[EN BANC ORAL ARGUMENT SCHEDULED FOR DECEMBER 17, 2014]

No. 14-5018

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JACQUELINE HALBIG, ET AL.,

Appellants,

v.

SYLVIA M. BURWELL,
SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA (NO. 13-623 (PLF))

BRIEF FOR APPELLANTS

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Plaintiffs-Appellants certify as follows:

1. Parties and Amici

Plaintiffs in the district court were Jacqueline Halbig; David Klemencic; Carrie Lowery; Sarah Rumpf; Innovare Health Advocates; GC Restaurants SA, LLC; Olde England's Lion & Rose, LTD; Olde England's Lion & Rose at Castle Hills, LTD; Olde England's Lion & Rose Forum, LLC; Olde England's Lion & Rose at Sonterra, LTD; Olde England's Lion & Rose at Westlake, LLC; and Community National Bank. All plaintiffs are before this Court as appellants. Pursuant to Circuit Rule 26.1, undersigned counsel certifies the following:

1. Plaintiff Innovare Health Advocates has no parent, affiliate, or subsidiary companies.

2. Plaintiff GC Restaurants SA, LLC has no affiliates or subsidiaries, and is 99% owned by ATA Restaurant Holding Company, LLC and 1% owned by Allen Tharp and Associates, Inc.

3. Plaintiffs Olde England's Lion & Rose, LTD, Olde England's Lion & Rose at Castle Hills, LTD, Olde England's Lion & Rose Forum, LLC, Olde England's Lion & Rose at Sonterra, LTD, and Olde England's Lion & Rose at Westlake, LLC have no affiliates or subsidiaries, and are each 99% owned by Allen Tharp and 1% owned by Allen Tharp and Associates, Inc.

4. Plaintiff Community National Bank has no affiliates or subsidiaries, but it is wholly owned by Community Bancshares, Inc.

5. No publicly held corporation owns ten percent or more of the stock in any of the companies listed above.

Defendants before the district court were Kathleen Sebelius; the U.S. Department of Health and Human Services; Jacob Lew; the U.S. Department of the Treasury; Daniel Werfel; and the Internal Revenue Service. All defendants are before this Court as appellees, except that Sylvia Burwell and John Koskinen, respectively, have been substituted for Kathleen Sebelius as Secretary of Health and Human Services and Daniel Werfel as Commissioner of Internal Revenue.

Amici before the district court were Jonathan Adler, Michael Cannon, the Commonwealth of Virginia, the American Hospital Association, and Families USA. Amici who participated before the original three-judge panel are Pacific Research Institute; Cato Institute; American Hospital Association; Jonathan Adler; Michael Cannon; Oklahoma; Alabama; Georgia; West Virginia; Nebraska; South Carolina; Consumer's Research; America's Health Insurance Plans; National Federation of Independent Business Small Business Legal Center; Kansas; Michigan; Galen Institute; Senator John Cornyn; Senator Ted Cruz; Senator Orrin Hatch; Senator Mike Lee; Senator Rob Portman; Senator Marco Rubio; Rep. Dave Camp; Rep. Darrell Issa; a group of Public Health Deans, Chairs, and Faculty;

American Cancer Society; American Cancer Society Cancer Action Network; American Diabetes Association; American Heart Association; Families USA; Henry Aaron; Stuart Altman; Susan Athey; Linda Blumberg; Barry Bosworth; Gary Burtless; Amitabh Chandra; Philip Cook; Janet Currie; David Cutler; Karen Davis; Bradford DeLong; Peter Diamond; Ezekiel Emanuel; Austin Frakt; Sherry Glied; Paul Ginsburg; Claudia Goldin; Jonathan Gruber; Genevieve Kenney; Vivian Ho; John Holohan; Jill Horwitz; Lawrence Katz; Frank Levy; Peter Lindert; Eric Maskin; Marilyn Moon; Alan Monheit; Joseph Newhouse; Mark Pauly; Harold Pollack; Daniel Polsky; James Rebitzer; Michael Reich; Robert Reischauer; Alice Rivlin; Meredith Rosenthal; Isabel Sawhill; John Shoven; Jonathan Skinner; Lawrence Summers; Katherine Swartz; Kenneth Thorpe; Laura Tyson; Paul Van de Water; Justin Wolfers; Stephen Zuckerman; and a group of Members of Congress and State Officials.

2. Ruling Under Review

Plaintiffs-Appellants appeal from the final order of the district court (Friedman, J.) entered on January 15, 2014, granting defendants' cross-motion for summary judgment. The district court's order can be found at A324.

3. Related Cases

This case was not previously before this Court or any other court, and there are no related cases within the meaning of Circuit Rule 28(a)(1)(C).

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GLOSSARY

A__	Joint Appendix
ACA	Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010
APA	Administrative Procedure Act
HHS	U.S. Department of Health and Human Services
IRS	Internal Revenue Service

JURISDICTIONAL STATEMENT

Plaintiffs-Appellants brought suit under the APA to vacate regulations promulgated by the IRS. The district court had jurisdiction under 28 U.S.C. § 1331, and on January 15, 2014, the court granted defendants' motion for summary judgment and dismissed the case. (A324) Appellants noticed an appeal. (Dkt. 68) This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF ISSUE

The ACA authorizes federal subsidies only for health coverage obtained on an "Exchange established by the State under section 1311 [of the ACA, *codified at* 42 U.S.C. § 18031]." The issue is whether the IRS may by regulation extend such subsidies to health coverage obtained on Exchanges established instead by the *federal government* under § *1321* of the ACA, *codified at* 42 U.S.C. § 18041.

STATEMENT OF PERTINENT AUTHORITIES

The following provisions are reproduced in the addendum hereto: 42 U.S.C. §§ 18031 & 18041 (which are ACA §§ 1311 & 1321) and 42 U.S.C. § 1396c; 26 U.S.C. § 36B (which is ACA § 1401(a)); 26 C.F.R. § 1.36B (excerpts); and 45 C.F.R. § 155.20 (excerpts).

STATEMENT OF THE CASE

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

A. For Constitutional Reasons, the ACA Encourages Rather Than Compels States To Establish Exchanges, And Does So Principally by Limiting Subsidies to State-Established Exchanges.

The ACA regulates the individual health insurance market primarily through insurance "Exchanges" organized along state lines. An Exchange is "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality." (A327)

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 commands, however, Congress cannot *compel* sovereign states to create Exchanges. *Printz v. United States*, 521 U.S. 898, 935 (1997). The Act accordingly recognizes that some states may not be "electing State[s]," as they may choose not "to apply the requirements" for an Exchange or otherwise "fai[l] to establish [an] Exchange." ACA § 1321(b)-(c), *codified at* 42 U.S.C. § 18041(b)-(c). The Act authorizes HHS to establish fallback Exchanges in states that do not establish their own. In such cases, HHS "shall … establish and operate such Exchange within the State." ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). In short, if a state declines the role that the ACA urges it to accept, that obligation falls upon the federal government instead.

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

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

Critically, the Act only subsidizes coverage through Exchanges *established by a state*. It provides that a credit "shall be allowed" in an "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, there are no "coverage months" and no subsidy. Confirming that fact, the subsidy for any "coverage month" is based on premiums for coverage "enrolled in through an Exchange established by the State under [§] 1311 of the [ACA]." *Id.* § 36B(b)(2)(A); *see also id.* § 36B(b)(3)(B)(i) (referring back to "same Exchange" for purpose of calculating another subsidy value).

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. H.R. 3962, § 308, 111th Cong. (2009). As the district court agreed, however, "these proposals proved politically untenable and doomed to failure in the Senate." (A360) In particular, Senator Ben Nelson of Nebraska, whose vote was critical to passage, called the national Exchange model 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 other swing-vote Senators, it was important to keep the federal government *out* of the process. It was thus insufficient to merely allow states the *option* to establish Exchanges, as the House bill did. 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—in particular, the conditioning of tax credits on state-run Exchanges—were thought sufficient to do so. As one of the Act's architects, Prof. Jonathan Gruber, explained, "if 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'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&feature=youtu.be&t=31m25s.

Perhaps in light of that political reality, "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; *see also* Elise Viebeck, *Obama Faces Huge Challenge in Setting up Health Insurance Exchanges*, THE HILL, Nov. 25, 2012 ("The law assumed states would create and operate their own exchanges …."). Congress did not appropriate *any* funds for HHS to build Exchanges, even as it appropriated unlimited funds to help states establish theirs. ACA § 1311(a), *codified at* 42 U.S.C. § 18031(a). Indeed, ACA proponents boasted that "[a]ll the health insurance exchanges … are run by states," to rebut charges of a federal "takeover." SENATE 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 Promulgates Regulations Expanding the Availability of Subsidies to HHS-Established Exchanges.

