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

DAVID KING, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 3:13-cv-00630-JRS
	)	
KATHLEEN SEBELIUS, in her official capacity as U.S. Secretary of Health and Human Services, *et al.*,	)	
	)	
Defendants.	)	
	)	

DEFENDANTS' MEMORANDUM IN OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases: **Page**

Statutes:

Rules and Regulations:

Miscellaneous:

Introduction

The Patient Protection and Affordable Care Act ("ACA" or "Act") includes a series of measures that will expand the availability of affordable health coverage. In particular, the ACA creates new health insurance Exchanges, in which the purchasing power of individuals and small businesses will be combined so that they can buy more affordable insurance. States operate these Exchanges or, where a state has chosen not to do so consistent with federal standards, the federal government operates the Exchange in place of the state. The ACA provides for financial assistance and tax incentives to encourage the purchase of insurance, including premium tax credits for eligible individuals to help defray the cost of insurance purchased through the Exchange. 26 U.S.C. § 36B. These tax credits, which become available in 2014, will help millions of Americans purchase affordable health insurance.

The plaintiffs in this case seek to interfere with the Treasury Department's administration of these tax credits. They reside in Virginia, where the federal government is operating the Exchange. They read the ACA to provide for premium tax credits only for the purchase of insurance through a state-operated Exchange, not a federally-facilitated Exchange. They now ask the Court to issue a preliminary injunction that would require the Treasury to administer the ACA's tax credits in accordance with their reading of the statute. The plaintiffs are not entitled to the extraordinary relief of a preliminary injunction.

The plaintiffs are not likely to succeed on the merits, because they are unlikely to overcome threshold barriers that are fatal to their suit. First, they lack Article III standing. The plaintiffs contend that they would prefer to purchase a "catastrophic" plan on the new Exchange. Because they may do so only if they lack other affordable insurance options, they claim that the Section 36B tax credits harm them by making comprehensive insurance more

affordable for them, thereby preventing them from buying a catastrophic plan. But comprehensive coverage in the Exchange (subsidized by the tax credits) will be cheaper for the plaintiffs than a catastrophic plan. Their desire to buy a less generous, but more expensive, catastrophic plan does not state any cognizable injury for the purposes of Article III standing.

Second, the plaintiffs lack prudential standing. Congress had an obvious purpose in enacting Section 36B: to make insurance more affordable. The plaintiffs, however, seek to make insurance *less* affordable. Their purpose in bringing this suit is diametrically opposed to Congress's purpose, and they do not fall within the zone of interests that the statute protects.

Third, the plaintiffs' claims are not ripe to proceed now. They complain of their potential tax liability for a failure to maintain minimum health coverage. But their claims are not fit for resolution, because that potential liability would be decided on the basis of facts as established in a later tax refund proceeding, not on the basis of plaintiffs' allegations here. Nor do the plaintiffs suffer any hardship that could justify a departure from the principle that Article III courts should make decisions only when they have to, and then, only once.

Fourth, the plaintiffs may not bring this Administrative Procedure Act (APA) action, because Congress has specified a different form of proceeding for their claims, namely, an action for a tax refund. Congress specified in unmistakable terms that a plaintiff seeking to litigate matters of federal tax liability must first pay the tax assessed, file an administrative refund claim, and only then proceed to federal court. The plaintiffs may not depart from the exclusive form of review that Congress provided for tax claims by filing a pre-enforcement APA action.

The plaintiffs are also not likely to succeed on the merits, because the Treasury Department has reasonably interpreted the ACA to provide for the tax credits that the plaintiffs challenge. The plaintiffs admit that, if a state runs an Exchange, individuals can obtain federal

tax credits for the insurance they purchase on the Exchange. But they assert that, if the *federal* government itself runs an Exchange, the same individuals cannot receive these *federal* tax credits. That assertion defies common sense, and ignores Congress's specification in 42 U.S.C. § 18041(c)(1) that the federally-facilitated Exchange would be the *same* entity as the Exchange that the Act contemplated that the state would create, as well as its specification in Section 36B itself that the federally-facilitated Exchange would administer the premium tax credits. Treasury's reading of the Act gives effect to these provisions, and avoids a series of anomalies that would be created under the plaintiffs' theory. Most notably, under the plaintiffs' theory, not only would federal premium tax credits be unavailable on the federally-facilitated Exchange, but no person could qualify to buy coverage at all (subsidized or not) under a plan offered on the federally-facilitated Exchange. Congress plainly did not intend this result.

