IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Richmond Division

DAVID KING, *et al.*,

Plaintiffs,

v.

KATHLEEN SEBELIUS, in her official capacity as U.S. Secretary of Health and Human Services, *et al.*,

Defendants.

Case No. 3:13-cv-00630-JRS

DEFENDANTS' MEMORANDUM IN SUPPORT OF THEIR MOTION TO DISMISS OR, IN THE ALTERNATIVE, THEIR CROSS-MOTION FOR SUMMARY JUDGMENT, AND IN OPPOSITION TO PLAINTIFFS' SUMMARY JUDGMENT MOTION

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Introduction

The Patient Protection and Affordable Care Act ("ACA" or "Act") includes several key measures that will expand the availability of affordable health coverage. Most relevant here, the ACA authorizes federal tax credits and cost sharing subsidies for insurance purchased through new health insurance Exchanges, which are to be operated by states or, where the state chooses not to do so or fails to do so consistent with federal standards, by the federal government. These tax credits, which become available in 2014, are vital to the operation of the Exchanges and will help millions of Americans purchase affordable health insurance, consistent with Congressional intent; indeed, Congress understood that the tax credits would be "key" to its goal of ensuring the availability of affordable health coverage.

The plaintiffs in this case seek to deny these tax credits to millions of Americans who need the credits to purchase health insurance. They assert their claim by reading one phrase of the Act incorrectly and out of context, contrary to all recognized canons of statutory construction, and contrary to Congress's intent in providing for tax relief that would be available nationwide. As an initial matter, however, the plaintiffs have failed to show any basis to adjudicate even their own tax liabilities here, let alone those of millions of absent third parties who would be harmed by the relief that plaintiffs seek. This suit suffers from multiple threshold defects. In particular, the plaintiffs lack any injury from a rule providing them with a benefit, and they must bring their claims in a tax refund action, not this APA action.

In any event, the plaintiffs are wrong on the merits. Their argument is based on an improper method of statutory construction, in which they read one provision in isolation while turning a blind eye to surrounding provisions and the structure of the Act, as well as legislative history and Congressional purpose. If anything, the plain meaning of the statute is as the

Treasury Department reads it. At the very least, Treasury has reasonably interpreted the ACA to provide for the tax credits that the plaintiffs challenge. The plaintiffs agree that, where a state runs an Exchange, individuals can obtain federal tax credits for the insurance they purchase on the Exchange. But they assert that, if the *federal* government itself runs the Exchange, the same individuals cannot receive these *federal* tax credits. That assertion defies the statutory text. To begin with, it ignores Congress's specification in 42 U.S.C. § 18041(c)(1) that a federally-facilitated Exchange is the *same* entity as the Exchange that the Act contemplated that the state would create, as well as its specification in Section 36B itself that the federally-facilitated Exchange must assist in administering the federal premium tax credits. Treasury's reading of the Act gives effect to these provisions, and avoids a series of anomalies that would be created under the plaintiffs' theory. Among other things, under the plaintiffs' reading, not only would federal premium tax credits be unavailable on the federally-facilitated Exchange, but no person could qualify to buy coverage at all (subsidized or not) under a plan offered on that Exchange. Congress plainly did not intend this result.

Moreover, the legislative history reveals that Congress intended that premium tax credits would be available nationwide. Indeed, the plaintiffs fail to cite any evidence that their contrary theory was ever contemplated by any legislator. Most fundamentally, their theory runs contrary to the basic purpose of the ACA, which is to expand the availability of affordable health coverage. Premium tax credits are a central feature of the system that Congress established to achieve this goal, and it is simply not plausible to contend that it meant for these tax credits to be available in some states but not in others, simply to give states an incentive to create Exchanges. Treasury, then, has permissibly read Section 36B to provide for eligibility for tax credits for participants in any Exchange, and this Court should defer to the agency's interpretation.

Background

I. The Affordable Care Act

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), to address a crisis in the national health care market, namely, the absence of affordable, universally available health coverage. This case involves three features of the Act: (1) the health insurance Exchanges, which serve as organized marketplaces on which individuals and small groups may buy insurance; (2) federal premium tax credits, which assist individuals with the purchase of affordable insurance on the Exchanges; and (3) the minimum coverage provision, which requires most individuals either to maintain qualifying coverage or to pay a tax penalty for the failure to do so.

A. The Health Insurance Exchanges

For the individual and small-group markets, Congress established health insurance Exchanges to serve "as an organized and transparent marketplace for the purchase of health insurance where individuals and employees (phased-in over time) can shop and compare health insurance options." H.R. REP. NO. 111-443, pt. II, at 976 (2010) (internal quotation omitted) (Exhibit 1). The Exchanges allow qualified individuals and qualified employers to use the leverage of collective buying power to obtain prices and benefits that are competitive with those of large-employer health plans. 42 U.S.C. §§ 18031-18044. Among other functions, the Exchanges certify the qualified health plans ("QHPs") offered on the Exchanges; determine the eligibility of individuals to enroll in these QHPs; determine the eligibility of individuals for advance payments of the Act's premium tax credits and cost-sharing reductions (discussed below); and grant certifications that individuals are exempt from the penalty under the Act's minimum coverage provision (also discussed below). 42 U.S.C. § 18031(d)(4); 45 C.F.R.

§ 155.200 *et seq.* Each Exchange also reports information to the IRS for the purpose of determining whether participants are eligible for premium tax credits. 26 U.S.C. § 36B(f)(3).

Through the Exchanges, health insurance issuers offer plans offering different levels of coverage, designated as "bronze," "silver," "gold," and "platinum" coverage. 42 U.S.C. § 18022(d). Each plan offered through an Exchange must provide coverage of essential health benefits, as defined in regulations promulgated by the Department of Health and Human Services (HHS). 42 U.S.C. § 18021(a)(1)(B); *see* 45 C.F.R. §§ 156.20, 156.200(b)(3); *see also* 45 C.F.R. § 156.110 *et seq.* (defining essential health benefits package). A bronze plan offers coverage that is "designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan." 42 U.S.C. § 18022(d)(1). Silver, gold, and platinum plans are designed to offer benefits equivalent to 70, 80, and 90 percent of the actuarial value of the benefits provided under the plan, respectively. *Id.*

Insurers may also offer "catastrophic" plans through the Exchanges. 42 U.S.C. § 18022(e). A catastrophic plan covers at least three primary care visits per year, and also covers essential health benefits, but only after the insured person incurs the annual limitation on cost-sharing expenses. 42 U.S.C. § 18022(c), (e).[1] A catastrophic plan may not impose cost-sharing requirements on recommended preventive health services. 42 U.S.C. § 18022(e); 45 C.F.R. § 156.155(a), (b). Enrollment in these plans is limited to persons who are under 30 years old, or who have been certified as exempt from the minimum coverage provision due to hardship or the lack of affordable insurance. 42 U.S.C. § 18022(e); 45 C.F.R. § 156.155(a).

The Act provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State." 42

[1] For 2014, the annual cost-sharing limit is $6,350 for individual coverage and $12,700 for family coverage. 26 U.S.C. § 223(c)(2)(A)(ii); Rev. Proc. 2013-25, 2013-21 I.R.B. 1110.

U.S.C. § 18031(b)(1). The Act does not impose any sanction, however, if a state elects not to establish an Exchange that complies with federal standards. Instead, the Act directs that, if the state does not create a "required Exchange," the Secretary of HHS shall "establish and operate such Exchange within the State." 42 U.S.C. § 18041(c)(1); *see* 45 C.F.R. § 155.105(f). A state thus has the option to operate its own Exchange, or to permit the federal government to operate the Exchange for that state in its stead. A state that chooses not to operate its own Exchange, however, loses access to federal grants that would otherwise be available to fund the establishment of the Exchange. *See* 42 U.S.C. § 18031(a). The Act also vests the Exchanges with certain regulatory power with respect to insurers seeking to offer plans on the Exchanges. *See* 42 U.S.C. § 18031(e) (power to certify QHPs and to review proposed QHP premium increases); 42 U.S.C. § 18021(a)(1)(C)(iv) (power to impose additional requirements for QHPs). A state that declines to operate its own Exchange, therefore, forgoes that regulatory power.

State and the federal government also may work together to operate an Exchange. In a "state partnership Exchange," the state assumes some functions of a federally-facilitated Exchange. *See* Center for Consumer Information and Insurance Oversight (CCIIO), *Guidance on the State Partnership Exchange* at 1 (Jan. 3, 2013) (Exhibit 2). Under this model, states "work with HHS to establish an Exchange that best meets the needs of state residents." *Id.*

Health plans offered on the Exchanges for 2014 will offer coverage effective on January 1, 2014. 45 C.F.R. § 155.410(c). The enrollment period for plans offered through the Exchanges for 2014 is now open, and will close on March 31, 2014. 45 C.F.R. § 155.410(b).

B. Premium Tax Credits and Cost-Sharing Reductions

Congress also enacted new premium tax credits and cost-sharing reduction payments in order to make health insurance more affordable. The Act establishes federal premium tax

credits to assist eligible individuals with household incomes from 100% to 400% of the federal poverty level to purchase insurance through the new Exchanges. 26 U.S.C. § 36B. These tax credits, which are advanceable and fully refundable such that individuals with little or no income tax liability can still benefit, are designed to help make health insurance affordable by reducing a taxpayer's net cost of insurance. For eligible individuals with household income from 100% to 250% of the federal poverty level, the Act also provides for federal payments to insurers to help cover those individuals' cost-sharing expenses (such as co-payments or deductibles) for insurance obtained through an Exchange. 42 U.S.C. § 18071(c)(2); 45 C.F.R. § 155.305(g).