Nevertheless, the IRS promulgated regulations ("the IRS Rule") extending subsidies to coverage purchased through *any* Exchange, including ones established by HHS under § 1321 of the Act. Specifically, the IRS Rule states that subsidies shall be available to anyone enrolled "through an Exchange," and then adopts by cross-reference an HHS definition of "Exchange" that includes *any* Exchange, "regardless of whether the Exchange is established and operated by a State … or by HHS." 26 C.F.R. § 1.36B-2; 45 C.F.R. § 155.20. Under the Rule, subsidies are thus available in *all* states, even those that failed to establish their own 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 Comm. on Ways and 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 [ACA] 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 [ACA] as a whole.

77 Fed. Reg. 30377, 30378 (May 23, 2012).

C. 34 States Decline To Establish Their Own Exchanges.

After the IRS announced that taxpayers would be eligible for subsidies whether or not their states established Exchanges, 34 states decided not to establish Exchanges. (A328)[1] Two states also failed to establish Exchanges in time for 2014. Jennifer Corbett Dooren, *Two States Seek Help With Health Exchanges*, WALL ST. J., May 22, 2013. Pursuant to § 1321 of the ACA, HHS therefore established federal Exchanges (*i.e.*, HealthCare.Gov) to serve those states.

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

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

For individuals, the availability of the subsidy triggers the Act's individual mandate penalty for many who would otherwise be exempt. That 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). Under regulations implementing these exemptions, an individual may obtain an advance exemption from the individual mandate penalty if the annual cost of health coverage exceeds eight percent of his projected household income. *See* 45 C.F.R. § 155.605(g)(2); *see*

[1] Of these states, 7 (including West Virginia) have chosen to assist HHS with operation of the federal Exchanges. (A373 n.1) 77 Fed. Reg. 18310, 18325 (Mar. 27, 2012) (categorizing "partnership" Exchanges as federally established).

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 insurance plan available in the Exchange in that person's state, minus "the credit allowable under section 36B." 26 U.S.C. § 5000A(e)(1)(B)(ii). Thus, by purporting to make credits "allowable" in states served by an HHS Exchange, the IRS Rule increases the number of people in those states subject to the individual mandate's penalty. Now ineligible for exemptions, those individuals are no longer free to forgo coverage, or to buy "catastrophic" coverage (otherwise restricted to those under age 30, ACA § 1302(e)(1)(A), (2), *codified at* 42 U.S.C. § 18022(e)(1)(A), (2)).

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

E. Injured Individuals and Employers Challenge the IRS Rule.

Appellants in this case are individuals residing, and employers operating, in states that declined to establish their own Exchanges and therefore are being served by HealthCare.Gov. (A332) The proceedings below focused on one individual plaintiff: David Klemencic, a resident of West Virginia (which has declined to establish an Exchange). Klemencic does not want to purchase health coverage in 2014, and, given his low income, would not be subject to any penalty for failing to do so—but for the IRS Rule, which renders him eligible for a subsidy that would reduce the cost of his coverage and disqualify him from the mandate's exemption. (A334-35) The Rule "places Klemencic in a position where he has to purchase subsidized health insurance … or he will have to pay … [a] tax penalty." (A335)

F. The District Court Rejects the Government's Motion To Dismiss, But Upholds the IRS Rule on the Merits.

The district court denied the Government's motion to dismiss, concluding that Klemencic had Article III and prudential standing to challenge the IRS rule, that his challenge was ripe, and that the APA offered him a cause of action. (Dkt. 46) But the court upheld the Rule on the merits, concluding that while § 36B's "plain language … appears to support plaintiffs' interpretation," Congress clearly intended just the contrary. (A350, 359) The court inferred that counter-textual intent from (i) Congress's policy goal "to provide affordable health care" (A357); (ii) the absence of legislative history confirming the ACA's plain text (A358, 361);

(iii) supposed "anomalies" in operation of some of the Act's other provisions (A354); and (iv) a contorted construction of statutory cross-references to imply that HHS somehow acts as a state when it establishes an Exchange (A352-53).

G. A Panel of This Court Reverses, Invalidating the IRS Rule.

On July 22, 2014, a panel of this Court reversed the decision below and invalidated the IRS Rule. Writing for the majority, Judge Griffith explained that "the ACA unambiguously restricts the section 36B subsidy to insurance purchased on Exchanges 'established by the State.'" (A368) The subsidy provision "plainly distinguishes Exchanges established by states from those established by the federal government." (A378) The panel majority thoroughly considered and rejected the Government's contentions that this plain-meaning construction "render[s] other provisions of the ACA unworkable" or absurd. (*Id.*) And then, weighing the ACA's "purpose and legislative history," the panel concluded that the Government "again comes up short in its efforts to overcome the statutory text. Its appeals to the ACA's broad aims do not demonstrate that Congress manifestly meant something other than what section 36B says." (A378-79) Because "Congress is supreme in matters of policy," the court limited to review to "ascertain[ing] the meaning of the words of the statute duly enacted through the formal legislative process" (A404)—and those words directly foreclosed the Rule. Judge Edwards dissented. (A407) This Court then agreed to rehear the case en banc.

SUMMARY OF ARGUMENT

I. There is no legitimate way to construe the phrase "Exchange established by the State under section 1311" in the ACA's subsidy provision to mean "Exchange established by the State under section 1311 *or HHS under section 1321*." Congress contemplated both state-established Exchanges (the default) and HHS-established Exchanges (in states that refuse to establish them); where it specifically referred to one type or the other, courts must give effect to that language.

A. The Government complains that this reading analyzes the Act's subsidy provision (26 U.S.C. § 36B) "in isolation," ignoring "context." But § 36B is the *only* provision that speaks to subsidies. And statutory context only confirms the plain language. *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 Exchanges in another subsection of § 36B itself. Finally, *context* shows that § 36B, far from being a "mousehole" in which Congress would not have naturally limited subsidies, is the only provision that defines and delimits the subsidy-eligible purchases. So the panel majority did not ignore context; it simply rejected the Government's meritless contextual arguments.

B. In the face of plain text and corroborating context, the Government, district court, and Judge Edwards propose a series of attenuated theories by which to transform an Exchange established by HHS into one "established by the State." None can work that alchemy.

The Government's principal argument is that because § 1321 authorizes HHS to establish "such Exchange" "within the State" when the state fails to establish an Exchange, HHS somehow acts "on behalf of" the state in doing so and the HHS-established Exchange is therefore somehow "established by the State." But the fact that HHS is *authorized* to establish Exchanges in states that fail to obviously does not make those HHS Exchanges "established by the State." As for "such Exchange," that simply means that HHS is to establish the same *type* of Exchange as a state. But § 36B makes subsidies turn not on the *type* of exchange, but on *who* established it. Finally, the notion that HHS acts "on behalf of" the state is both untrue and irrelevant. Section 1321 does not *say* HHS acts "on behalf of" the state, and HHS *must* be acting *instead of* the state because its power to establish this Exchange is triggered by the state's refusal. And even if HHS were acting *on states' behalf*, subsidies are authorized only in Exchanges established *by* the state. An HHS Exchange could be "established by the State" only if Congress expressly deemed it so. But, unlike numerous other places in the U.S. Code and an earlier version of the ACA, the Act contains no such language.

C. Trying to avoid the inexorable conclusion that flows from § 36B's text, the Government claims that its plain meaning would lead to anomalous results for *other* provisions in the Act. Even assuming that anomalies in other provisions could somehow justify ignoring *§36B's* non-absurd text, the Government's contention fails on its own terms. Not only has the Supreme Court directly warned that courts may not invoke such anomalies to override plain text, but the "anomalies" here are contrived. As even the Fourth Circuit found, all of the Act's provisions are just as compatible with the plain meaning of § 36B as with the Government's unlawful revision of it. They certainly come nowhere close to absurdity, even in the extraneous provisions themselves, much less in § 36B.

D. The Government next invokes policy reasons for ignoring the Act's text: Subsidies are important to the scheme and Congress would have wanted them available to everyone. Yet as the Supreme Court has said on countless occasions, courts cannot reject plain statutory language in favor of vague speculation about abstract purposes. That is because such counter-textual analysis arbitrarily elevates one abstract purpose (here, desire for subsidies) over another purpose set forth in the text (here, conditional subsidies, to induce states to create Exchanges), improperly substituting the former *judicially preferred* policy for the latter *congressionally enacted* one.

Under the Government's "purposes" logic, the ACA requires subsidies for insurance purchased *outside* of any Exchange (state or federal), because limiting subsidies to coverage on "an Exchange" is contrary to Congress's broader purpose to make subsidies widely available. Similarly, the Government's "interpretive" methodology would require that Medicaid funds be available even to states that refuse to expand Medicaid eligibility, even though the Act's text limits such funds to states that have done so. As with Exchange subsidies, there is no express "if, then" threat in the Act and no legislative history or letters from HHS to Governors referencing the Medicaid "deal" or warning states about the consequences of rejecting it. But if a state nonetheless had rejected it, that would plainly have required cutting off its Medicaid funds, even though Congress really wanted to continue—indeed, to expand—Medicaid everywhere.