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

In any event, the plaintiffs cannot satisfy the remaining elements for a preliminary injunction. They do not suffer any injury at all, let alone the immediate and irreparable injury required for a preliminary injunction. And they have an available remedy, namely, a tax refund

action to contest their potential liability under the ACA's minimum coverage provision, 26 U.S.C. § 5000A. Moreover, the public interest and the balance of the equities weigh heavily against granting the relief that the plaintiffs seek, that is, an order that would deprive millions of Americans of the access to affordable health coverage that the ACA has provided to them.

Background

I. The Affordable Care Act

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), to address a crisis in the national health care market. The claims raised by the plaintiffs here involve three features of the Act: (1) the health insurance Exchanges, which facilitate the purchase of insurance by individuals and small groups; (2) the availability of premium tax credits to assist individuals with the purchase of insurance on the Exchanges; and (3) the minimum coverage provision, which requires most individuals either to maintain qualifying coverage or to pay a tax penalty for the failure to do so.

A. The Health Insurance Exchanges

For the individual and small-group health insurance markets, Congress established health insurance Exchanges to serve "as an organized and transparent marketplace for the purchase of health insurance where individuals and employees (phased-in over time) can shop and compare health insurance options." H.R. REP. NO. 111-443, pt. II, at 976 (2010) (internal quotation omitted). The Exchanges allow qualified individuals and qualified employers to use the leverage of collective buying power to obtain prices and benefits that are competitive with those of large-employer health plans. 42 U.S.C. §§ 18031-18044. Among other functions, the Exchanges certify the qualified health plans offered on the Exchanges; determine the eligibility of individuals to enroll in these qualified health plans; determine the eligibility of individuals for

advance payments of the Act's premium tax credits and cost-sharing reductions (discussed below); and grant certifications that individuals are exempt from the penalty under the Act's minimum coverage provision (also discussed below). 42 U.S.C. § 18031(d)(4); 45 C.F.R. § 155.200 *et seq*. Each Exchange is also directed to report information to the IRS for the purpose of determining whether participants in that Exchange are eligible for premium tax credits. 26 U.S.C. § 36B(f)(3).

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

The Exchanges may also offer "catastrophic" plans. 42 U.S.C. § 18022(e); *see* 45 C.F.R. § 156.155. A catastrophic plan must provide coverage for at least three primary care visits per year, and it must also cover essential health benefits, but only after the insured person has incurred the annual limitation on cost-sharing expenses. 42 U.S.C. § 18022(c), (e).[1] A catastrophic plan may not impose cost-sharing requirements on preventive health services. 42 U.S.C. § 18022(e); 45 C.F.R. § 156.155(a), (b). Enrollment in these plans is limited to persons

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

who are under 30 years of age, or whom the Exchange has certified to be exempt from the minimum coverage provision due to hardship or the lack of affordable insurance options. 42 U.S.C. § 18022(e); 45 C.F.R. § 156.155(a).

The Act provides that "[a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State." 42 U.S.C § 18031(d)(1); *see also* 42 U.S.C. § 18031(b)(1) ("Each State shall, not later than January 1, 2014, establish [an Exchange] for the State"). The Act does not impose any sanction, however, if a state elects not to establish an Exchange that complies with federal standards. Instead, the Act directs that, if the state does not create the "required Exchange," the Secretary of HHS shall "establish and operate such Exchange within the State." 42 U.S.C. § 18041(c)(1); *see* 45 C.F.R. § 155.105(f).

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

B. Premium Tax Credits and Cost-Sharing Reductions

Congress also enacted new premium tax credits and cost-sharing reduction payments in order to make health insurance more affordable. The Act establishes federal premium tax credits to assist eligible individuals with household incomes from 100% to 400% of the federal poverty level to purchase insurance through the new Exchanges. 26 U.S.C. § 36B. These premium tax credits, which are advanceable and fully refundable such that individuals with little or no income tax liability can still benefit, are designed to help make health insurance affordable by reducing a taxpayer's net cost of insurance. For eligible individuals with household from 100% to 250% of the federal poverty level, the Act also provides for federal payments to insurers to help cover those individuals' cost-sharing expenses (such as co-payments or deductibles) for

insurance obtained through an Exchange. 42 U.S.C. § 18071(c)(2); 45 C.F.R. § 155.305(g).

