's subsidy provision is codified in the Internal Revenue Code, but nobody contends that the language of *26 U.S.C. § 36B* is itself ambiguous. Whether on the Fourth Circuit's theory or on the Government's, it is only the provisions authorizing state and HHS Exchanges, 42 U.S.C. §§ 18031 & 18041 respectively, that purportedly allow for the construction of the Act as authorizing subsidies in the latter. Pet.App.17a-18a. Yet those provisions are codified in Title 42 of the U.S. Code—the domain of *HHS*, not the IRS.

It is therefore irrelevant that the IRS has the "authority to resolve ambiguities in 26 U.S.C. § 36B," Pet.App.32a—because § 36B is not even arguably the ambiguous provision. And because the IRS has no power to administer 42 U.S.C. §§ 18031 & 18041, it is entitled to no deference in construing ambiguities therein. *See Chevron*, 467 U.S. at 844 (recognizing deference to agency as to statute "it is entrusted to administer"); *Nat'l Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 809 (2003) (giving agency's interpretation no legal effect because the agency "is not empowered to administer the [Contract Disputes Act]"); *Cheney R.R. Co. v. R.R. Ret. Bd.*, 50 F.3d 1071, 1073-74 (D.C. Cir. 1995) (no deference to agency where issue "turn[ed] on the interpretation" of laws that were "not the Board's governing statutes"). By the same token, HHS may fill gaps and construe ambiguities in Title 42—but its regulations cannot control this case, since it has no authority to construe the Internal Revenue Code.

What all this shows, in short, is that Congress did not delegate this question either to the IRS *or* to HHS. Rather, it unambiguously made the decision itself, by "directly sp[eaking] to the precise question" at issue in § 36B. *Chevron*, 467 U.S. at 842. Needless to say, the Court should take that decision seriously.

CONCLUSION

The decision below should be reversed.

DECEMBER 2014 Respectfully submitted,

MICHAEL A. CARVIN
Counsel of Record
YAAKOV M. ROTH
JONATHAN BERRY
JONES DAY
51 Louisiana Ave., NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

STATUTORY & REGULATORY ADDENDUM

No. 14-114

David King *et al.*, Petitioners
v.
Sylvia Burwell, Secretary of Health and Human Services *et al.*, Respondents

PETITIONERS' STATUTORY & REGULATORY ADDENDUM TABLE OF CONTENTS

Reproduction of Relevant Authorities:

42 U.S.C. § 18031

§ 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 the date of enactment of this Act [enacted 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 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 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 USCS § 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 USCS § 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 USCS § 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 USCS § 280j-3], 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 USCS § 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 1103(a) [42 USCS § 18003(a)] 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 [2715] of the Public Health Service Act [42 USCS § 300gg-15] 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 the Internal Revenue Code of 1986 [26 USCS § 9801] and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act [42 USCS §§ 1395w-101 et seq.]; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act [25 USCS § 1603]).

(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 the Internal Revenue Code of 1986 [42 USCS § 9832(c)(2)(A)] 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 1302(b)(1)(J) [42 USCS § 18022(b)(1)(J)]).

(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 1302(b) [42 USCS § 18022(b)].

(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 1302(b) [42 USCS § 18022(b)].

(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 USCS § 300gg-15];

(F) in accordance with section 1413 [42 USCS § 18083], inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act [42 USCS §§ 1396 et seq.], the CHIP program under title XXI of such Act [42 USCS §§ 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 the Internal Revenue Code of 1986 [26 USCS § 36B] and any cost-sharing reduction under section 1402 [42 USCS § 18071];

(H) subject to section 1411 [52 USCS § 18081], grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986 [26 USCS § 5000A], 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 the Internal Revenue Code of 1986 [26 USCS § 36B] 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 Code [26 USCS § 36B(c)(2)(C)] 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

1411(b)(4) [42 USCS § 18081(b)(4)] 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 self-sustaining 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 USCS § 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 USCS § 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 the Internal Revenue Code of 1986 [26 USCS § 52] 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 USCS §§ 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 USCS §§ 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 self-employed 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 the Internal Revenue Code of 1986 [26 USCS § 36B] and cost-sharing reductions under section 1402 [42 USCS § 18071];

(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 USCS § 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 USCS § 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 subtitle.

42 U.S.C. § 18032

§ 18032. Consumer choice

(a) Choice.

(1) Qualified individuals. A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) Qualified employers.

(A) Employer may specify level. A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) [42 USCS § 18022(d)] to be made available to employees through an Exchange.

(B) Employee may choose plans within a level. Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) Payment of premiums by qualified individuals. A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) Single risk pool.

(1) Individual market. A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) Small group market. A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) Merger of markets. A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) State law. A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) Empowering consumer choice.

(1) Continued operation of market outside exchanges. Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) Continued operation of state benefit requirements. Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) Voluntary nature of an exchange.

(A) Choice to enroll or not to enroll. Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) Prohibition against compelled enrollment. Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) Individuals allowed to enroll in any plan. A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e) [42 USCS § 18022(e)], a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2) [42 USCS § 18022(e)(2)].