The obvious point is that *conditioning* a benefit is not contrary to a purpose of making that benefit available, because conditions do not *eliminate* the benefit—they simply also advance *other* purposes. Here, conditioning subsidies on state establishment of Exchanges advanced Congress's purpose of having states run the Exchanges, by providing them a strong inducement to do so. Thus, far from being absurd, limiting subsidies to state Exchanges was the best, and perhaps the only, way Congress could accomplish *both* of its purposes—nationwide subsidies *and* state-run Exchanges. Absent such a financial incentive, it was quite unlikely that

states would assume this logistically, politically, financially costly responsibility. By contrast, with such incentives, Congress reasonably expected that no state would reject a "deal" providing their citizens with billions of dollars of free federal money to purchase needed health insurance. But the IRS Rule preemptively *eliminated* the irresistible incentive of subsidies, replacing a deal too good to refuse with a "deal" that offered states nothing at all, making it unsurprising that many chose to dump the burden on HHS. So to the extent that vacating the Rule would have adverse policy effects—at least temporarily, until states can establish Exchanges going forward—those effects are the *result* of the unlawful Rule. They cannot be invoked to *sustain* it.

Because the Government cannot deny that so conditioning subsidies serves an eminently sensible "purpose"—even the Fourth Circuit agreed with that—it instead objects that Congress did not affirmatively *state* this purpose. But, again, the only requirement is that the plain text further an *objectively non-absurd* policy; there is no requirement that Congress in the legislative history expressly articulate this reasonable purpose in order to render the unequivocal text enforceable. Even *express* legislative history cannot overcome plain text; the *absence* of confirmation from the legislative record is obviously irrelevant. And such absence is especially unsurprising for a statute negotiated behind closed doors and rammed through Congress in record time. In any case, there is ample evidence that Congress meant

exactly what it said—from a pre-debate proposal by an influential commentator, to a draft Senate bill that similarly conditioned subsidies on state action, to the political failure of a House bill that offered states no incentives, to the subsequent public explanations by one of the Act's principal architects.

II. *Chevron* deference cannot save the IRS Rule. *First*, the ACA's subsidy provision unambiguously answers the precise question presented, and Congress would never have delegated a decision of such momentous significance to the IRS. *Second*, any deference would be displaced here by the venerable canon requiring tax credits to be provided unambiguously. *Third*, the *IRS* is owed no deference in construing the language critical to the Government's theory, which is found in Title 42 of the U.S. Code, *not* the Tax Code. *Fourth*, rendering express statutory text meaningless is the epitome of an unreasonable construction.

* * *

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 especially consequential and politically sensitive, but that only heightens the importance of judicial fidelity to the rule of law and to well-established interpretive principles. Under those principles, there is no question that the IRS Rule cannot stand.

ARGUMENT

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

"If the statute is clear and unambiguous 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *Bd. of Governors of the Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 368 (1986) (quoting *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984)). Applying *de novo* review, *Holland v. Nat'l Mining Ass'n*, 309 F.3d 808, 814 (D.C. Cir. 2002), this Court must assess whether the ACA unambiguously limits subsidies to health coverage purchased on *state-established* Exchanges. It does, and the IRS Rule is therefore illegal.

A. The IRS Rule Contradicts the Only Plausible Construction of the ACA's Subsidy Provision.

1. The ACA grants eligible taxpayers 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, *codified at* 42 U.S.C. § 18031]." *Id.* § 36B(c)(2)(A)(i). These provisions are 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 a 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 [*codified at* 42 U.S.C. § 18031]." *Id.* § 36B(b)(2)(A). *Second*, the excess, over a 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 [*codified at* 42 U.S.C. § 18031]." *Id.* § 36B(b)(2)(B), (3)(B). These sums can only be computed if the taxpayer buys coverage through a state-established Exchange.

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," with no limit based on the entity that established the Exchange. 26 C.F.R. § 1.36B-2(a)(1). The regulations then adopt by cross-reference an HHS definition of "Exchange" defined to include *any* Exchange, "regardless of whether [it] is established and operated by a State … or by HHS." 26 C.F.R. § 1.36B-1(k); 45 C.F.R. § 155.20. Under these regulations, therefore, an individual who enrolls in coverage even through 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 latter expressly restricts subsidies to coverage obtained through "an Exchange established by the State under section 1311" of the Act, but the former expands those subsidies to coverage obtained through *any* Exchange, "regardless of whether [it] is established and operated by a State … or by HHS."

At the risk of belaboring the obvious, HHS is not a "State." If there could be any doubt, the Act clarifies: "[T]he term 'State' means each of the 50 States and the District of Columbia." ACA § 1304(d), *codified at* 42 U.S.C. § 18024(d). And sections 1311 and 1321 are distinct grants of authority to distinct entities. "As the text is clear, [the court's] inquiry is complete." *Blackmon-Malloy v. U.S. Capitol Police Bd.*, 575 F.3d 699, 705 (D.C. Cir. 2009).

4. This text is corroborated by every conceivable canon of construction. *First*, if "Exchange established by the State under section 1311" is read to include *all* Exchanges, then the statutory modifiers "established by the State" and "under section 1311" would serve no purpose at all, violating the "cardinal principle" that "no clause, sentence, or word [of a statute] shall be superfluous, void, or insignificant." *Duncan v. Walker*, 533 U.S. 167, 174 (2001). More to the point, these two modifiers suggest the very *opposite* of what the Government contends Congress intended. Why would Congress add clauses that, on the Government's view, are not only completely redundant but also entirely misleading?

Second, Congress elsewhere in the ACA used broader phrases—"Exchange established *under this Act*," ACA § 1312(d)(3)(D)(i)(II), *codified at* 42 U.S.C. § 18032(d)(3)(D)(i)(II), for example, or "Exchange established *under this subtitle*," ACA § 1331(d)(3)(A)(i), *codified at* 42 U.S.C. § 18051(d)(3)(A)(i) (emphases added). Those phrases clearly do include HHS-established Exchanges. The IRS Rule, however, says that the narrower phrase "Exchange established *by the State*" means "established under this Act," violating yet another canon—that "differing language" in "two subsections" of a statute should not be given "the same meaning." *Russello v. United States*, 464 U.S. 16, 23 (1983). As even the Fourth Circuit agreed, "[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." *King v. Burwell*, 759 F.3d 358, 368 (4th Cir. 2014).

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

Fourth, a venerable canon of construction holds that tax credits, deductions, and exemptions "must be expressed in clear and unambiguous terms." *Yazoo & Miss. Valley R.R. Co. v. Thomas*, 132 U.S. 174, 183 (1889). These benefits must be "unquestionably and conclusively" established, *Stichting Pensioenfonds Voor De Gezondheid v. United States*, 129 F.3d 195, 198 (D.C. Cir. 1997); they "are not to be implied," *United States v. Wells Fargo Bank*, 485 U.S. 351, 354 (1988). This canon fulfills the Constitution's express requirement that *Congress* directly control all "Money … drawn from the Treasury," such that "the President" and his subordinates "cannot touch moneys in the Treasury of the United States, except [as] *expressly* authorized by act of Congress." *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)). Thus, any doubts over whether the subsidies apply to federal Exchanges must be resolved *against* expanding the credit.

5. For all these reasons, there is only one legitimate way to read the ACA's plain text: Exchanges may be established by either the state or by HHS, but subsidies are available only for coverage through the former. Congress could not have used any clearer language to express that intent, and no one has even attempted to explain why it would have used this language *absent* such intent.

B. The Government's "Textual" Hook for the IRS Rule Is Preposterous.

The Government has nevertheless argued that "established by the State" could mean "established by the State *or by HHS when the state fails to establish one*." No rationale for that countertextual view withstands minimal scrutiny; none would be taken seriously in any other context. Simply put, these arguments plainly do not "comport with normal English usage." *Pruitt v. Burwell*, No. 6:11-cv-00030, Dkt. No. 118, slip op. at 14 (E.D. Okla. Sept. 30, 2014).

1. The district court reasoned that the ACA "directs the Secretary of HHS to establish such Exchange and bring it into operation if the state does not do so" (A352), and the HHS Exchange in such a scenario effectively takes the place of the absent state-established Exchange. That is, because HHS Exchanges may *replace* state Exchanges, they somehow *become* state Exchanges.

That makes no sense. That the Act *envisions* HHS Exchanges (when states default) obviously cannot suggest that § 36B's reference to "Exchange established by the State" somehow connotes an HHS Exchange. To the contrary, it reinforces that the reference to state Exchanges does not include HHS Exchanges. Precisely *because* the ACA calls for 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 state- and HHS-established Exchanges; its reference to *one* cannot be construed to include *both* simply because both exist.