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

The amount of the premium tax credit available to a taxpayer under Section 36B varies depending on the taxpayer's household income. That amount is defined as the difference between the cost of the "applicable second lowest cost silver plan" available on the Exchange to the taxpayer and a defined percentage of the taxpayer's household income. 26 U.S.C. § 36B(b)(2), (b)(3). For example, a taxpayer with income at 200% of the federal poverty level could receive a credit that is equal to the cost of the second lowest cost silver plan available on the Exchange, less 6.3% of the taxpayer's household income. 26 U.S.C. § 36B(b)(3); 26 C.F.R. § 1.36B-3(g). A taxpayer need not purchase a silver plan to receive the premium tax credit. He or she may receive a credit in the same amount (subject to a cap equal to the amount of the premiums for the plan he or she purchases) for a cheaper bronze plan, or for a more expensive

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

gold or platinum plan. 26 U.S.C. § 36B(c)(3)(A). Premium tax credits are not available for the purchase of catastrophic plans, however. *Id.*

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

The Congressional Budget Office ("CBO") has projected that, by 2018, twenty million people, or 80% of people who buy non-group insurance policies through Exchanges, will receive premium tax credits. CBO, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act: May 2013 Baseline*, tbl. 3 (May 14, 2013). It has also projected that the average subsidy, for each person who receives subsidized coverage through the Exchanges, will amount to $5,290 per person in 2014, rising to $7,900 in 2023. *Id.*, tbl. 1. Those credits, on average, will cover nearly two-thirds of the premiums for policies purchased through the Exchanges. CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6-7 (Nov. 30, 2009).

Premiums for plans on the Exchanges will be substantially lower than previous projections. The cost of a silver plan is, on average, 16% lower than what was contemplated under the CBO's original projections, even before tax credits are considered. Office of the Ass't Sec'y for Planning & Evaluation, U.S. Dep't of Health & Human Servs., *ASPE Issue Brief:*

Health Insurance Marketplace Premiums for 2014 at 2-3 (Sept. 25, 2013). After taking tax credits into account, 56% of uninsured Americans may qualify for health coverage for less than $100 per person per month. *Id.* at 3-4.

C. The Minimum Coverage Provision

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

The Exchanges will administer some applications for exemptions from the minimum coverage provision. 42 U.S.C. § 18031(d)(4)(H). In particular, the Exchanges will provide a certificate of exemption to an applicant who shows that, based on his or her projected annual household income, his or her contributions toward coverage would exceed 8% of his or her

household income. 45 C.F.R. § 155.605(g)(2); *see* 45 C.F.R. § 155.615(f)(2) (describing procedures for verification of exemption applications on account of lack of affordable coverage). An applicant for an exemption under this unaffordability provision must apply before the last date on which he is eligible to enroll in a qualified health plan offered on the Exchange, *i.e.*, for the coming year, March 31, 2014. 45 C.F.R. § 155.605(g)(2)(v). The Exchanges will also exempt individuals who demonstrate financial hardship, such as "a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan." 45 C.F.R. § 155.605(g)(1). An applicant who is denied an exemption may pursue an administrative appeal of that denial before an HHS appeals entity; that appeal may be taken only after the applicant first exhausts any appeals that may be available in the Exchange. 45 C.F.R. § 155.505(b)(2), (c). This process is independent of the IRS's process for assessment of any penalty under the minimum coverage provision, however. The IRS will follow the same procedures for the assessment and collection of that penalty as those that apply to other taxes and penalties under the Internal Revenue Code, subject to limitations on levies and the filing of notices of liens. *See* 26 U.S.C. § 5000A(g).

II. This Litigation

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

The plaintiffs allege that, under the Treasury regulation, they will qualify for Section 36B premium tax credits. Compl., ¶¶ 11-14. They allege that these tax credits will make health insurance more affordable for them. Compl., ¶ 5. They contend that this *benefit* will *harm* them, because they would prefer that insurance be *unaffordable*, so that they could qualify for a certificate of exemption, which they would then use to purchase what they characterize as "cheaper, high-deductible catastrophic coverage." *Id.* The plaintiffs ask the Court to enjoin the Treasury Department from awarding premium tax credits to them, or to any participants in any of the federally-facilitated Exchanges. Mot. for Prelim. Inj. (ECF 6) at 1.