Individuals who purchase coverage either through state-based Exchanges or through federally-facilitated Exchanges can be eligible for these premium tax credits and cost-sharing reductions. 26 U.S.C. § 36B(c), (f); *see* 26 C.F.R. §§ 1.36B-1(k), 1.36B-2(a); 45 C.F.R. § 155.20. The statute imposes certain conditions on eligibility for the tax credits. For example, if the taxpayer is married, he or she must file a joint return to receive the credit. 26 U.S.C. § 36B(c)(1)(C). The credit is available only to persons lawfully present in the United States. 26 U.S.C. § 36B(e). And the taxpayer may not receive a premium tax credit if he or she is eligible for any other form of coverage that qualifies as "minimum essential coverage" under the ACA, such as Medicare or Medicaid. 26 U.S.C. § 36B(c)(2)(B).[2]

The amount of the premium tax credit available to a taxpayer under Section 36B varies depending on the taxpayer's household income. That amount is defined as the difference between the cost of the "applicable second lowest cost silver plan" available on the Exchange to

[2] Employer-sponsored coverage is minimum essential coverage under the ACA. Section 36B nonetheless permits an employee who is eligible for, but does not enroll in, such coverage to receive premium tax credits or cost-sharing reductions, if the employer-sponsored plan is unaffordable, meaning that the employee would pay more than 9.5% of his household income for that coverage, or if that plan does not offer minimum value, meaning that it fails to cover at least 60% of the total allowed costs of benefits under the plan. 26 U.S.C. § 36B(c)(2)(C).

the taxpayer and a defined percentage of the taxpayer's household income. 26 U.S.C. § 36B(b)(2), (b)(3). For example, a taxpayer with income at 200% of the federal poverty level can receive a credit that is equal to the cost of the second lowest cost silver plan available on the Exchange, less 6.3% of the taxpayer's household income. 26 U.S.C. § 36B(b)(3); 26 C.F.R. § 1.36B-3(g). A taxpayer need not purchase a silver plan to receive the premium tax credit. He or she may receive a credit in the same amount (subject to a cap equal to the amount of the premiums for the plan he or she purchases) for a cheaper bronze plan, or for a more expensive gold or platinum plan. 26 U.S.C. § 36B(c)(3)(A). Premium tax credits are not available for the purchase of catastrophic plans, however. *Id.*

The Exchanges also administer a program for the advance payments of the premium tax credits for eligible individuals. 42 U.S.C. §§ 18081-18082. Under this program, the Exchange will determine a taxpayer's anticipated eligibility for the premium tax credit when the taxpayer or a household member applies for coverage under a plan offered on the Exchange and seeks such financial assistance. 42 U.S.C. § 18082(a). If the Exchange approves advance payments of the premium tax credit, the payments will be made directly to the insurer offering the plan in which the individual is enrolled, and the individual will be responsible to pay only the net cost of the premium after those payments are applied. *Id.*

The Congressional Budget Office ("CBO") has projected that, by 2018, twenty million people, or 80% of people who buy non-group insurance policies through Exchanges, will receive premium tax credits. CBO, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act: May 2013 Baseline*, tbl. 3 (May 14, 2013) ("*May 2013 Baseline*") (Exhibit 3). It has also projected that the average subsidy, for each person who receives subsidized coverage through the Exchanges, will amount to $5,290 per

person in 2014, rising to $7,900 in 2023. *Id.*, tbl. 1. The credits, on average, will cover nearly two-thirds of the premiums for policies purchased through the Exchanges. CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6-7 (Nov. 30, 2009) ("*Analysis of Health Insurance Premiums*") (Exhibit 4).

Premiums for plans on the Exchanges will be substantially lower than previous projections. The cost of a silver plan is, on average, 16% lower than what was contemplated under the CBO's original projections, even before tax credits are considered. Office of the Ass't Sec'y for Planning & Evaluation, U.S. Dep't of Health & Human Servs., *ASPE Issue Brief: Health Insurance Marketplace Premiums for 2014* at 2-3 (Sept. 25, 2013) (Exhibit 5). After taking tax credits into account, 56% of uninsured Americans may qualify for health coverage for less than $100 per person per month. *Id.* at 3-4.

The Act's success in lowering premiums is attributable in large part to the availability of the Section 36B tax credit. The Act's financial assistance will encourage individuals with lower expected health care costs to participate in the Exchanges, resulting in an expansion of the risk pool, and a decrease in the expected costs of plans offered on the Exchanges. *See* Linda J. Blumberg & John Holahan, *Health Status of Exchange Enrollees: Putting Rate Shock in Perspective* at 2, 8 (Urban Institute July 2013) (Exhibit 6). Because of this economic effect, then, Congress recognized that the Section 36B tax credits "are *key* to ensuring people affordable health coverage." H.R. REP. NO. 111-443, vol. I, at 250 (emphasis added).

C. The Minimum Coverage Provision

Beginning in 2014, the minimum coverage provision requires non-exempted individuals to maintain a minimum level of health insurance or else pay a tax penalty that is reported with their annual income tax return. 26 U.S.C. § 5000A. An individual may satisfy this provision

through enrollment in an employer-sponsored health plan; an individual market plan, including a plan offered through the new Exchanges; a grandfathered health plan; certain government-sponsored health coverage programs such as Medicare, Medicaid, or TRICARE; or other coverage recognized by HHS in coordination with the Treasury Department. 26 U.S.C. § 5000A(f). The penalty does not apply to, among others, individuals whose household income is insufficient to require them to file a federal income tax return, who would need to contribute more than 8% of their household income toward coverage (after taking into account any allowable Section 36B premium tax credits), who establish that the requirement would impose a hardship, or who satisfy certain religious exemptions. 26 U.S.C. § 5000A(d), (e). For 2014, the penalty for an individual will be the greater of $95 or 1.0% of the excess of the taxpayer's household income over a statutory floor, subject to a cap equal to the cost of qualifying insurance. 26 U.S.C. § 5000A(c).[3]

The Exchanges will administer some applications for exemptions from the minimum coverage provision. 42 U.S.C. § 18031(d)(4)(H). In particular, the Exchanges will provide a certificate of exemption to an applicant who shows that, based on his or her projected annual household income, his or her contributions toward coverage would exceed 8% of his or her household income. 45 C.F.R. § 155.605(g)(2); *see* 45 C.F.R. § 155.615(f)(2) (describing procedures for verification of exemption applications on account of lack of affordable coverage). An applicant for an exemption under this unaffordability provision for a given year must apply before the last date on which he is eligible to enroll in a qualified health plan offered on the

[3] This tax penalty is assessed on a monthly basis. 26 U.S.C. § 5000A(c). A taxpayer who enrolls in coverage through an Exchange by the end of the open enrollment period for 2014, *i.e.*, March 31, 2014, will not be liable under section 5000A for the months preceding that enrollment. CCIIO, *Shared Responsibility Provision Question and Answer* at 2-3 (Oct. 28, 2013) (Exhibit 7).

Exchange, *i.e.*, for the coming year, March 31, 2014. 45 C.F.R. § 155.605(g)(2)(v). An applicant who is denied an exemption may pursue an administrative appeal of that denial before an HHS appeals entity; that appeal may be taken only after the applicant first exhausts any appeals that may be available in the Exchange. 45 C.F.R. § 155.505(b)(2), (c). This process is independent of the IRS's process for assessment of any penalty under the minimum coverage provision, however. The IRS will follow the same procedures for the assessment and collection of that penalty as those that apply to other taxes and penalties under the Internal Revenue Code, subject to limitations on levies and the filing of notices of liens. *See* 26 U.S.C. § 5000A(g).

II. This Litigation

The plaintiffs are Virginia residents. Compl. (ECF 1), ¶¶ 11-14. They acknowledge that the Act extends premium tax credits to participants in state-based Exchanges, but they contend that these tax credits are not available in states, like Virginia, where a federally-facilitated Exchange operates. They argue that the Treasury Department incorrectly interprets the ACA to provide for premium tax credits for participants in all of the Exchanges, *see* 26 C.F.R. § 1.36B-1(k), and they seek to challenge the validity of that regulation under the Administrative Procedure Act (APA).

The plaintiffs allege that, under the Treasury regulation, they will qualify for Section 36B premium tax credits. Compl., ¶¶ 11-14. They allege that these tax credits will make health insurance more affordable for them. Compl., ¶ 5. They contend that this *benefit* will *harm* them, because they would prefer that insurance be *unaffordable*, so that they can qualify for a certificate of exemption, which they would then use to purchase what they characterize as "cheaper, high-deductible catastrophic coverage." *Id.* The plaintiffs ask the Court to enjoin the Treasury Department from awarding premium tax credits to them, or to any participants in

any of the federally-facilitated Exchanges. Mot. for S.J. (ECF 5) at 1.

III. Response to Statement of Material Facts

1-2. Undisputed.