2. Judge Edwards' panel dissent emphasized that the ACA directs HHS to establish "*such* Exchange," ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c) (emphasis added), referring back to the Exchange states are asked to establish. (A415) On this theory, the Act required the impossible: directing HHS to establish a "state-established Exchange." But "such" simply requires HHS to establish the same Exchange that the State would have established if it had chosen to establish one. If the provision had said "*an* Exchange," HHS could have created *any* type of Exchange; "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 that "the State would otherwise have established." *But it is established by HHS, not the state*. And that is the critical fact, under § 36B, for subsidy purposes. As the 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." (A379)

The contrary view fails because an Exchange is established either by a state or by HHS; it cannot be both at once. A "federally established state-established Exchange" is an oxymoron. If Congress asked states to build certain airports, and described the airports in great detail, but added that the Secretary of Transportation should construct "such airports" if states fail to, would anyone refer to the latter as "state-constructed airports"? Obviously not.

3. Yet another iteration of the same argument is that, when a state fails to establish an Exchange, HHS establishes one "*on behalf of*" the state and thus, by some bizarre transitivity, the HHS-established Exchange is "established by the State." (A352-53 (district court); A415 (Edwards, J.)) The premise is wrong, and the conclusion does not follow in any event.

First, the ACA does not say that HHS should establish an Exchange "for" or "on behalf of" the state. It says that HHS should establish an Exchange "within" a declining state. ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). That language signifies *geography*, not *agency*. Moreover, the crucial fact allowing HHS to act is the state's *failure* to act, making it particularly illogical to describe HHS as acting on the state's behalf. Since HHS is doing something the state has rejected doing, it cannot be acting *on the state's behalf*—only acting "instead of" the state.

In any event**,** even if the Act expressly directed HHS to establish an Exchange "on the State's behalf," that Exchange would still be established *by HHS for the state*, not "*by the State*," which is what matters under § 36B. The only way one could equate HHS- and state-established Exchanges would be if the Act's plain language instructed that the HHS Exchanges should be "deemed" to be established by the state. But the Act does no such thing, which, as the panel explained, "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."

(A380) Specifically, § 1323 of the Act provides that if a U.S. territory establishes an Exchange, it "shall be treated as a State" for such purposes. ACA §1323(a)(1), *codified at* 42 U.S.C. § 18043(a)(1). This conclusively demonstrates that Congress knew how to create such equivalence when it wanted to, but there is no provision adopting such language for federal Exchanges.

Likewise, an earlier House version of the ACA—which created a national Exchange but allowed states to "opt-in" to run Exchanges themselves—also stated *expressly* that, if a state opted-in, "any references in this subtitle to the Health Insurance Exchange … shall be deemed a reference to the State-based Health Insurance Exchange." (A247-48 (H.R. 3962, § 308(e), 111th Cong. (2009)) No equivalent language regarding HHS Exchanges appears in the ACA as enacted.

The point is that even if the ACA allows HHS to "step into the shoes" of the state and establish an Exchange in its place, that hardly means the HHS Exchange *is* "established by the State." When Congress wants the federal government to step into the shoes of an entity *and be treated as if it were that entity*, it always 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 "the 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 providing

that FDIC "shall … succeed to … all [their] rights, titles, powers, and privileges"). In all the U.S. Code, there is not a single example of Congress "deeming" one entity to be another *without saying so*.

4. Nor does the ACA's global definition of "Exchange" add anything further. The Act defines "Exchange" as "an American Health Benefit Exchange established under section 1311." ACA § 1563(b)(21). If anything, that makes *Appellants'* argument stronger, as it suggests that § 36B's mere use of the term "Exchange"—even *without* the qualifiers "established by the State under section 1311"—should be read as limiting subsidies to the state-run Exchanges established under that section. Yet, to avoid doubt, Congress clarified further.

Conversely, the definition does nothing to advance the Government's argument. Even absent the definitional section, it would be crystal clear that the HHS-established Exchange should be the same as the Exchange the state should ("shall") create under "Section 1311." So the definition adds nothing not already clearly conveyed by "such." And, again, the dispositive point is that, however the HHS-created Exchange is characterized, it is created by *HHS*.

At most, as the panel recognized, this definition could sow doubt over the metaphysical, immaterial question whether Exchanges established by HHS pursuant to § 1321 of the ACA are established "under" that section (as HHS regulations recognize, 45 C.F.R. § 155.20) or rather "under" § 1311. (A379-380)

But this metaphysical ambiguity over whether the HHS-established Exchange is a "§ 1311" or "§ 1321" Exchange creates no ambiguity over the only relevant question: whether it is "established by the *State*." Indeed, the plain language of § 36B directly *eliminates* any *potential* ambiguity. A careful draftsman instructed to eliminate subsidies on HHS Exchanges, and who noted the potential "§ 1311" ambiguity created by the definitional section, would authorize subsidies on an "Exchange established *by the State* under Section 1311," rather than just one "established under Section 1311." Needless to say, the fact that § 36B's language is the language *best designed* to *eliminate* any ambiguity created by the definitional section precludes construing § 36B as ambiguous *because of* that section.

Raising a theory that even the Government has not pressed, Judge Edwards pointed to the specification—in § 1311 itself—that an Exchange must be "a governmental agency or nonprofit entity that is established by a State." ACA § 1311(d)(1), *codified at* 42 U.S.C. § 18031(d)(1). According to Judge Edwards, this means that "established by the State" is simply "term of art that includes any Exchange within a State." (A415) That does not rationally follow. Section 1311 is the ACA provision that directs states to establish Exchanges. Obviously it deals only with state-established Exchanges, and § 1311(d)(1) simply provides that the state-created Exchange can either be a state-created "agency" or state-created "nonprofit entity." (A381-384) The fact that "Exchange established by the State"

denotes an agency or non-profit established by the state cannot rationally imply that it denotes *any* Exchange, even one established by *HHS*. Thus, this definitional argument suffers from precisely the same flaw as the countertextual interpretation of § 36B it is trying to "solve"—both wrongly equate an Exchange "established by the State" with one "established by HHS."

5. Judge Edwards also objected that the phrase "Exchange established by the State under section 1311" appears in the formula for calculating the subsidy (specifically, the definition of "premium assistance credit amount"), as opposed to the provision defining the "applicable taxpayers" eligible for subsidies. This supposedly "sits awkwardly with the section's structure." (A416) Not at all.

The "applicable taxpayer" provision only specifies the *people* eligible for subsidies, while the "premium assistance credit amount" provision specifies the *purchases* eligible for subsidies. Indeed, all agree that the same "formula" that Appellants rely on is the *only* ACA provision that limits subsidies to coverage purchased on an Exchange (as opposed to directly from insurers). Thus, as the panel majority 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." (A382 n.4) The statutory formula simply goes one step further, also limiting subsidies to coverage purchased on an Exchange *established by a state*.

Nor is it unusual for Congress to insert conditions on receipt of a tax credit into the formula for calculating its value, as opposed to using the magic words "if, then"—even if the conditions require states to take action to render their citizens eligible for the credit. Indeed, as the panel noted (A382 n.4), a *neighboring* health-related tax credit uses an analogous structure, first broadly providing a credit for any "individual" based on the cost of health coverage "for eligible coverage months," and then defining "eligible coverage month" as one during which the individual is covered by certain types of insurance only if the state has "elected" to impose guaranteed-issue and community-rating regulations. 26 U.S.C. § 35(a), (b), (e). In other words, taxpayers are entitled to credits for "coverage months" but cannot qualify unless their state has agreed to take specific action. Notably, the § 35 "coverage months" structure echoed by § 36B was also devised by Senator Baucus, Chairman of the Finance Committee that drafted § 36B. *See* Amici Br. of Michael Cannon & Prof. Jonathan Adler at 17-18.

Similarly, in the ACA itself, the Medicaid "deal" is set forth in a provision defining Medicaid eligibility—just like the condition on subsidies here. *See* ACA § 2001(a), *codified at* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (amending definition of who must be eligible for state Medicaid coverage). Judge Edwards wrongly claimed that the ACA's Medicaid provision, by contrast to § 36B, "lays out an express conditional statement in the form of '*if, then*.'" (A422) That is manifestly

incorrect. The cited provision is 42 U.S.C. § 1396c, which sets forth the standards for *discontinuing* Medicaid payments to states when it has been determined, "after reasonable notice and opportunity for hearing," that the state's Medicaid "plan has been so *changed*" that "it *no longer* complies with the [eligibility] provisions of Section 1396a," requiring termination of "*further payments*" (emphases added). Thus, § 1396c sets forth the due process to follow before taking the draconian step of cutting off funds already provided. The relevant analogy here, however, is whether the Medicaid provision's *condition* for eligibility for Medicaid funds differed from that of § 36B, by issuing clear "warnings" or adopting an "if, then" formulation. In fact, the Medicaid condition is materially indistinguishable from § 36B. The "condition" is never stated as such; the statute simply defines a "State plan for medical assistance" (*e.g.*, whom it must cover) and then appropriates funds for "each State which has a plan approved under this subchapter." *Id*. §§ 1396a, 1396b. And the ACA's historic, uniquely unconstitutional *addition* to that spending condition simply added some words to the existing eligibility formula—there was no "warning" that the ACA had dramatically changed the Medicaid "deal" in a manner dispositively different from the original "deal" and subsequent eligibility amendments. *See generally Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012) ("*NFIB*").