Argument

I. A Preliminary Injunction May Only Be Awarded Upon a Clear Showing that the Plaintiff Is Entitled to Such Relief

A preliminary injunction is "an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter v. Natural Res. Def. Council*, 555 U.S. 7, 22 (2008). "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Id*. at 20. These four factors must be met independently. *See Pashby v. Delia*, 709 F.3d 307, 320-21 (4th Cir. 2013). This burden is a heavy one; the plaintiffs must make a "clear showing" that they will likely succeed on the merits, and a separate "clear showing" that they will likely suffer irreparable harm if an injunction is not granted. *United States v. South Carolina*, 720 F.3d 518, 533 (4th Cir. 2013). Moreover, because the plaintiffs here ask the Court to upset the status quo by ordering mandatory preliminary injunctive relief, they face an even heavier burden. Such relief "in any circumstance is disfavored, and

warranted only in the most extraordinary circumstances." *Taylor v. Freeman*, 34 F.3d 266, 270 n.2 (4th Cir. 1994). No such extraordinary circumstances exist here.

II. The Plaintiffs Are Unlikely to Succeed on the Merits Because Their Suit Is Not Justiciable

A. The Plaintiffs Lack Article III Standing to Pursue This Action

"No principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or controversies." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 341 (2006) (internal quotation omitted). "One element of the case-or-controversy requirement" is that plaintiffs "must establish that they have standing to sue." *Raines v. Byrd*, 521 U.S. 811, 818 (1997). "The law of Article III standing, which is built on separation-of-powers principles, serves to prevent the judicial process from being used to usurp the powers of the political branches." *Clapper v. Amnesty Int'l USA*, 133 S. Ct. 1138, 1146 (2013). To establish Article III standing, an injury must be "concrete, particularized, and actual or imminent; fairly traceable to the challenged action; and redressable by a favorable ruling." *Id.* at 1147 (internal quotation omitted).

Under these standards, the plaintiffs do not have standing to challenge the Treasury regulation, because that regulation does not injure them at all; it only confirms that they are eligible for a *benefit*. The plaintiffs claim that they are harmed by this benefit, because they would prefer to buy "cheaper" catastrophic coverage, which they cannot do because the tax credits will make comprehensive health coverage affordable for them. But two plaintiffs, David King and Rose Luck, are already eligible to buy a catastrophic plan, so they suffer no injury even under their own theory. Declaration of Donald B. Moulds, ¶¶ 7, 10 (attached as Exhibit 1). In any event, catastrophic coverage will not be "cheaper" for any of the plaintiffs. After federal premium tax credits are applied, each of the plaintiffs will be eligible for coverage

under a comprehensive plan offered on the Exchange that will cost less than an (unsubsidized) catastrophic plan. *See* Moulds Decl., ¶¶ 7-10. Douglas Hurst, for example, would pay $62.49 for a bronze-level plan, but would pay $415.61 for an unsubsidized catastrophic plan. *Id.*, ¶ 8.

The plaintiffs' desire to spend more to obtain less generous coverage in a catastrophic plan, rather than spending less money to gain more comprehensive coverage in a bronze plan, is not a cognizable injury. "No [plaintiff] can be heard to complain about damage inflicted by [his] own hand." *Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976). *See McConnell v. FEC*, 540 U.S. 93, 228 (2003) (political candidates lacked standing to challenge law increasing limits on "hard money" contributions; injury was caused by "their own personal 'wish' not to solicit or accept large contributions, *i.e.*, their personal choice"), *overruled in part on other grounds by Citizens United v. FEC*, 558 U.S. 310 (2010). *See also Bhd. of Locomotive Eng'rs & Trainmen v. STB*, 457 F.3d 24, 28 (D.C. Cir. 2006) (self-inflicted injury is not traceable to defendant's actions). If the plaintiffs truly prefer catastrophic coverage, they may buy a bronze-level plan, and then submit only those claims that would be paid under a catastrophic plan. Their "own personal wish" not to do so does not state a legally recognized injury.

The plaintiffs also allege that their "financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities" from the possibility that they would later be assessed a penalty under the minimum coverage provision, if they do not buy a comprehensive plan. *E.g.*, Compl., ¶ 11. But a plaintiff "cannot manufacture standing by choosing to make expenditures based on hypothetical future harm that is not certainly impending," *Clapper*, 133 S. Ct. at 1143 – particularly when the hypothetical future harm that the plaintiffs fear is that they will *save* money that they don't want to save. In sum, the plaintiffs do not suffer any harm from a regulation that clarifies that they may buy a policy with

more generous coverage, for less money, than the policy they claim they would prefer to buy.