3. The lowest-cost bronze plan available to Mr. King would cost $648.38 per month, before any 26 U.S.C. § 36B tax credit is applied. Moulds Decl. (ECF 18-1), ¶ 7.

4. Assuming the facts set forth by Mr. King, he would be entitled to a Section 36B tax credit of $373.00 per month. His net cost of a bronze plan would be $275.38 per month, entitling him to a certificate of exemption under 26 U.S.C. § 5000A(e) for 2014. *Id.*

5. There is no legal obligation to purchase health insurance with which plaintiffs must "comply." *Nat'l Fed'n of Indep. Business v. Sebelius* ("*NFIB*"), 132 S. Ct. 2566, 2600 (2012). The plaintiffs allege that they do not wish to purchase a comprehensive insurance plan on the Exchange, but have not alleged with specificity that they wish to forgo all coverage. *E.g.*, King Decl. (ECF 5-1), ¶ 8. For each plaintiff, a comprehensive plan, after the tax credit is applied, would be cheaper than an unsubsidized catastrophic plan. Moulds Decl., ¶¶ 7-10.

6-7. Undisputed.

8. The lowest-cost bronze plan available to Mr. Hurst would cost $477.49 per month, before any 26 U.S.C. § 36B tax credit is applied. *Id.*, ¶ 8.

9. Assuming the facts set forth by Mr. Hurst, he would be entitled to a tax credit of $415.00 per month. His net cost of a bronze plan would be $62.49 per month. *Id.*

10. *See* Response to Statement of Material Facts, ¶ 5, *supra*.

11-12. Undisputed.

13. The lowest-cost bronze plan available to Ms. Levy would cost $392.72 per month, before any 26 U.S.C. § 36B tax credit is applied. Moulds Decl., ¶ 9.

14. Assuming the facts set forth by Ms. Levy, she would be entitled to a tax credit of $244.00 per month. Her net cost of a bronze plan would be $148.72 per month. *Id.*

15. *See* Response to Statement of Material Facts, ¶ 5, *supra*.

16-17. Undisputed.

18. The lowest-cost bronze plan available to Ms. Luck would cost $428.67 per month, before any 26 U.S.C. § 36B tax credit is applied. Moulds Decl., ¶ 10.

19. Assuming the facts set forth by Ms. Luck, she would be entitled to a tax credit of $96.00 per month. Her net cost for a bronze plan would be $332.67 per month, entitling her to a certificate of exemption under 26 U.S.C. § 5000A(e) for 2014. *Id.*

20. *See* Response to Statement of Material Facts, ¶ 5, *supra*.

Argument

I. This Suit Is Not Justiciable

The plaintiffs seek to bring a virtually unheard-of claim, a suit to challenge their own eligibility for the substantial tax benefits that the Affordable Care Act makes available to them. Their claim suffers from multiple threshold defects. First, the plaintiffs lack Article III standing. The plaintiffs have not alleged with specificity that they wish to forgo health insurance coverage entirely. The absence of any such allegation is not surprising; a person in the position of, for example, Mr. King (a 63-year-old smoker) would presumably see a benefit in at least some form of insurance coverage. The plaintiffs have alleged that they foresee harm, because they may not be able to buy a catastrophic plan if other coverage is affordable for them. But a comprehensive plan on the Exchange would provide the same coverage as a catastrophic plan, on more generous terms, for less cost to the plaintiffs. *See* ECF 18-1, ¶¶ 7-10. (Moreover, two plaintiffs, Mr. King and Ms. Luck, are already eligible to buy catastrophic plans

if they so wish. *Id.*, ¶¶ 7, 10.) The plaintiffs' desire to forgo this benefit does not state a legally cognizable injury. *See, e.g.*, *McConnell v. FEC*, 540 U.S. 93, 228 (2003), *overruled in part on other grounds by Citizens United v. FEC*, 558 U.S. 310 (2010).

Second, the plaintiffs must bring their action in tax refund action, not this APA action. Congress has specified that challenges to tax liabilities must be brought in an action for a tax refund, only after paying the tax assessed, and the APA does not provide a cause of action that duplicates that review procedure. 5 U.S.C. §§ 703, 704. Third, the plaintiffs lack prudential standing, because their purpose in bringing this suit – which is to make health insurance *unaffordable* – is directly contrary to Congress' purpose in enacting Section 36B, which was to "ensure that health coverage is *affordable*." S. REP. NO. 111-89, at 4 (2009) (emphasis added) (Exhibit 8). Fourth, this action is not ripe, because the issue of the plaintiffs' eligibility for an exemption from the minimum coverage provision is not presented here in "clean-cut and concrete form," and the plaintiffs have alleged no hardship from a deferral of review. *Doe v. Va. Dep't of State Police*, 713 F.3d 758 (4th Cir. 2013). The defendants respectfully refer the Court to their prior briefing on the plaintiffs' preliminary injunction motion for a fuller discussion of the threshold barriers to this suit. *See* Mem. in Opp. to Mot. for P.I. at 12-19.

II. The Treasury Department Has Reasonably Construed Section 36B to Provide that Participants in Any of the Exchanges May Be Eligible for Premium Tax Credits

A. The Treasury Regulation Is Entitled to *Chevron* Deference

Congress has directed that the Treasury Department "shall prescribe such regulations as may be necessary to carry out the provisions of" Section 36B. 26 U.S.C. § 36B(g); *see also* 26 U.S.C. § 7805(a). In the exercise of this authority, after notice and comment, the Treasury Department published a rule that interprets 26 U.S.C. § 36B to provide that participants in any of the Exchanges, whether state-operated or federally-facilitated, may be eligible for federal

premium tax credits. 26 C.F.R. § 1.36B-1(k). This regulation is entitled to deference so long as the Treasury Department did not exceed the expansive scope of its rulemaking authority. *See Mayo Found. for Med. Educ. & Research v. United States*, 131 S. Ct. 704, 714 (2011).[4] The familiar two-step framework established in *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984), governs the Court's resolution of this question.

Under this test, "[f]irst, applying the ordinary tools of statutory construction, the court must determine whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter[.]" *City of Arlington v. FCC*, 133 S. Ct. 1863, 1868 (2013). Under the second step of the *Chevron* test, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *City of Arlington*, 133 S. Ct. at 1868. In other words, no matter whether the case involves a "big, important" issue or a "humdrum, run-of-the-mill" one, "the question a court faces when confronted with an agency's interpretation of a statute it administers is always, simply, *whether the agency has stayed within the bounds of its statutory authority*." *Id.* (emphasis in original). "If the agency's answer is based on a permissible construction of the statute, that is the end of the matter." *Id.* at 1874-75.

Here, Congress did not express the intent to deprive residents of states with federally-facilitated Exchanges of federal premium tax credits. There are no credible indications based on accepted canons of statutory construction that Congress intended such an inequitable result. In fact, if anything, the statute's text, structure, purpose and legislative

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[4] The plaintiffs argue offhandedly that *Chevron* deference does not apply, because Treasury shares authority with HHS under the Affordable Care Act. ECF 21 at 15 n.4. This claim is mistaken. Congress has expressly granted Treasury rulemaking authority, *see* 26 U.S.C. §§ 36B(g), 7805(a). These delegations make clear that Treasury regulations construing the Internal Revenue Code are entitled to *Chevron* deference, even if Treasury shares administrative authority on some issues with another agency. *See Mayo Found.*, 131 S. Ct. at 715.

history clearly establish the opposite under *Chevron* step one. And certainly, at minimum, a permissible reading of the Act is that participants in any of the Exchanges may be eligible for these tax credits, and the Treasury regulation is thus owed deference under *Chevron* step two.

B. The Plaintiffs' *Chevron* Step One Argument Ignores Settled Principles of Statutory Construction

The plaintiffs argue that 26 U.S.C. § 36B conditions a taxpayer's eligibility for federal premium tax credits on whether his or her state's government has created a state-operated Exchange. In their view, residents of states with federally-facilitated Exchanges are ineligible for these federal tax credits. They premise their theory on an isolated reading of a phrase in 26 U.S.C. § 36B(b)(2)(A), which limits the amount of the credit to no more than the amount of premiums for a qualified health plan in which the taxpayer (or a spouse or dependent) is "enrolled in through an Exchange established by the State under [42 U.S.C. § 18031, *i.e.*, Section] 1311 of the Patient Protection and Affordable Care Act." 26 U.S.C. § 36B(b)(2)(A); *see also* 26 U.S.C. § 36B(c)(2)(A). Because the federal government will operate the Exchange in the states where they reside, the plaintiffs reason, they will not enroll in a plan on an "Exchange established by the State," and the amount of their credit under the Section 36B(b)(2)(A) formula must be zero.

But "[c]ourts have a duty to construe statutes, not isolated provisions." *Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 290 (2010) (internal quotation omitted). Thus, "[i]n ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole." *Household Credit Servs., Inc. v. Pfennig*, 541 U.S. 232, 239 (2004) (internal quotation omitted). "Statutory ambiguity is a creature not just of definitional possibilities but also of statutory context. [The] meaning – *or ambiguity* – of certain words or

phrases may only become evident when placed in context." *Zuni Pub. Sch. Dist. No. 89 v. Dep't of Educ.*, 550 U.S. 81, 98-99 (2007) (emphasis in original; internal quotations omitted). Courts also must consider the statute's "history and purpose" in determining whether Congress has clearly expressed its intent for purposes of the *Chevron* test. *See id.* at 93.