6. Ultimately, even the Government does not actually believe that HHS Exchanges are, in fact, state-established. HHS regulations themselves concede that federal Exchanges are "established … by the Secretary under *section 1321(c)(1)*," not a state under *§ 1311*. 45 C.F.R. § 155.20. And the definition of "Exchange" that the IRS adopted encompasses any Exchange, "regardless of whether [it] is established and operated by a State … or by HHS." *Id.* HHS, at least, is under no illusions about who establishes state- and HHS-established Exchanges.

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

* * *

In short, the IRS Rule "engage[s] in distortion, not interpretation." (A406 (Randolph, J., concurring)) The Government has offered confusion, distractions, and non-sequiturs, but cannot deny that HHS Exchanges are unambiguously not "established by the State." That ought to be the end of this case.

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

Because the subsidy provision itself is concededly "plain and unambiguous," this Court's analysis should "en[d] with the text." *Chao v. Day*, 436 F.3d 234, 235 (D.C. Cir. 2006); *Performance Coal Co. v. Fed. Mine Safety & Health Review Comn'n*, 642 F.3d 234, 238-39 (D.C. Cir. 2011). The only permissible basis for the "extraordinary" step of departing from "plain language" is if the text creates an *absurd* result. *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488, 494 (D.C. Cir. 2004) (Roberts, J.). "[W]hen the statute's language is plain, the sole function of the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms." *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). And, given the risks of substituting judges' policy views for those of Congress, the absurdity doctrine requires "an extraordinarily convincing justification." *Appalachian Power Co. v. EPA*, 249 F.3d 1032, 1041 (D.C. Cir. 2001) (per curiam). No such justification is even remotely present here.

1. Construing the ACA to provide subsidies only for coverage purchased on state-established Exchanges is plainly not absurd. Given the plausible concern that states would be reluctant to undertake the thankless job of establishing and operating Exchanges, offering them a seemingly irresistible incentive—billions of dollars in federal subsidies to their citizens—is extraordinarily sensible. 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 is eminently sensible not to treat states that reject the invitation to establish an Exchange just as well as those who agree to bear that burden. Indeed, treating them equally is plainly *not* sensible because it eliminates any incentive to establish Exchanges.

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* of their Medicaid funds. *See NFIB*, 132 S. Ct. at 2601 ("Congress is coercing the States to adopt the changes it wants by threatening to withhold all of a State's Medicaid grants … ."). To be sure, Congress wanted and expected all states to comply with those new conditions, and in that sense intended for all states to continue to receive Medicaid funds. Yet, quite obviously, if a state had nonetheless refused to comply with the new rules, it could not have asked a court to ignore the ACA's plain text on the ground that it would be "absurd" to deprive it of all of its Medicaid funds, given the Act's strong "purpose" of expanding, not contracting, Medicaid.

The district court claimed that there was "no evidence … in the legislative history of any intent by Congress" to offer states this deal as a means of inducing them to establish Exchanges. (A358) That is not true (*see infra* Part I.D.2)—but the fundamental point is that the legislative history (and certainly its absence) is

irrelevant. When text is plain, the only question is whether it is *objectively absurd*, not whether Congress *subjectively* intended its *non-absurd* result. *Lamie*, 540 U.S. at 534. "[C]lear text speaks for itself and requires no 'amen' in the historical record." (A394) To require legislative history proving that Congress intended the text's *clearly reasonable* result eviscerates the absurdity and plain-language doctrines. "[T]here would be no need for a rule … that there should be no resort to legislative history when language is plain and does not lead to an absurd result, if the rule did not apply precisely when plain language and legislative history may seem to point in opposite directions." *Totten*, 380 F.3d at 494-95.

Indeed, given the Act's plain text, even legislative history explicitly stating that subsidies are *not* limited to state Exchanges would not suffice to overcome it. *Performance Coal*, 642 F.3d at 238. Obviously, then, the purported absence of legislative history *echoing* the statute's language, or expressing the self-evident point that limiting federal subsidies to state Exchanges would induce states to create their own Exchanges, is utterly meaningless. Again, there is no legislative history echoing or explaining that Medicaid funds are conditioned on the state's adoption of more generous eligibility criteria or that § 36B subsidies are limited to coverage bought on an Exchange. But it would be manifest error to eliminate those textual conditions and limitations on that basis, as it would be here.

2. Nor would giving the subsidy provision its plain-text meaning create absurdity as to any *other* ACA provision. While the Government has criticized the panel for applying an absurdity standard, the Supreme Court last Term made clear that apparent statutory "anomalies" are no basis to depart from 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). Anyway, the alleged anomalies either do not result from Appellants' reading of § 36B, or are not anomalous. Even the Fourth Circuit was "unpersuaded" by the Government's claims about these provisions, recognizing "reasonable arguments and counterarguments" that precluded treating the so-called anomalies as probative of Congress's intent. *King*, 759 F.3d at 371.

a. Reporting Requirement. The Government argues that one of the Act's reporting requirements, which expressly calls for *both* types of Exchanges to report information about enrollees, premiums, and subsidies, 26 U.S.C. § 36B(f), would serve no purpose if the HHS Exchanges could not offer subsidies. That is wrong. Treasury has good, obvious reasons to want this data even for plans that are not subsidized. As Judge Griffith explained, that is why the reporting extends to *all* plans obtained on Exchanges—including those purchased by individuals ineligible for subsidies (because, *e.g.*, their income is too high). (A388)

Most obviously, "reporting by [HHS] Exchanges still serves the purpose of enforcing the individual mandate." (A387) The Government responds that another ACA provision, 26 U.S.C. § 6055, already requires *insurers* to report such information to the IRS, and thus that § 36B(f)(3) reporting serves no purpose other than to allow the IRS to track subsidy payments. But this conclusion does not follow. It is undisputed that the § 36B(f)(3) information reported by Exchanges includes information irrelevant to subsidies, thus showing that it serves a broader purpose. This conclusion is in no way altered by the fact that insurers also provide information relevant (and irrelevant) to subsidies. It simply reflects duplicative reporting—which is ubiquitous in the Act, *e.g.*, ACA §§ 1311(e), 1313, 1314, and which makes particularly good sense here because there is an especially obvious reason not to rely on *insurers* alone for this information: Exchanges have more comprehensive information than any particular insurer, and the Act was broadly premised on distrust of insurers. This is why the IRS affirmatively elected to use the *Exchanges'* reporting of coverage information over that provided by insurers, by *exempting* the insurers from their § 6055 reporting requirements where the two sets of reports would overlap. 79 Fed. Reg. 13220, 13221 (Mar. 10, 2014). The notion that reporting by HHS Exchanges "serves no purpose other than reconciling credits is therefore simply not true." (A388)

In addition, the very same section of the ACA calls for a comprehensive "study on affordable coverage" to be conducted, ACA § 1401(c); to conduct it, the Government obviously needs complete enrollment and premium data. (A388 n.5)

Finally, the § 36B(f)(3) reports must also be sent to the *enrollees*, so it serves a purpose wholly unrelated to IRS enforcement—*i.e.*, informing *consumers* about their health insurance, so they can understand what they have purchased, potentially correct mistakes, and, perhaps, lobby their states to establish Exchanges so that they can receive subsidies.

In sum, it is hardly odd—and not remotely absurd—for Congress to have required HHS Exchanges to conduct reporting. If anything, the reporting provision *confirms* § 36B's plain meaning by expressly including any "Exchange under section 1311(f)(3) or 1321(c)," proving that Congress knew how to refer to both.

b. Qualified Individuals. The provision following § 1311 defines "qualified individuals" as those who "resid[e] in the State that established the Exchange," ACA § 1312(f)(1)(A), *codified at* 42 U.S.C. § 18032(f)(1)(A), among other things. The Government argues that if the plain language governs, there would be no "qualified individuals" in states that did not establish Exchanges, and therefore that nobody could enroll in HHS Exchanges. (A355-56) Accordingly, it argues that the plain text should be ignored both in this provision and in § 36B.

But it is self-evident that Appellants' interpretation of § 36B will not lead to this absurd result in § 18032(f). Dispositively, not even the Government contends otherwise—it has not and will not suggest that, if Appellants' construction of § 36B is accepted, then this will somehow bleed over to § 18032(f), causing the mass expulsion of enrollees on federal Exchanges for failure to meet the requisite qualifications. To the contrary, there are many reasons why interpreting § 36B to mean what it says will create no "anomaly" or absurdity in the "qualified individual" provision.