(D) Members of Congress in the Exchange.

(i) Requirement. Notwithstanding any other provision of law, after the effective date of this subtitle [effective March 23, 2010], the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) Definitions. In this section:

(I) Member of Congress. The term "Member of Congress" means any member of the House of Representatives or the Senate.

(II) Congressional staff. The term "congressional staff" means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) No penalty for transferring to minimum essential coverage outside exchange. An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 [26 USCS § 5000A(f)] without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code [26 USCS § 36B(c)(2)(C)]).

(e) Enrollment through agents or brokers. The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals and employers in any qualified health plans in the individual or small

group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

(f) Qualified individuals and employers; access limited to citizens and lawful residents.

(1) Qualified individuals. In this title:

(A) In general. The term "qualified individual" means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange.

(B) Incarcerated individuals excluded. An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) Qualified employer. In this title:

(A) In general. The term "qualified employer" means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) Extension to large groups.

(i) In general. Beginning in 2017, each State may allow issuers of health insurance coverage in the large group

market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) Large employers eligible. If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) Access limited to lawful residents. If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

42 U.S.C. § 18041

§ 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 the date of enactment of this Act, 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 V [42 USCS §§ 18061 et seq.]; 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 USCS §§ 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) of the Public Health Services [Service] Act [42 USCS § 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.

42 U.S.C. § 18043

§ 18043. Funding for the Territories

(a) In general. A territory that—

(1) elects consistent with subsection (b) to establish an Exchange in accordance with part II of this subtitle [42 USCS §§ 18031 et seq.] and establishes such an Exchange in accordance with such part shall be treated as a State for purposes of such part and shall be entitled to payment from the amount allocated to the territory under subsection (c); or

(2) does not make such election shall be entitled to an increase in the dollar limitation applicable to the territory under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for such period in such amount for such territory and such increase shall not be taken into account in computing any other amount under such subsections.

(b) Terms and conditions. An election under subsection (a)(1) shall—

(1) not be effective unless the election is consistent with section 1321 [42 USCS § 18041] and is received not later than October 1, 2013; and

(2) be contingent upon entering into an agreement between the territory and the Secretary that requires that—

(A) funds provided under the agreement shall be used only to provide premium and cost-sharing assistance to residents of the territory obtaining health insurance coverage through the Exchange; and

(B) the premium and cost-sharing assistance provided under such agreement shall be structured in such a manner so as to prevent any gap in assistance for individuals between the income level at which medical assistance is available through the territory's Medicaid plan under title XIX of the Social Security Act [42 USCS §§ 1396 et seq.] and the income level at which premium and cost-sharing assistance is available under the agreement.

(c) Appropriation and allocation.

(1) Appropriation. Out of any funds in the Treasury not otherwise appropriated, there is appropriated for purposes of payment pursuant to subsection (a) $ 1,000,000,000, to be available during the period beginning with 2014 and ending with 2019.

(2) Allocation. The Secretary shall allocate the amount appropriated under paragraph (1) among the territories for purposes of carrying out this section as follows:

(A) For Puerto Rico, $ 925,000,000.

(B) For another territory, the portion of $ 75,000,000 specified by the Secretary.

26 U.S.C. § 36B

§ 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 [26 USCS §§ 1 et seq.] 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 [26 USCS § 152]) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act [42 USCS § 18031], 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

[42 USCS § 18071] 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) [26 USCS § 1(c)] (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 [26 USCS § 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 [26 USCS § 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 [42 USCS § 300gg]. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act [42 USCS § 300g-4(d)], 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 [42 USCS § 18022(b)(5)] 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 [42 USCS § 18031(d)(3)(B)] 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) of the Patient Protection and Affordable Care Act [42 USCS § 18031(d)(2)(B)(ii)(I)] 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 [42 USCS § 18022(b)(1)(J)] 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 [42 USCS §§ 1396 et seq.] 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 [26 USCS § 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 [26 USCS § 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 [42 USCS § 18031], 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 [42 USCS § 18082]).

(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) [26 USCS § 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) [26 USCS § 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) [26 USCS § 5000A(f)(2)]), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B) [26 USCS § 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) [26 USCS §

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 [42 USCS § 18021(a)], except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act [42 USCS § 18022(e)].

(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 [42 USCS § 18011].

(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 [26 USCS § 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 [26 USCS § 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) [26 USCS §

86(d)]) which is not included in gross income under section 86 [26 USCS § 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 [42 USCS § 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 [42 USCS § 18082].

(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 [42 USCS § 18082] 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 [26 USCS § 1(f)(3)], 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 [42 USCS § 18031(f)(3) or 18041(c)]) 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 [42 USCS § 18022(d)] 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 [42 USCS § 18071].

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act [42 USCS § 18082].

(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 [42 USCS § 18082], 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.

42 U.S.C. § 1396c

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title [42 USCS §§ 1396 et seq.], finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902 [42 USCS § 1396a]; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

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.