The plaintiffs err by ignoring these principles of statutory construction. As elaborated below, the text of Section 36B, when read in full and in conjunction with the Act's other provisions, makes clear that federal premium tax credits are available both in state-operated Exchanges and in federally-facilitated Exchanges. At the very least, a contrary reading is not compelled by the plain language of the Act, and the Treasury Department has reasonably interpreted Section 36B in a manner consistent with Congress's intent to make affordable health coverage available on a nationwide basis. In either case, the plaintiffs' challenge to the Treasury regulation fails under *Chevron.*

C. Treasury Reasonably Reads Section 36B Together with 42 U.S.C. §§ 18031 and 18041 to Provide that Participants in Federally-Facilitated Exchanges May Be Eligible for Federal Premium Tax Credits

Section 36B(b)(2)(A) expressly refers to 42 U.S.C. § 18031, which declares that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State" that meets certain statutory requirements. 42 U.S.C. § 18031(b)(1). *See also* 42 U.S.C. § 18031(d)(1) ("An Exchange shall be a governmental agency or nonprofit entity that is established by a State."). Despite this use of the term "shall," however, the Act does not impose any sanction if a state elects not to establish an Exchange that complies with federal standards. Instead, the Act directs that, if a state will "not have any required Exchange operational by January 1, 2014, … the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate *such Exchange* within the

State[.]" 42 U.S.C. § 18041(c)(1) (emphasis added). This language shows that Congress intended the federally-facilitated Exchange to constitute the "required Exchange," that is, the Exchange that the Act contemplates that the state is to establish under Section 18031. In other words, the federal government stands in the shoes of the state when operating "such Exchange."

Congress's use of the phrase "such Exchange" shows that it meant for the federally-facilitated Exchange to be the *same entity* as the earlier-referenced Exchange, that is, the Exchange contemplated under 42 U.S.C. § 18031. *See* Black's Law Dictionary 1570 (9th ed. 2009) ("such" means "[t]hat or those; having just been mentioned"); *see also* Webster's Third New International Dictionary 2283 (1961) ("something previously characterized or specified"); Random House Dictionary of the English Language 1899 (2d ed. 1987) ("being the person or thing or the persons or things indicated"); 2 New Shorter Oxford English Dictionary 3129 (4th ed. 1993) ("the person(s) or thing(s) specified or implied contextually; *spec.* the aforesaid thing or things; it, they, them; that, those").

"Read in context," then, the federally-facilitated Exchange "*must be the same* ['Exchange'] mentioned at the beginning of [the provision] …. Indeed, because there are no other ['Exchanges'] mentioned in the section, there is no other antecedent to which the word 'such' could refer." *Miller v. Clinton*, 687 F.3d 1332, 1344 (D.C. Cir. 2012) (emphasis added). Congress frequently uses the term "such" to show that a person or thing is the same entity as the person or thing that it had described before. *See, e.g.*, *Gatlin Oil Co. v. United States*, 169 F.3d 207, 210-11 (4th Cir. 1999) (agency's treatment of the term "such incident" to mean the same incident previously mentioned in statutory text "is permissible because it is grammatically correct and it accommodates the purpose of the Act"); *United States v. Joseph*, 716 F.3d 1273, 1278 (9th Cir. 2013) ("'such' means 'the specific'"); *Alliance 3PL Corp. v. New Prime, Inc.*, 614

F.3d 703, 707 (7th Cir. 2010) ("such" is "legalese for the proposition that 'this use of the word "traffic" refers to the same "traffic" that this clause already mentioned'").

If there were any doubt on this score, the ACA's definitional provisions would resolve that doubt. For each use of the term "Exchange" in Title I of the ACA (which includes 42 U.S.C. § 18041), that term "means an American Health Benefit Exchange established under [42 U.S.C. § 18031]." 42 U.S.C. § 300gg-91(d)(21) (defining term for purpose of Public Health Services Act); *see* 42 U.S.C § 18111 (incorporating this definition for Title I of ACA). Thus, in light of the fact that "Exchange" is a defined term of art in the ACA, Section 18041(c)(1) reads, "the Secretary shall … establish and operate such [American Health Benefit Exchange established under 42 U.S.C. § 18031]." 42 U.S.C. § 18041(c)(1). The Exchange established by the federal government, then, *is* the Section 18031 Exchange.

The plaintiffs' contrary reading fails to give effect to the ACA's definitional provisions. Moreover, their reading fails to give effect to Section 18031's instruction that each state is to establish an Exchange, or to Section 18041's use of the term "such Exchange" to refer to the state-established Exchange in Section 18031. That reading, accordingly, should be rejected. *See Joseph*, 716 F.3d at 1278 (rejecting interpretation that would render the term "such" superfluous).[5]

Further confirmation is provided within 26 U.S.C. § 36B itself. That provision directs

[5] The plaintiffs rely entirely on the canon against surplusage. They contend that an isolated reading of Section 36B(b)(2)(A) is needed to give effect to the provision's use of the phrase "established by a State under [42 U.S.C. § 18031]." Mot. for S.J. (ECF 5) at 17. But, as the Supreme Court has noted with considerable understatement, "instances of surplusage are not unknown" in federal statutes. *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 299 n.1 (2006). In any event, "the canon against surplusage assists only where a competing interpretation gives effect to every clause and word of a statute." *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013) (internal quotation omitted). The plaintiffs do not offer such an interpretation, so the canon does not help their argument here. *See also* note 8, *infra*.

"[e]ach Exchange (or any person carrying out 1 or more responsibilities of an Exchange under [42 U.S.C. § 18031(f)(3) *or 42 U.S.C. § 18041(c)*])" to provide certain information to the Treasury and to taxpayers, including "[t]he aggregate amount of any advance payment" of tax credits or cost-sharing reductions that the taxpayer receives under the ACA, "[a]ny information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit," and "[i]nformation necessary to determine whether a taxpayer has received excess advance payments" of the credit. 26 U.S.C. § 36B(f)(3) (emphasis added).[6] This provision's cross-reference to 42 U.S.C. § 18041(c) makes clear that Congress used the term "Exchange" to include the Exchange operated by the federal government under that provision, and that it intended that taxpayers would receive federal tax credits and cost-sharing reductions when purchasing insurance on that Exchange.

Under the plaintiffs' reading, by contrast, Section 36B(f)(3) would direct the federally-facilitated Exchange to perform an empty act; the "amount of such credit," and "the aggregate amount of any advance payment" of such credit to be reported would necessarily always be zero. It is not plausible that Congress meant for the federally-facilitated Exchange to report information that it thought would not exist. "That plaintiffs interpret [Section 36B(f)(3)] to be an empty gesture is yet another indication that their submission is erroneous." *Fund for Animals, Inc. v. Kempthorne*, 472 F.3d 872, 878 (D.C. Cir. 2006). *See also Henderson v. United States*, 133 S. Ct. 1121, 1131 (2013) (Scalia, J., dissenting) ("A rudimentary principle of textual interpretation … is that if one interpretation of an ambiguous provision causes it to serve a purpose consistent with the entire text, and the other interpretation renders it pointless, the

[6] 42 U.S.C. § 18031(f)(3), referenced in the text quoted above, permits a state-based Exchange to contract with an outside entity to perform one or more of the Exchange's responsibilities. Similarly, 42 U.S.C. § 18041(c) permits the Secretary of HHS to enter into an agreement with a non-profit entity to operate a federally-facilitated Exchange.

former prevails.").

The plaintiffs' reading of the text of the Affordable Care Act, then, fails to account for the language in Section 18031, Section 18041, and Section 36B itself that clarifies that the federal government stands in the shoes of the state in operating the Exchange that the Act contemplates that the state would establish. The plaintiffs' theory, moreover, runs afoul of the canon of construction that directs, "in the absence of plain language to the contrary," it must be assumed "when Congress enacts a statute that it does not intend to make its application depend on state law." *United States v. Midgett*, 198 F.3d 143, 145 (4th Cir. 1999) (internal quotation omitted). The courts presume that "federal statutes are generally intended to have uniform nationwide application," *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 43 (1989) (internal quotation omitted), so as to avert "the danger that the federal program would be impaired if state law were to control," *id.* at 44 (internal quotation omitted). This principle applies with special force to federal taxation statutes such as Section 36B. "[T]he revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. 224, 238 (1994) (quoting *United States v. Pelzer*, 312 U.S. 399, 402-03 (1941)). Thus, "[s]tate law may control only when the federal taxing act, by express language or necessary implication, makes its own operation dependent upon state law." *Burnet v. Harmel*, 287 U.S. 103, 110 (1932).

In sum, Section 36B must be read in its entirety, and also in conjunction with the provisions of the ACA describing the Exchange, 42 U.S.C. §§ 18031 and 18041. When these provisions are read together and as a whole, they make plain that Congress envisioned the federally-facilitated Exchange to be the same entity as the Exchange that the Act contemplates that the state would establish, and that it intended Section 36B "to establish a nationwide scheme

of taxation uniform in its application," *Irvine*, 511 U.S. at 238 (internal quotation omitted), in which participants in any Exchange in any of the states could be eligible to receive federal premium tax credits. Because the intent of Congress is clear, "applying the ordinary tools of statutory construction," the Treasury Department's interpretation should be upheld under *Chevron* step one. *City of Arlington*, 133 S. Ct. at 1868. At a minimum, Treasury has offered a reasonable reading, which is owed deference under *Chevron*'s second step.