At the threshold, if it is absurd to interpret "[r]eside in the State that established the Exchange" to be a prerequisite for enrollment on HHS Exchanges, the complete—and only permissible—solution is to excise the words causing the absurdity, *i.e.*, to read it as: "reside in the State [containing] the Exchange." It is certainly not to construe "state-established Exchange" to mean "HHS-established Exchange" and then *transport* that countertextual definition *throughout the Act*, even where, as in § 36B, it produces no absurdity. *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 statute, it "readily yields" where "context" so demands, *e.g.*, where it produces an absurd result in one section, but not another. *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2441 (2014).

There is also no absurdity. First, the "obvious flaw" in the Government's argument is that § 1312 does not establish a minimum eligibility criterion, *limiting* enrollment to "qualified individuals" and excluding all others. (A389) Entitled "Consumer Choice," the provision says only that a qualified individual "may enroll in any qualified health plan available to such individual and for which such individual is eligible." ACA § 1312(a)(1), *codified at* 42 U.S.C. § 18032(a)(1). It does not address enrollment by persons who are *not* "qualified individuals." In other words, this provision establishes a *floor* specifying who must be *included*, not a *ceiling* specifying who must be *excluded*. That this definition does not restrict enrollment is confirmed by other parts of the Act. *E.g.*, ACA § 1312(f)(3), *codified at* 42 U.S.C. § 18032(f)(3) (illegal alien "shall not be treated as a qualified individual" *and* "may not be covered … through an Exchange"); ACA § 1311(d)(2), *codified* at 42 U.S.C. § 18031(d)(2) (providing that Exchange "may not" sell plans other than "qualified *health plan[s]*" but not correspondingly limiting sales to qualified *individuals*). Thus, even if nobody in the states served by HealthCare.Gov is a "qualified individual," that does *not* mean that they may *not* be allowed to enroll in coverage, and so no absurdity arises. (A389-391)

Moreover, even if the "qualified individual" language is understood as an implicit restriction on enrollment, there is no anomaly because it would apply *only* where the "State … established the Exchange." The definition of "qualified

individual" is "with respect to an Exchange." 42 U.S.C. § 18032(f)(1)(A). Since "Exchange" is defined as an "Exchange established under section 1311," ACA § 1563(b)(21), the definition of "qualified individual" only applies to those § 1311 state-run Exchanges. It does not, therefore, limit enrollment on HHS Exchanges.[2] Again, dispositively, the Government *does not contest* this interpretation.

In short, the plain-text reading of "Exchange established by the State" in § 36B does not preclude enrollment on HHS-established Exchanges, or suggest that a countertextual reading of that phrase must be adopted to avoid absurdity.

c. Medicaid Maintenance of Effort. An ACA provision precludes states from tightening Medicaid eligibility until "the date on which the Secretary determines that an Exchange established by the State under section 1311 of [the ACA, *codified at* 42 U.S.C. § 18031] is fully operational." ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg)(1). (A356) This plain language forbids states from restricting Medicaid eligibility in that state unless it establishes an Exchange.

Far from being absurd, this "seem[s] sensible." (A392) Congress wanted to induce states to run Exchanges, and the maintenance-of-effort proviso creates a

[2] Even if the "qualified individual" definition is read as a limit on enrollment and applicable to HHS Exchanges, it does not mean nobody is eligible to enroll on the latter. After all, one who seeks to enroll through an HHS Exchange does not *fail* the requirement that he "resid[e] in the State that established the Exchange." That definition simply rests on the assumption that a state-created Exchange exists; where that assumption proves false, it has no application. By contrast, the subsidy provision does not *assume* a state-created Exchange; it *limits* subsidies to such.

substantial "stick" if they fail to. Further, Congress would obviously want to preserve Medicaid benefits for the most impoverished in states where low-income people could not access Exchange subsidies. Notably, the Government *agrees* that this was the provision's purpose *until 2014*, *i.e.*, that Congress wanted to "freeze" Medicaid because the States *could not* establish Exchanges with subsidies until 2014. (Govt. Br. 32.) Congress surely would have imposed the same limit (and incentive) on states that *chose not to* establish Exchanges *after* 2014.[3]

D. Legislative Purpose and History Are Irrelevant, But They Further Confirm the Plain Meaning of the Subsidy Provision.

Because the text of the statute is clear and does not lead to any absurd results, there is no warrant to weigh policy or consult legislative history. As the Supreme Court just reiterated, an agency "has no power to 'tailor' legislation to bureaucratic

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[3] The district court (A356) cited another ACA provision, which says that if "funding shortfalls" prevent eligible children in a state from being covered by the Children's Health Insurance Program ("CHIP"), "the State shall establish procedures to ensure that the children are enrolled … through an Exchange established by the State under [section 1311 of the ACA, *codified at* 42 U.S.C. § 18031]." 42 U.S.C. § 1397ee(d)(3)(B). It further provides that, in such a case, children who so enroll shall be deemed eligible for subsidies, even though children eligible for CHIP are generally excluded. *See id*.

Again, this is quite sensible, if "established by the State" is given its plain-text meaning. For states served by *HHS* Exchanges, it would make no sense to require the *state* to ensure enrollment of children affected by funding shortfalls. Rather, it is *HHS* that should "step in and perform the same service." (A392 n.10) Moreover, the point of this provision is to prevent these children's CHIP eligibility from disqualifying them from § 36B subsidies. But those who live in states served by HHS Exchanges are not eligible for the subsidies anyway, and so this provision would be of no use to them.

policy goals by rewriting unambiguous statutory terms" or to "revise clear statutory terms" even if they "turn out not to work in practice." *Util. Air*, 134 S. Ct. at 2446. In any event, these inquiries only confirm the plain text. There is a very good reason why Congress would write the statute as it did, and there is not a scintilla of legislative history in any tension with the Act's plain language.

1. The district court simplistically reasoned that the ACA's goal was to make insurance "affordable," and expanding subsidies to federal Exchanges would promote that goal. (A357) Yet particularly with a complex Act like the ACA, "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam); *see also Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261 (1993) ("[V]ague notions of a statute's 'basic purpose' are … inadequate to overcome the words of its text …."). Rewriting a law "to further what a court perceives to be Congress's general goal … is simply too susceptible to error to be tolerated within our scheme of separated powers." *Consol. Rail Corp. v. United States*, 896 F.2d 574, 578 (D.C. Cir. 1990). That is, the only judicially cognizable statutory "purpose" is the "purpose" *expressed* in the *text*. Here, the ACA's "purpose" was not to "provide subsidies," but to "provide subsidies on state-established Exchanges," because the text only provides for subsidies in that circumstance.

Anyway, this "purpose" argument misses the point. Granted, Congress wanted subsidies to be broadly available. But it also wanted states to run Exchanges, and limiting subsidies to state Exchanges was a perfectly sensible (and probably the only) way to induce such participation (just as the ACA's condition on Medicaid funds was a sensible way to ensure state expansion of Medicaid). 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," a purpose that would "certainly comport with a literal reading of 26 U.S.C. § 36B's text." *King*, 759 F.3d at 372.

In the end, Congress's assumption about universal state establishment of Exchanges proved false only because the IRS failed to transmit to the states Congress's condition on the subsidies. Rather, the IRS Rule promised states the "quid" of subsidies without demanding the "quo" of Exchanges, thereby eliminating any incentive for states to establish their own Exchanges. Thus, there is good reason to believe that, if the original "deal" is restored, far more states would establish Exchanges for future years. *See* Louise Radnofsky, *States Try To Protect Health Exchanges from Court Ruling*, WALL ST. J., July 25, 2014 ("A leading proponent of a fully state-run exchange [in Illinois] said he believed legislators would back his position if the D.C. panel's decision is upheld.").

As noted, under this subsidies-above-all analysis, agencies could send billions of federal dollars to a state that *rejected* the Medicaid "deal," in the face of plain language foreclosing such expenditures. Similarly, this simplistic logic would mean that subsidies must be given even to those who buy coverage directly from insurers, instead of through an Exchange. In both cases, Congress obviously conditioned the benefits in order to induce certain actions it found desirable—*i.e.*, state expansion of Medicaid, and purchasing coverage through Exchanges. But, just as with § 36B, there is no legislative history *articulating* these incentivizing purposes or "warning" about the consequences of *not* satisfying the plainly-stated conditions. Yet, just as with § 36B, it would clearly be improper to rewrite the limitations plainly set forth in the text.