D. The Larger Structure of the Act Confirms that Participants in Federally-Facilitated Exchanges May Be Eligible for Federal Premium Tax Credits

The larger structure of the ACA confirms this result. The Supreme Court has repeatedly stressed that "an interpretation of a phrase of uncertain reach is not confined to a single sentence when the text of the whole statute gives instruction as to its meaning." *Maracich v. Spears*, 133 S. Ct. 2191, 2203 (2013); *see also Morgan v. Sebelius*, 694 F.3d 535, 538 (4th Cir. 2012). In other words, "statutory construction is a holistic endeavor," and "a provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme." *Adoptive Couple v. Baby Girl*, 133 S. Ct. 2552, 2563 (2013) (internal quotation and alteration omitted). In this case, the statutory scheme confirms that Congress intended that the federally-facilitated Exchange would constitute the Exchange that the Act contemplates that the state would establish, and that participants in that Exchange would be eligible for premium tax credits. The plaintiffs' contrary reading would upset the framework of the ACA in a number of ways.

1. Under the Plaintiffs' Reading of the Act, Nobody Would Be Eligible to Buy Insurance on the Federally-Facilitated Exchanges, a Result that Congress Could Not Have Intended

Under the plaintiffs' theory, nobody could meet the standard for eligibility to buy insurance offered on the federally-facilitated Exchange. The ACA provides 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). The statute defines a "qualified individual" as an individual "who resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A)(ii).[7] Under the plaintiffs' reading, then, nobody would be a "qualified individual" in a state with a federally-facilitated Exchange. Obviously, Congress did not intend this result. It designed the Exchange, after all, to serve "as an organized and transparent marketplace for the purchase of health insurance." H.R. REP. NO. 111-443, pt. II, at 976. Congress certainly would not have gone to the trouble of creating a federally-facilitated Exchange that could serve only as a Potemkin marketplace.[8] "[C]ourts presume that Congress has used its scarce legislative time to enact statutes that have some legal consequence." *Fund for Animals*, 472 F.3d at 877; *see also Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 216 (1995) (interpretation that would leave a statutory provision "utterly without effect" is "a result to be avoided if possible").

The plaintiffs have offered three arguments in response, none of which is persuasive. First, they have argued that 42 U.S.C. § 18032 does not contain precisely the same language as the language that appears in Section 36B. ECF 21 at 21. But it is not readily apparent what distinction the plaintiffs mean to draw between the phrase "the State that established the

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[7] *See also* 42 U.S.C. § 18032(f)(1)(B) (incarcerated persons excluded from definition of "qualified individual"), (f)(3) (aliens not lawfully present in the United States are excluded from definition of "qualified individual").

[8] It would follow, moreover, that the language in Section 36B that the plaintiffs rely upon is surplusage, even under their theory. If residents of a state with a federally-facilitated Exchange could not enroll in coverage through that Exchange, they could not obtain tax credits for that coverage, and there would be no need to specify also that they must enroll in a plan on an Exchange "established by the State under [42 U.S.C. § 18031]." An interpretation that compounds, rather than resolves, any surplusages in the Act is not compelled by the Act's plain language. *See* note 5, *supra*.

Exchange," 42 U.S.C. § 18032(f)(1)(A)(ii), and the phrase "an Exchange established by the State," 26 U.S.C. § 36B(b)(2)(A). Both phrases, quite obviously, refer to the same concept. *See Adoptive Couple*, 133 S. Ct. at 2563 (adjacent statutory provisions "should be read in harmony").[9]

Second, the plaintiffs have argued that no person would be eligible to buy insurance on the federally-facilitated Exchange even under the defendants' interpretation. ECF 21 at 22. This is plainly wrong. As discussed above, the defendants read the Act to provide that a state is considered to have established an Exchange under 42 U.S.C. § 18031, and that if a state does not take the steps necessary to bring the "required" Exchange into operation, 42 U.S.C. § 18041(c)(1), HHS will stand in the shoes of the state to perform those steps. Thus, residents of a state with a federally-facilitated Exchange "reside[] in the State that established the Exchange"; those persons may buy insurance on the Exchange; and the Exchange then functions as a marketplace, as Congress obviously intended. In contrast, under the plaintiffs' reading, nobody could buy insurance on the federally-facilitated Exchange, a result that Congress could not possibly have intended.

Third, the plaintiffs have argued that the definition of a "qualified individual" applies only where a state operates its own Exchange. ECF 21 at 22. They reason that Section 18032 defines eligibility "with respect to an Exchange," and they read the term "Exchange" to refer only to a state-operated Exchange. This argument fails, too. As discussed above, the term "Exchange" in Section 18032 has the same meaning as it does in the phrase "the Secretary shall

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[9] The definition of "qualified individual" appears in the section immediately following 42 U.S.C. § 18031, in the same title, subtitle, and part of the ACA as the provision that directs that "[e]ach State shall … establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State," 42 U.S.C. § 18031(b)(1).

… establish and operate such Exchange," 42 U.S.C. § 18041(c)(1).[10] The term thus refers both to state-operated and federally-facilitated Exchanges, as the plaintiff themselves have explicitly argued in other portions of their argument. ECF 21 at 15, 23.[11]

In sum, Congress plainly intended that all of the Exchanges would operate as marketplaces for the sale and purchase of health insurance, no matter which entity operates the Exchange. Under the plaintiffs' theory, no persons could buy insurance on the federally-facilitated Exchange (and, thus, no insurer would bother to try to sell insurance on that Exchange). Because Congress could not have intended to create a federally-facilitated Exchange that would be completely inoperative, the plaintiffs' reading should be rejected.

2. The Plaintiffs' Reading Would Create Numerous Additional Anomalies that Are Inconsistent with the Basic Statutory Scheme of the ACA

Other provisions in the Affordable Care Act provide further proof that Congress intended the federally-facilitated Exchange to be the same entity as the state-operated Exchange. *First,* the plaintiffs' theory would undermine the ACA's process for state innovation waivers. The ACA enacts a procedure for a state to seek a waiver from some of the Act's provisions. 42

[10] Indeed, if the plaintiffs were now to deny that the term "Exchange" refers both to state-operated and federally-facilitated Exchanges, their theory would create numerous additional anomalies in the Act. For example, their theory would upset Congress's compromise regarding coverage for abortions by plans on the Exchanges. The ACA provides that "[a] State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition." 42 U.S.C. § 18023(a)(1). If the plaintiffs read the term "Exchange" to refer only to state-operated Exchanges, contrary to 42 U.S.C. § 18041(c)(1), then this authorization would not apply in states with a federally-facilitated Exchange. "[I]dentical words and phrases within the same statute should normally be given the same meaning." *Powerex Corp. v. Reliant Energy Servs.*, 551 U.S. 224, 232 (2007).

[11] In any event, even if the term "Exchange" could be limited as the plaintiffs now (inconsistently) suggest, this would not resolve the dilemma posed by their reading. Under their theory, no statutory definition of qualified individual would apply for the federally-facilitated Exchanges. It is not plausible that Congress intended this result.

U.S.C. § 18052. Beginning in 2017, if a state has enacted legislation that provides coverage that is "at least as comprehensive," "at least as affordable," and "that reaches at least a comparable number of its residents" as does the coverage provided for under the ACA, and if that legislation would not increase the federal deficit, that state may seek a waiver of certain provisions of the Act. 42 U.S.C. § 18052(a), (b)(1). In particular, the state could seek to opt out of provisions relating to Exchanges, the distribution of premium tax credits and cost-sharing subsidies, and the large employer tax provision (26 U.S.C. § 4980H) and the minimum coverage provision (26 U.S.C. § 5000A). *Id.* The amount of forgone premium tax credits would then be distributed directly to the state to administer its alternative plan. 42 U.S.C. § 18052(a)(3).

This waiver procedure would be an empty formality if, as the plaintiffs would have it, a state already had the power to prevent the application of central features of the ACA within its borders, simply by declining to establish its own Exchange. Congress intended a state to be eligible for a waiver only after first enacting an alternative system to provide equally comprehensive and affordable health coverage. Congress certainly did not intend, then, that simply by declining to operate an Exchange, a state could effectively obtain a waiver from providing a functioning and affordable health care system in that state.[12]

Second, under the plaintiffs' theory, the federally-facilitated Exchange would not be able to perform a number of the core functions that Congress charged it with (if it could operate at all, in the absence of qualified individuals eligible to buy insurance on the Exchange, *see supra*). The ACA sets forth a number of responsibilities that Exchanges must fulfill, and a number of those functions would be meaningless under the plaintiffs' reading. Under 42 U.S.C.

[12] Under the plaintiffs' theory, moreover, for a state that had not established its own Exchange, the amount of funding under Section 18052's provision for the redirection of Section 36B funds would always be zero. There is no reason to believe that Congress intended such a result.

§ 18031(d)(4)(G), for example, the Exchange is required to make available an electronic calculator for purchasers to compare the cost of different coverage options, after the application of federal premium tax credits and cost-sharing subsidies. If the plaintiffs' theory were correct, this calculator could only perform a meaningless computation in states with a federally-facilitated Exchange. Under 42 U.S.C. § 18031(d)(4)(I), the Exchange is also required to send information to the IRS concerning individuals who are determined to be eligible for federal premium tax credits. If the plaintiffs' theory were correct, the federally-facilitated Exchange would be required to send blank pieces of paper to the Treasury under this provision. And under 42 U.S.C. § 18083, the Exchange is required to use a "single, streamlined form" that facilitates applicants to qualify for "health subsidy programs," which the statute expressly defines to include Section 36B tax credits. 42 U.S.C. § 18083(b)(1), (e)(1). If the plaintiffs' theory were correct, applicants in states with a federally-facilitated Exchange would fill out paperwork for financial assistance that they could never qualify for. It is not plausible to claim that Congress intended any of these results. Rather, a straightforward reading of these provisions makes clear that federal tax credits are to be available to participants in any Exchange, including an Exchange operated by the federal government.

Third, the plaintiffs' reading would create an unanticipated obligation for states in the operation of their Medicaid plans. The ACA expands the scope of eligibility for the Medicaid program, beginning January 1, 2014. *E.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).[13] As a bridge until that date, the ACA provides, as a condition of continued federal funding, that participating states shall maintain their then-existing eligibility standards, until the effective date

[13] The Supreme Court has held that HHS may not withdraw existing Medicaid funds for a state's failure to comply with this eligibility expansion provision. *NFIB*, 132 S. Ct. at 2607 (plurality opinion).

of the ACA's Medicaid eligibility expansion provisions. In particular, this "maintenance of effort" provision directs states, as a condition for the receipt of federal Medicaid funds, not to impose any "eligibility standards, methodologies, or procedures" under their Medicaid state plan, or any applicable waiver, that are "more restrictive" than the standards that the state had in place as of the date the ACA was enacted. 42 U.S.C. § 1396a(gg)(1). This condition applies until "the date on which the Secretary determines that an Exchange established by the State under [42 U.S.C. § 18031] is fully operational." *Id.* As the plaintiffs acknowledge, ECF 21 at 20, under their theory, a state with a federally-facilitated Exchange would *never* be relieved of this maintenance-of-effort requirement.[14] It is not plausible that Congress intended this result; if it had so intended, it certainly would have stated so more directly. *See Arlington Central Sch. Dist. v. Murphy*, 548 U.S. 291, 296 (2006).[15]

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[14] The plaintiffs candidly note "[p]rospectively" that they anticipate a constitutional challenge to this maintenance-of-effort provision if the Court adopts their reading of the Act. ECF 21 at 20. Ordinarily, however, litigants ask courts to interpret statutes to resolve constitutional doubts, not to create new ones. *E.g.*, *Clark v. Martinez*, 543 U.S. 371, 385 (2005).

[15] This list of anomalies in the plaintiffs' theory is far from exhaustive. Other examples abound. *See, e.g.*, 26 U.S.C. § 125(f)(3) (effective 2014) (exclusion from employee's gross income for benefits offered in a cafeteria plan would apply for plans offered on a federally-facilitated Exchange, but not on a state-operated Exchange); 42 U.S.C. § 1320b-23(a)(2) (pharmacy benefits managers would provide certain pricing information to HHS if the plan is offered on a state-operated Exchange, but not on a federally-facilitated Exchange); 42 U.S.C. § 1396w-3(b)(1)(D) (federally-facilitated Exchange would not be subject to provisions concerning coordination of Medicaid and CHIP benefits); 42 U.S.C. § 1397ee(d)(3)(B) (federally-facilitated Exchange would not be obligated to enroll children in CHIP program in the Exchange, as states would in certain circumstances); 42 U.S.C. § 1397ee(d)(3)(C) ("*[w]ith respect to each State*," HHS must review and certify whether QHPs offer benefits for children that are at least comparable to those offered in the state's CHIP plan, but this review extends only to plans "offered through an Exchange established by the State under [42 U.S.C. § 18031]"; thus, HHS could not fulfill this obligation in "each State" with a federally-facilitated Exchange) (emphasis added); 42 U.S.C. § 18054(c)(3)(A) (individual enrolled in a multi-state health plan in a federally-facilitated Exchange would not be eligible for premium tax credit, contrary to statutory direction that such individual "shall be eligible for credits under section 36B of Title 26 … in the same manner as an individual who is enrolled in a

In sum, the "statutory scheme," *Adoptive Couple*, 133 S. Ct. at 2563, confirms that Congress intended the federally-facilitated Exchange to be the same entity, with the same functions, as the Exchange that the Act contemplates that the state would establish, and that federal premium tax credits would be available in all of the Exchanges. The plaintiffs' contrary theory is fundamentally inconsistent with the intended operation of the Exchanges and with numerous other features of the Act. Treasury's interpretation avoids the incongruities that the plaintiffs' reading would create. That interpretation thus should prevail under *Chevron* step one. At a minimum, it is a permissible reading that is owed deference under *Chevron* step two.

E. The Purpose of the Affordable Care Act Confirms that Participants in Federally-Facilitated Exchanges May Be Eligible for Federal Premium Tax Credits

The plaintiffs fundamentally err by suggesting a reading of the ACA that would undermine Congress's basic goals in passing that legislation. Their theory is in tension with the principle that a law must be interpreted in light of its "object and policy": "In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Maracich v. Spears*, 133 S. Ct. at 2203 (internal quotation omitted). In other words, in evaluating the plaintiffs' theory, the Court must guard against "the danger that the federal program would be impaired if state law were to control," and thus must "look to the purpose of the statute to ascertain what is intended." *Mississippi Band of Choctaw Indians*, 490 U.S. at 44 (internal quotation omitted).

When it enacted the ACA, Congress "'intended to solve a national problem on a national scale.'" *Id.* (quoting *NLRB v. Hearst Publ'ns, Inc.*, 322 U.S. 111, 123 (1944)). Congress's

qualified health plan"); 42 U.S.C. § 18081(a) (directing HHS to create program to collect information needed to determine an applicant's eligibility for federal premium tax credits, without including state of residence among relevant factors).

basic goal in enacting Section 36B was "[t]o ensure that health coverage is affordable," and "to help offset the cost of private health insurance premiums." S. REP. NO. 111-89, at 4; *see also* H.R. REP. NO. 111-443, vol. II, at 977. Indeed, Congress recognized that the Section 36B tax credits "are *key* to ensuring people affordable health coverage." H.R. REP. NO. 111-443, vol. I, at 250 (emphasis added). Congress's goal would be undermined if the plaintiffs were to prevail here; many individuals would find it difficult (if not impossible) to obtain affordable health coverage if they were to be deprived of tax credits worth, on average, more than $5,000 annually.[16] But the effects would be even broader. A substantial adverse selection effect would arise, because healthier individuals would lose a powerful incentive to purchase coverage. According to the calculations of one health care economist, without the minimum coverage provision and subsidized insurance coverage, premiums for single individuals would be *double* the amount anticipated under the ACA.[17] The result would be "essentially no increase" in the number of persons enrolled in individual coverage. *Id.*

Indeed, Congress heard testimony that this adverse selection effect would undermine the ability of the Exchanges to offer affordable coverage. As CBO put the issue, "[i]f no subsidies were provided, the total premiums charged to nonfederal enrollees would probably be much higher than those observed in the program today – so the number of new enrollees would probably be limited." CBO, *Expanding Health Insurance Coverage and Controlling Costs for Health Care: Testimony Before the S. Comm. on the Budget*, at 19 (Feb. 10, 2009) (written

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[16] *See* CBO, *May 2013 Baseline*, at tbl. 1 (estimating that federal premium tax credits will average $5,290 per person in 2014, rising to $7,900 in 2023).

[17] *See* Jonathan Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act* at 5 (Center for American Progress Aug. 2010) (Exhibit 9) (analyzing effect of proposed repeal of minimum coverage provision, and additional effect of repeal of subsidy provisions as well).

testimony of Douglas W. Elmendof, Director, CBO) (Exhibit 10) (discussing proposal to allow uninsured persons to enroll in federal employees' plans without subsidies).[18]

As Representative Andrews put it the day before the House voted to enact the ACA:

> [W]e've heard almost universally across the House that people say they want to avoid discrimination based on pre-existing conditions. It's hard to find a member who says he or she is not for that. In order to accomplish that and not spike premiums for insured people, you have to have a larger pool of people that are covered eventually. … [P]eople say, well, why do you have to have the subsidies? Well, to get people into this marketplace, if somebody's making $25,000, $35,000, $40,000 a year, you can have all the marketplace you want, but they can't buy in without the subsidies. … [T]his easy answer, which is so glibly stated by people, 'Let's just take care of the pre-existing condition problem,' it doesn't fit together if you don't take the next step and the next step and the next step and make it work."

H.R. 4872, the Reconciliation Act of 2010: Hearing Before the H. Comm. on Rules 71 (Mar. 20, 2010) (Exhibit 12).