As these examples illustrate, a court cannot assign an abstract "purpose" to an entire statute and then use that purpose to override its plain text. The only "purpose" that can fairly be derived from the Act is to subsidize coverage on state Exchanges. No other part of the Act suggests any broader purpose to subsidize coverage outside this situation, or contradicts the plausible basis for such a purpose. Section 36B's text is therefore "conclusive evidence of Congress's intent." (A404)

2. The district court reasoned, however, that "there is simply no evidence in the statute itself or in the legislative history of any intent by Congress to ensure that states established their own Exchanges." (A358) The proof "in the statute,"

of course, is its *text*; the best evidence of what Congress "means in a statute [is] what it says there." *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992). And requiring *confirmation* of the plain meaning through legislative history is plainly improper. (A397) Indeed, the *absence* of legislative history "cuts *against*" the Rule because, without such history, there is not even a *potential* "basis for the court to conclude that [Congress] voted for a regulatory scheme other than that provided by the words in the statute." *Engine Mfrs. Ass'n v. EPA*, 88 F.3d 1075, 1091-92 (D.C. Cir. 1996) (emphasis added). As this Court noted there in an observation equally applicable here, "[t]he haste and confusion attendant upon the passage of this massive bill do not license the court to rewrite it; rather, they are all the more reason for us to hew to the statutory text because there is no coherent alternative to be gleaned from the historical record." *Id.* at 1092.

Anyway, the "scant legislative history" (A395) supports the proposition that Congress conditioned the subsidies on state creation of Exchanges as a means to induce states to act. To be sure, only sparse legislative history exists for the ACA in general because, at various important stages of the process, "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 King*, 759 F.3d at 371 ("[T]he legislative history of the Act is

somewhat lacking, particularly for a bill of this size."). And, specifically, Congress barely discussed federal Exchanges during legislative debate, likely because the uniform consensus was that states would establish their own. *See* Pear, *U.S. Officials Brace for Huge Task*, *supra* ("Mr. Obama and lawmakers assumed that every state would set up its own exchange."); Viebeck, *Obama Faces Huge Challenge*, *supra* ("The law assumed states would create and operate their own exchanges …."). Legislative history is thus "not particularly illuminating on the issue of tax credits." *King*, 759 F.3d at 371. It "sheds little light on the precise question at issue." (A395) But what little history does exist shows that conditioning subsidies on state Exchanges was a proposal adopted by the Senate, forced onto the House when ACA supporters lost their filibuster-proof majority, and clearly understood by the Act's architects.

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

That was hardly a novel suggestion; Congress, after all, used—in the very same Act—the same "too good to turn down" offer of huge federal grants to coerce states to expand Medicaid. *NFIB*, 132 S. Ct. at 2601. And Congress previously conditioned *other* tax credits on state compliance with federal health policies. 26 U.S.C. § 35(a), (e)(2). More generally, using federal grants to induce state action is ubiquitous, forming the basis for Medicaid and CHIP, among other programs.

In all events, the Senate committees working on ACA legislation took up Professor Jost's suggestion. The Health, Education, Labor, and Pensions ("HELP") Committee proposed a draft bill that would have conditioned subsidies for a state's residents on the state's adoption of certain "insurance reform provisions" and on its agreement to sponsor coverage for state and local employees. S. 1679, § 3104(a), (d), 111th Cong. (2009). If a state failed to take those steps, "the residents of such state *shall not be eligible for credits*." *Id.* § 3104(d)(2) (emphasis added). That alone is ample evidence, as Judge Griffith noted, that "members of Congress at least considered the notion of using subsidies as an incentive to gain states' cooperation" (A397), belying the Government's claim that this policy is so absurd that no legislator ever contemplated it. The Senate Finance Committee, whose version of the bill in this respect became law, simply conditioned subsidies on state establishment of Exchanges, rather than on states' adoption of insurance reforms.

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

Contrary to Judge Edwards' insistence that nobody understood the law's text to mean what it plainly says (A431-34), its incentive function was well understood by, among others, Prof. Jonathan Gruber, a leading ACA architect who helped "draft the specifics of the legislation," Catherine Rampell, *Mr. Health Care Mandate*, N.Y. TIMES, Mar. 29, 2012, at B1. As he 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 that 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&feature=youtu.be&t=31m25s. *See Pruitt*, No. 6:11-cv-00030, slip op. at 19 n.24 (citing Gruber's comments to rebut Judge Edwards).

Moreover, contrary to the district court's (A358) and Judge Edwards' (A433) unsupported contentions, a crystal-clear purpose of the Act was to have states run

Exchanges. That Act says that states "shall" establish Exchanges and authorizes funding for state-run Exchanges. ACA § 1311(a), (b), *codified at* 42 U.S.C. § 18031(a), (b). That is the strongest possible language to "cajol[e]" state participation. (A379) The reason for this is standard federalism policy: As critical swing Senator Ben Nelson put it, a federal Exchange "would start us down the road of federal regulation of insurance and a single-payer plan." Brown, *Nelson: National Exchange a Dealbreaker*, *supra*. Indeed, that is why the House bill—which *allowed* states to run Exchanges but provided no incentives to do so—was concededly "politically untenable and doomed to failure in the Senate." (A360)

3. There is certainly no legislative history *contradicting* the subsidy provision's text. The district court noted a Congressional Budget Office ("CBO") report, which, in forecasting the cost of premiums, assumed (like Congress) that subsidies would be available everywhere. (A361) Of course, that analysis was conducted years before any state had opted out of establishing an Exchange, so there would have been no principled basis to assume that any of them would.

Rather, the natural assumption—the one Congress evidently made—was that no state would turn down its irresistible "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 obviously does not imply that Congress thought its Medicaid spending was unconditional, the assumption about subsidies does not imply that Congress thought subsidies were unconditional. Both conditions are obvious, and both CBO assumptions merely reflected the very plausible view that all states would participate in both programs.[4]

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

For four reasons, *Chevron* deference does not affect this analysis. *First*, the ACA's text is unambiguous, and Congress did not intend to delegate this matter of enormous importance to the IRS. *Second*, even if there were some ambiguity, it would be resolved by the "clear statement" rule for tax exemptions and credits, not by the agency. *Third*, ambiguity in Title 42 of the U.S. Code, as opposed to the Internal Revenue Code, is not within the IRS's power to resolve. *Fourth*, the IRS Rule is in any case not a reasonable construction of any ambiguity that may exist.

[4] The district court cited a committee report stating that HHS would contract to establish "state exchanges" in states that failed to do so. (A193) Two sentences earlier, however, the report explained that HHS would contract to establish Exchanges "*within the* state." (A193 (emphasis added)) The subsequent short-hand thus obviously referred to "state-based" Exchanges, not nonsensical "HHS-established state-established" Exchanges.

A. The Relevant Statutory Text Is Unambiguous, and Congress Did Not Intend a Delegation to the IRS.

If Congress has "unambiguously expressed [its] intent" in the statute, "that is the end of the matter." *Chevron*, 467 U.S. at 842-43. Moreover, "ambiguity is not enough per se to warrant deference to the agency's interpretation. The ambiguity must be such as to make it appear that Congress either explicitly or implicitly delegated authority to cure that ambiguity." *Am. Bar Ass'n v. FTC*, 430 F.3d 457, 469 (D.C. Cir. 2005). In that regard, the Supreme Court recently clarified that it "expect[s] 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; *see also Loving v. IRS*, 742 F.3d 1013, 1021 (D.C. Cir. 2014).

Few decisions will have greater "economic and political significance" than one triggering tens or hundreds of billions of dollars per year in federal spending and expanding major components of the groundbreaking ACA to more than two-thirds of the states. As such, it is inherently implausible that Congress intended to implicitly direct the IRS to exercise its *discretion* on that question (particularly since it relates to *fiscal expenditures*). The IRS Rule is a major policy in search of ambiguity as a hook to sustain it, not a mere "detail" that Congress intended the IRS to fill—and that is precisely 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 Venerable "Clear Statement" Rule for Tax Exemptions and Credits.

The premise of *Chevron* deference is that the agency may resolve ambiguity and consequently expand the 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. *See* 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). Similarly, 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, in *INS v. St. Cyr*, 533 U.S. 289 (2001), the Court held that "a statute that is ambiguous with respect to retroactive

application is construed … to be unambiguously prospective" given the presumption against retroactivity, such that "there is, for *Chevron* purposes, no ambiguity in such a statute." *Id.* at 320 n.45. *See also Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444-45 & n.8 (D.C. Cir. 1988) (refusing to defer because Indian law canon provides that if law "can reasonably be construed" in Tribe's favor, "it *must* be construed that way"); *Cal. State Bd. of Optometry v. FTC*, 910 F.2d 976, 982 (D.C. Cir. 1990) ("An agency may not exercise authority over States as sovereigns unless that authority has been unambiguously granted to it."). In all these cases, the interpretive principle, not the agency, resolves the ambiguity.

As explained earlier, the Supreme Court has adopted a canon holding that tax credits "must be expressed in clear and unambiguous terms." *Yazoo*, 132 U.S. at 183; *accord Wells Fargo Bank*, 485 U.S. at 354.[5] Such benefits "must rest … on more than a doubt or ambiguity." *United States v. Stewart*, 311 U.S. 60, 71 (1940). Only that "extremely high standard" properly respects Congress's "exclusive authority" over taxation and public spending. *Stichting*, 129 F.3d at 197-98.