F. The Legislative History of the Act Confirms that Participants in Federally-Facilitated Exchanges May Be Eligible for Federal Premium Tax Credits

If Congress had intended to penalize states for a failure to establish an Exchange by depriving those states' citizens of federal premium tax credits, Congress would have explained those terms clearly and directly at the time that the Act was passed. *See Arlington Cent. Sch. Dist.*, 548 U.S. at 296 ("we must ask whether the [Act] furnishes clear notice" of the conditions that Congress allegedly created); *see also Mississippi Band of Choctaw Indians*, 490 U.S. at 43 (plain language required before Congress will be presumed to intend federal law to turn on state action). Indeed, such a dramatic condition on the availability of federal premium tax credits would have been a central feature of Congress's reform effort. But there is not a word in the

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[18] *See also Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 13 (Apr. 22, 2009) (statement of Uwe Reinhardt, Prof. of Econ., Princeton Univ.) (Exhibit 11) (noting importance of "adequate public subsidies" to achievement of Congress's purposes in health reform legislation); *id*. at 50 (statement of Linda Blumberg, Principal Res. Assoc., Urban Inst.) (same).

legislative history that anybody in Congress contemplated such a result. "Congress' silence in this regard can be likened to the dog that did not bark." *Chisom v. Roemer*, 501 U.S. 380, 396 n.23 (1991); *see also Koons Buick Pontiac GMC, Inc. v. Nigh*, 543 U.S. 50, 63 (2004).

Instead, the legislative history consistently points to the conclusion that Congress meant premium tax credits to be available in every state, consistent with Treasury's rule. *First*, the House passed a bill that explicitly so provided. Its bill created a federal Exchange that would operate as the default Exchange, unless a state received a waiver to operate its own Exchange. H.R. 3962, 111th Cong., §§ 301, 308 (2009) (Exhibit 13). The bill provided for tax credits for participants in any of the Exchanges. *Id.*, §§ 308(b)(1)(A)(iv), 341(a). If the Senate-passed bill had changed this scheme to provide for tax credits in some states but not others, one would expect House members to have noticed this change. There is no indication, however, that any member of Congress believed that the two bills differed on this issue. Instead, the House recognized that, under the ACA, "[f]or states that choose not to operate their own Exchange, there will be a multi-state Exchange run by the Department of Health and Human Services," and the Exchanges would "provide[] premium tax credits to limit the amount individuals and families up to 400% poverty spend on health insurance premiums." House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Health Insurance Reform at a Glance: The Health Insurance Exchanges* at 1-2 (Mar. 20, 2010) (Exhibit 14).

Moreover, the House paid careful attention to the amount of federal premium tax credits under the Act. As a condition to the enactment of the ACA, the Senate accepted the House's amendments to Section 36B in contemporaneously-enacted legislation, the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029. HCERA adjusted the income formula for the calculation of premium tax credits, establishing

credits in the amounts that the House had initially provided for, but that the Senate had reduced in its version of the proposed legislation. *Id.*, § 1001(a), 124 Stat. at 1030-31. It is doubtful that the House would have paid such close attention to the *amount* of these credits, while at the same time silently acceding to legislation that foreclosed tax credits *entirely* in some states.

Second, although the language that became 26 U.S.C. § 36B was developed in the Senate Finance Committee, that Committee did not at any time express any intent to condition the availability of federal premium tax credits on the existence of a state-operated Exchange. To the contrary, to the extent that the issue arose at all, the Finance Committee expressed its understanding that the federally-facilitated Exchange would be the *same entity* as the state-operated Exchange. Its bill provided that, if a state did not establish an operational Exchange (in the bill's parlance, an "interim exchange") within a specified time, then "*the Secretary* would be required to contract with a nongovernmental entity to establish *state exchanges* during this interim period." S. REP. NO. 111-89, at 19 (emphasis added). The committee would not have used such language in its report if it had believed the Secretary-established Exchange was a different entity from the "state exchange."

Third, the Congressional Budget Office's ("CBO") cost analyses provide further proof that Congress understood that the federal premium tax credits would apply nationwide. CBO played a central role in Congress's deliberations on the ACA. CBO, along with the Joint Committee on Taxation ("JCT"), prepared analyses that estimated the cost of premiums in the Exchanges and the numbers of individuals who would enroll in plans on the Exchanges; these analyses assumed that tax credits would be available in every state. *See, e.g.*, CBO, *Analysis of Health Insurance Premiums*, at 6-7. Congress relied heavily on these estimates in debating the merits of the ACA; indeed, the Act itself recites that Congress adopted CBO's findings. Pub. L.

No. 111-148, § 1563(a), 124 Stat. 119, 270-71 (2010). There is no indication anywhere in the legislative record that any member of Congress took issue with CBO's assumption that tax credits would be available nationwide.[19] *See* 155 Cong. Rec. S12,764 (Dec. 9, 2009) (Sen. Baucus) (Exhibit 16) (discussing CBO's finding that most participants in "the exchange" would receive premium tax credits, reducing their overall costs); 155 Cong. Rec. S13,559 (Dec. 20, 2009) (Sen. Durbin) (Exhibit 17) (describing comprehensive availability of tax credits).

To the contrary, members of Congress consistently affirmed that tax credits would be available in every state. Senator Landrieu quoted a poll question describing the ACA as legislation in which "[l]ower and middle income people would receive subsidies to help them afford" insurance bought on a "[n]ational [i]nsurance Exchange," and declared that description to be "very accurate." 155 Cong. Rec. S13,733 (Dec. 22, 2009) (Exhibit 18). Senator Johnson noted that the ACA would "form health insurance exchanges in every State" and would "provide tax credits to significantly reduce the cost of purchasing" coverage on the Exchanges. 155 Cong. Rec. S13,375 (Dec. 17, 2009) (Exhibit 19). Similarly, Senator Bingaman noted that the ACA would create "a new health insurance exchange in each State which will provide Americans … refundable tax credits to ensure that coverage is affordable." 155 Cong. Rec. S12,358 (Dec. 4, 2009) (Exhibit 20).[20]

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[19] *See also* Letter from Douglas W. Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives at 1 (Dec. 6, 2012) (Exhibit 15) ("To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state.").

[20] Nor could these statements be explained away by asserting that Congress assumed that every state would establish an Exchange. It was well known that some states would not do so. *See*

Fourth, the JCT prepared a report on the ACA's tax provisions. That report further confirms that Congress intended federal premium tax credits to be available for the purchase of insurance on the federally-facilitated Exchange. The JCT stated that the Section 36B premium tax credit "subsidizes the purchase of certain health insurance plans through an exchange," without any suggestion that the identity of the entity operating the exchange would be relevant in any way. JCT, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act"* 12 (Mar. 21, 2010) (Exhibit 25). To be sure, a JCT report is prepared by committee staff, not legislators. But, because that staff is closely involved in the formulation of taxing provisions such as Section 36B, the courts have recognized that the JCT's reports are "highly indicative of what Congress did, in fact, intend." *Miller v. United States*, 65 F.3d 687, 690 (8th Cir. 1995) (internal quotation omitted). *See also Fed. Power Comm'n v. Memphis Light, Gas & Water Div.*, 411 U.S. 458, 472 (1973) (JCT report is a "compelling contemporary indication" of Congressional intent); *Capital One Fin. Corp. v. Commissioner*, 659 F.3d 316, 325 (4th Cir. 2011) (relying on JCT report). If Congress had intended federal premium tax credits to be available only in states with state-operated Exchanges, the JCT report would have made note of that fact.

In sum, all of the legislative history points to the same conclusion: Congress intended

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David D. Kirkpatrick, *Health Lobby Takes Fight to the States*, New York Times A1 (Dec. 28, 2009) (Exhibit 21) (describing numerous state proposals to "opt out" of health insurance marketplaces). *See also* 156 Cong. Rec. H2207 (Mar. 22, 2010) (Rep. Burgess) (Exhibit 22) (as many as 37 states "may not set up the State-based exchange"); 155 Cong. Rec. S12,543-S12,544 (Dec. 6, 2009) (Sen. Coburn) (Exhibit 23) (submitting letter from Oklahoma official stating that her state was unlikely to create an Exchange); Editorial, *Don't Trust States to Create Health Care Exchanges*, USA Today (Jan. 4, 2010) (Exhibit 24) (noting that "[s]ome state officials hostile to reform are already trying to block implementation," and would likely not create Exchanges).

that the federal premium tax credits would be available for the participants in every Exchange, as part of "a nationwide scheme of taxation uniform in its application," *Irvine*, 511 U.S. at 238. Nothing in the legislative history supports the plaintiffs' contrary theory. If Congress had intended such a dramatic result, surely some legislative history would so indicate. Some dog, somewhere, would have barked. That silence is a powerful indication that the plaintiffs' reading of the Act is incorrect.

G. The Plaintiffs' Assertion that Congress Had a Contrary Purpose Is Not Plausible

Despite the foregoing, the plaintiffs assert that Congress had a completely different purpose in enacting Section 36B. They claim that, in order to encourage states to create their own Exchanges, Congress deliberately decided to condition individual taxpayers' eligibility for federal tax credits on whether or not that taxpayer's state government created an Exchange. This assertion is implausible. Congress, after all, did not set out to create Exchanges (whether state- or federally-operated) simply for the sake of creating Exchanges. It did so, instead, as part of a comprehensive scheme to expand the availability of affordable health coverage. *See* S. REP. NO. 111-89, at 9 ("The purpose of Title I would be to ensure that all Americans have access to affordable and essential health benefits coverage … by establishing State exchanges to provide greater access to and information about [qualified health plans and] by making health benefits coverage more affordable with premium credits and cost-sharing subsidies[.]"); H.R. REP. NO. 111-443, vol. II, at 989 (describing same purpose for the Exchange). There is simply no credible indication that Congress would have sacrificed the Affordable Care Act's central mechanism for providing affordable coverage, simply to give states the incentive to create their own Exchanges.

Congress did, of course, intend to provide for states to be given the option whether to

operate an Exchange. That is why Congress enacted the statute that it did, presuming in the first instance that "[a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State," 42 U.S.C. § 18031(d)(1), but directing the federal government to stand in the shoes of the state to create the Exchange if the state chose not to take the necessary action to do so, 42 U.S.C. § 18041(c)(1). Thus, as Senator Baucus put it, the ACA "fundamentally gives States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges." 155 Cong. Rec. S13,832 (Dec. 23, 2009) (Exhibit 26). It does not follow, however, that a Congress that sought to show that it was *solicitous* of states' interests in choosing whether to operate their own Exchanges would try to prove the point by *threatening* to deprive those states' residents of tax credits, amounting to billions of dollars annually, if the states did not comply.

It is noteworthy that Congress directed HHS to establish a federally-facilitated Exchange not only when a state *chooses* not to operate its own Exchange, 42 U.S.C. § 18041(c)(1)(A), but also when a state affirmatively wants to establish an Exchange but fails to meet relevant federal standards, 42 U.S.C. § 18041(c)(1)(B). It is inconceivable that Congress would have wanted to punish a state for such a regulatory lapse by denying its innocent residents the tax credits they need to afford health insurance.

Given the implausibility of the plaintiffs' theory, it is not surprising that there is absolutely *no* evidence that any member of Congress had the intent that the plaintiffs now ascribe to that body. In prior briefing, the plaintiffs have cited to two sources that they claimed would show Congress's intent to deprive participants in the federally-facilitated Exchanges of premium tax credits. *See* ECF 21 at 25, 26. Neither source even remotely suggests this proposition. *See* Letter from Rep. Doggett, et al. (Jan. 11, 2010), available at

www.myharlingennews.com/?p=6426 (Exhibit 27); U.S. Senate, Committee on Finance, *Executive Committee Meeting to Consider Health Care Reform* at 325-327 (Sept. 23, 2009) (Exhibit 28).

If Congress had intended for the Section 36B tax credits to serve as an incentive to induce the states to set up their own Exchanges, Congress would have needed to explain clearly what the consequences for the states would be. *See Arlington Cent. Sch. Dist.*, 548 U.S. at 296 ("we must ask whether the [Act] furnishes clear notice" of the conditions that Congress allegedly created). For this and other reasons, as discussed above, the courts demand a clear statement of congressional intent before they will presume that Congress intended the application of federal law to depend on a state government's action. *Mississippi Band of Choctaw Indians*, 490 U.S. at 43; *see also Irvine*, 511 U.S. at 238-39.

In sum, when Congress enacted the ACA, it did not enact a statute that would be at war with itself. It did not enact comprehensive reform legislation for the purpose of expanding the availability of affordable health insurance, and at the same time hide a provision in the text that would undermine the possibility that that goal could be achieved. Congress did not intend to set up a mechanism for non-participating states that would create a lesser form of Exchange that Congress knew to be defective and would ultimately fail. The plaintiffs' reading of the ACA to allow for affordable health insurance in some states but not others is implausible. At the very least, it is not a reading that is compelled under *Chevron* step one.

H. The Treasury Department Has Reasonably Interpreted Section 36B to Provide for Tax Credits for Participants in Federally-Facilitated Exchanges

It follows from the foregoing that 26 C.F.R. § 1.36B-1(k) "is based on a permissible construction of the statute" under *Chevron* step two. *City of Arlington*, 133 S. Ct. at 1868. When it promulgated the regulation, the Treasury Department explained that "[t]he statutory

language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a … Federally-facilitated Exchange," and that this conclusion was supported by the "relevant legislative history" as well as "the language, purpose, and structure of section 36B and the Affordable Care Act as a whole." 77 Fed. Reg. 30,377, 30,378 (May 23, 2012). Treasury, certainly, arrived at a permissible construction of the ACA. Given Congress's instruction in the ACA to treat the federally-facilitated Exchange as the same entity as the Exchange that the Act contemplated that the state would establish, and its instruction in Section 36B itself that the federally-facilitated Exchange is to assist in administering premium tax credits; the long list of anomalies that a contrary reading would create in the operation of the ACA's provisions; the absence of any legislative history that would support that contrary reading; and the Congressional purpose to expand the availability of affordable health coverage, the Treasury Department reasonably concluded that premium tax credits are available for participants in federally-facilitated Exchanges. Summary judgment accordingly should be awarded to the defendants.

III. At All Events, This Court Should Not Order Equitable Relief Broader than Necessary to Address Any Injuries of the Plaintiffs before the Court

For the reasons explained above, the text of Section 36B, considered in its entirety and in conjunction with the remainder of the Affordable Care Act, shows that Congress intended that federal premium tax credits would be available on both state-operated and federally-facilitated Exchanges. The defendants pause, nonetheless, to address the stunning overbreadth of the relief that the plaintiffs seek. Even if the plaintiffs could present a justiciable claim and then prevail on the merits, they would be entitled, at most, to relief to remedy their own alleged injuries. Under no circumstances would they be entitled to nationwide relief, especially where

such relief would seriously injure millions of individuals not before the Court.

The plaintiffs ask for a nationwide injunction that would prohibit the Treasury Department from administering Section 36B tax credits in any state with a federally-facilitated Exchange. No injunction of any scope should issue here, even if the Court were to reject Treasury's construction of the Act. A party seeking a permanent injunction must meet the same four-part test that applies for preliminary injunctions. *See Monsanto Co. v. Geerston Seed Farms*, 130 S. Ct. 2743, 2756 (2010). The plaintiffs' request for a permanent injunction fails for the same reasons that their request for a preliminary injunction failed: they have alleged only economic harm, and thus have not shown the existence of any irreparable injury. *See, e.g.*, *Va. Carolina Tools, Inc. v. Int'l Tool Supply, Inc.*, 984 F.2d 113, 120 (4th Cir. 1993). The public interest and the balance of the equities also strongly weigh against injunctive relief, given the strong interest in avoiding interference with the Treasury Department's performance of its duties in administering the tax laws. *See* Defs.' Mem. in Opp. to Mot. for PI (ECF 18) at 37-40.

Even if one or more plaintiffs could obtain an injunction as to their own tax liability, they plainly would not be entitled to an injunction concerning anyone else, much less the broad injunction they seek that would preclude Treasury from applying its interpretation of Section 36B in *any* circumstance. No such injunction may issue. The APA preserves all of the ordinary principles of equity. *See* 5 U.S.C. § 702(1) ("Nothing herein affects … the power or duty of the court to … deny relief on any other appropriate legal or equitable ground[.]"). One such principle of equity is that "injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979); *see also Monsanto Co.*, 130 S. Ct. at 2760 & n.5. Thus, any injunction in this case could be no broader than what would be needed to address the plaintiffs' particular injuries.

See Virginia Soc'y for Human Life v. FEC, 263 F.3d 379, 393-94 (4th Cir. 2001), *overruled in part on other grounds by The Real Truth About Abortion, Inc. v. FEC*, 681 F.3d 544, 550 n.2 (4th Cir. 2012). The plaintiffs would gain no additional relief from an order prohibiting the Treasury Department from applying its understanding of Section 36B to the circumstances of parties not before the Court, and thus no such order should issue here. *See id.* at 393.[21]

It would be particularly inappropriate to order equitable relief that would purport to determine the tax circumstances of parties who are not present in this case. It is well-established that one party may not challenge the tax liability of another. *See, e.g.*, *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 37 (1976). The plaintiffs' request to adjudicate the tax liabilities of parties not before the court would "seriously disrupt the entire revenue collection process." *Apache Bend Apartments, Ltd. v. United States*, 987 F.2d 1174, 1177 (5th Cir. 1993). Principles of equity counsel instead in favor of maintaining the operation of a central feature of the Affordable Care Act that will enable millions of Americans to receive the substantial tax relief to which they are entitled under the statute.

Conclusion

For the foregoing reasons, the complaint should be dismissed. In the alternative, the defendants' cross-motion for summary judgment should be granted, and the plaintiffs' motion for summary judgment should be denied.

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[21] Indeed, the plaintiffs' request for a broad injunction runs afoul of the principle that nonmutual collateral estoppel does not run against the United States. As the Supreme Court has explained, a contrary rule "would substantially thwart the development of important questions of law by freezing the first final decision rendered on a particular legal issue." *United States v. Mendoza*, 464 U.S. 154, 160 (1984). The Court's approach on this issue "better allow[s] thorough development of legal doctrine by allowing litigation in multiple forums." *Id.* at 163. The relief that the plaintiffs seek here is directly foreclosed by the *Mendoza* rule. *See Virginia Soc'y for Human Life*, 263 F.3d at 393.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of November, 2013, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send a notification of such filing (NEF) to the following:

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