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—

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

Chevron deference is displaced as to this dispute over the proper interpretation of 26 U.S.C. § 36B. The availability of § 36B tax credits in federal Exchanges "must be unambiguously proved," *Wells Fargo Bank*, 485 U.S. at 354; the IRS cannot by regulation extend the credits by resting on "doubt or ambiguity," *Stewart*, 311 U.S. at 71. As such, any ambiguity in § 36B must be construed against availability of the subsidy, and so "there is, for *Chevron* purposes, no ambiguity in [the] statute for [the IRS] to resolve." *St. Cyr*, 533 U.S. at 320 n.45. So long as § 36B "can reasonably be construed" to restrict the tax credit to state-established Exchanges, "it *must* be construed that way." *Muscogee (Creek) Nation*, 851 F.2d at 1445. It would be particularly inappropriate in *this* context to use agency discretion, rather than the interpretive canon, to resolve ambiguity. The whole point of the "clear statement" rule is to *prohibit* Executive "officers" from exercising "most dangerous discretion" over Treasury monies, in order to prevent "the control over public funds that the [Appropriations] Clause reposes in Congress [from] in effect … be[ing] transferred to the Executive." *Richmond*, 496 U.S. at 425, 428.[6]

[6] The Government has claimed that *Mayo Foundation for Medical Education and Research v. United States*, 131 S. Ct. 704 (2011), refutes this argument. But *Mayo* expressly *confirmed* that tax exemptions must be "construed narrowly." *Id.* at 715. Because the Government construed the exemption narrowly there, *Chevron* and the tax-credit canon reinforced one another. Here, however, the canon has the effect of eliminating any ambiguity, supplanting *Chevron*.

C. No *Chevron* Deference Is Owed Because the IRS Does Not Administer the Supposedly Ambiguous ACA Provisions.

The ACA subsidy provision is codified in the Internal Revenue Code, but nobody contends that the language of *26 U.S.C. § 36B* is ambiguous. Even on the Government's theory, only the provisions authorizing state and federal Exchanges, 42 U.S.C. §§ 18031, 18041, purportedly make it plausible to construe the Act as extending subsidies to the latter. (A352-53) Yet those provisions are codified in Title 42 of the U.S. Code—the domain of *HHS*, not the IRS.

Because the IRS has no power to administer those provisions, it is entitled to no deference in construing them. *U.S. Air Tour Ass'n v. FAA*, 298 F.3d 997, 1015-16 (D.C. Cir. 2002) (no deference to FAA where Secretary of Interior had "authority to interpret that [disputed] statutory term"); *Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.*, 250 F.3d 778, 782 (D.C. Cir. 2001) (no deference where agency interpretation rested, "in part," on "legislative enactments that are not part of its enabling statute"); *Cheney R.R. Co. v. R.R. Ret. Bd.*, 50 F.3d 1071, 1073-74 (D.C. Cir. 1995) (no deference where issue "turn[ed] on the interpretation" of laws "not the Board's governing statutes"). Indeed, the IRS itself recognizes that it has no authority to construe the term "Exchange" in Title 42, which is why its Rule simply adopts *HHS's* definition. 26 C.F.R. § 1.36B-1(k). Subsidy eligibility under the Rule is thus wholly dependent on *HHS's* definition, which was written for other purposes and which HHS may change at any time.

It does not matter that the subsidy provision in the Internal Revenue Code uses the term "Exchange" and cross-references Title 42. In *American Federation of Government Employees v. Shinseki*, a law administered by Veterans Affairs ("VA") used the term "collective bargaining" and cross-referenced the Federal Service Labor-Management Relations Statute ("FSLMRS"). 709 F.3d 29, 33 (D.C. Cir. 2013). The latter law defined "collective bargaining," but this Court owed no deference "to the VA's interpretation of the FSLMRS because the VA does not administer that statute." *Id.* The same is true here: The IRS "does not administer" the provisions of Title 42, and so is owed no deference as to their meaning. *See id.*

In short, the IRS does *not* administer the provisions purportedly creating the ambiguity and the provision it *does* administer creates no ambiguity.[7]

D. In All Events, the IRS Rule Is an Unreasonable Construction.

Even setting aside all the above, the IRS Rule fails "Step Two" of *Chevron*. Even "[i]f a statute is ambiguous, … the agency's interpretation must still stay within the boundaries of the statutory text." *EME Homer City Generation, L.P. v. EPA*, 696 F.3d 7, 23 (D.C. Cir. 2012). Under Step Two, "the court's deference to the [agency] is still limited by the particular language" of the statute; "whatever

[7] Contrary to Judge Edwards' dissent (A411), *National Association of Home Builders v. Defenders of Wildlife*, 551 U.S. 644 (2007), is not to the contrary. The provision there expressly designated two agencies to implement the statutory mandate. *See id.* at 652. Nothing in the ACA designates HHS to construe 26 U.S.C. § 36B or authorizes the IRS to implement Title 42.

ambiguity may exist cannot render nugatory restrictions that Congress has imposed." *AFL-CIO v. Chao*, 409 F.3d 377, 384 (D.C. Cir. 2005). For the reasons discussed above, the IRS Rule is not a *reasonable* construction of the ACA. Any ambiguity that may exist cannot justify ignoring statutory text, rejecting canons of construction, and eliminating the incentives for states to establish Exchanges.

CONCLUSION

For these reasons, this Court should reverse the judgment below.

October 3, 2014

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 13,908 words, excluding the parts of the brief exempted by that Rule and D.C. Cir. R. 32(a)(1), as counted using the word-count function on Microsoft Word 2007 software.

October 3, 2014

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CERTIFICATE OF SERVICE

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

October 3, 2014

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STATUTORY & REGULATORY ADDENDUM

No. 14-5018

Jacqueline Halbig, *et al.*, Appellants
v.

Sylvia Burwell, Secretary of Health and Human Services *et al.*, Respondents.

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42 U.S.C. §18031 (ACA § 1311)

§18031. Affordable choices of health benefit plans

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

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

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

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

(4) Renewability of grant.--

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

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

(I) establishing an Exchange; and

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

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

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

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

(b) American Health Benefit Exchanges.--

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

(A) facilitates the purchase of qualified health plans;

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

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

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

(c) Responsibilities of the Secretary.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Internet portals.--

The Secretary shall-

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

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

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

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

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

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

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

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

(d) Requirements.--

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

(2) Offering of coverage.--

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

(B) Limitation.--

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

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

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

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

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

(B) States may require additional benefits.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) transfer to the Secretary of the Treasury-

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

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

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

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

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

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

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

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

(5) Funding limitations.--

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

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

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

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

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

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

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

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

(e) Certification.--

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

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

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

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

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

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

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

(3) Transparency in coverage.--

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

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

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

(vi) Data on rating practices.

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

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

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

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

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

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

(f) Flexibility.--

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

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

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

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

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

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

(3) Authority to contract.--

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

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

(i) a person-

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Quality improvement.--

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

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

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

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

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

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

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

(i) Navigators.--

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

(2) Eligibility.--

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

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

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

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

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

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

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

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

(C) facilitate enrollment in qualified health plans;

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

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

(4) Standards.--

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

(i) be a health insurance issuer; or

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

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

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

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

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

42 U.S.C. §18041 (ACA § 1321)

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

(a) Establishment of standards.--

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

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

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

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

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

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

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

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

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

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

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

(1) In general.--

If-

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

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

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

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

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

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

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

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

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

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

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

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

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

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 U.S.C. §§ 1396 *et seq.*], finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902 [42 U.S.C. § 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 U.S.C. §36B (ACA § 1401(a))

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

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

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

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

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

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

(B) the excess (if any) of-

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

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

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

(A) Applicable percentage.--

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

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

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

(ii) Indexing.--

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

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

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

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

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

(ii) provides-

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

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

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

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

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

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

(D) Additional benefits.—

If-

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

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

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

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

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

(1) Applicable taxpayer.--

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

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

If-

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

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

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

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

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

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

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

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

(B) Exception for minimum essential coverage.--

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

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

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

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

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

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

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

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

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

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

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

(3) Definitions and other rules.--

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

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

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

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

(2) Household income.--

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

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

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

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

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

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

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

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

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

(3) Poverty line.--

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

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

(e) Rules for individuals not lawfully present

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

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

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

(i) A method under which-

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

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

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

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

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

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

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

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

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

(2) Excess advance payments

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

(B) Limitation on increase

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

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

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

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

(I) such dollar amount, multiplied by

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

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

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

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

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

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

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

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

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

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

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

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

26 C.F.R. § 1.36B (Excerpts)

§1.36B-1 Premium tax credit definitions.

…

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

…

§1.36B-2 Eligibility for premium tax credit.

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

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

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

…

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

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

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

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

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

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

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

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

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

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

…

45 C.F.R. 155.20 (Excerpts)

§155.20 Definitions.

The following definitions apply to this part:

…

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

…

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

…