B. The Plaintiffs Lack Prudential Standing to Pursue this Action

In addition to Article III standing, a plaintiff must also show that he or she has prudential standing to invoke the jurisdiction of a federal court. The doctrine of prudential standing "embodies judicially self-imposed limits on the exercise of federal jurisdiction." *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11 (2004) (internal quotation omitted). The plaintiffs run afoul of one such limit on federal jurisdiction, because their claims do not "fall[] within the 'zone of interests' sought to be protected by the statutory provision whose violation forms the legal basis for [their] complaint." *Air Courier Conf. of Am. v. Am. Postal Workers Union AFL-CIO*, 498 U.S. 517, 523-24 (1991) (internal quotation omitted).

The APA allows judicial review of agency action by a "person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute." 5 U.S.C. § 702. An "adversely affected or aggrieved" plaintiff must be seeking to protect an interest that is "arguably within the zone of interests to be protected" by the statute in question. *Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians v. Patchak*, 132 S. Ct. 2199, 2210 (2012) (internal quotation omitted). Although this test "is not meant to be especially demanding," it forecloses suit when "a plaintiff's interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit." *Id.*

To analyze prudential standing, the court looks "to the particular provision of law upon which the plaintiff relies," *Bennett v. Spear*, 520 U.S. 154, 175-76 (1997); *see also Taubman Realty Group Ltd. P'ship v. Mineta*, 320 F.3d 475, 480 (4th Cir. 2003). The "particular provision of law" at issue here is 26 U.S.C. § 36B. Congress had an obvious purpose when it

enacted Section 36B to provide tax credits for the purchase of health coverage: "[t]o ensure that health coverage is affordable," and "to help offset the cost of private health insurance premiums." S. REP. NO. 111-89, at 4 (2009); *see also* H. REP. NO. 111-443, vol. II, at 977 (2010). The plaintiffs' interest in this suit, however, is diametrically opposed to Congress's purpose. They aim to ensure that health coverage is *unaffordable*, and to ensure that the cost of private health insurance premiums is *not* offset. Because the plaintiffs' interests are "inconsistent with the purposes implicit in the statute," *TAP Pharms. v. U.S. Dep't of Health & Human Servs.*, 163 F.3d 199, 203 (4th Cir. 1998), they may not proceed under the APA. *See also Tax Analysts & Advocates v. Blumenthal*, 566 F.2d 130, 141-44 (D.C. Cir. 1977) (noting that "zone of interests" tests applies particularly strictly in tax cases).[3]

In sum, the plaintiffs do not seek to fulfill the purposes that Section 36B serves; they seek instead to undermine those purposes. They therefore lack prudential standing to bring an action under the APA to challenge the Treasury Department's interpretation of that provision.

C. This Action Is Not Ripe

Even if the plaintiffs had standing, they could not justify bringing suit at this time, because the Treasury Department has not yet applied its regulation to the plaintiffs' circumstances. Their claims therefore are not ripe. The ripeness doctrine recognizes the principle that "federal courts may exercise power only in the last resort, and as a necessity." *Allen v. Wright*, 468 U.S. 737, 752 (1984) (internal quotation omitted). In determining whether

[3] Nor could the plaintiffs argue that they satisfy the zone of interests test because they are themselves "the subject of the contested regulatory action." *Clarke v. Sec. Indus. Ass'n*, 479 U.S. 388, 399 (1987). Section 36B is not a "regulatory action"; it simply provides a benefit, in the form of tax credits, to the plaintiffs. The plaintiffs' claim instead is that they are potentially subject to regulation under a different provision, 26 U.S.C. § 5000A. This does not support an APA action, however, because the plaintiffs must show that they are within the zone of interests of the "particular provision of law" on which they are suing. *Taubman Realty*, 320 F.3d at 480.

a case is ripe, the court "balance[s] the fitness of the issues for judicial decision with the hardship to the parties of withholding court consideration." *Doe v. Virginia Dep't of State Police*, 713 F.3d 745, 758 (4th Cir. 2013). "A case is fit for judicial decision when the issues are purely legal and when the action in controversy is final and not dependent on future uncertainties." *Miller v. Brown*, 462 F.3d 312, 319 (4th Cir. 2006). The fitness prong prevents the court "from considering a controversy until it is presented in clean-cut and concrete form." *Doe*, 713 F.3d at 758. The hardship prong is "measured by the immediacy of the threat and the burden imposed on the petitioner who would be compelled to act under threat of enforcement of the challenged law." *Id.* at 759 (internal quotation omitted). The plaintiffs must show that they would suffer "direct and immediate" hardship from the deferral of review. *Regional Mgt. Corp. v. Legal Servs. Corp.*, 186 F.3d 457, 466 (4th Cir. 1999).

Under these principles, the plaintiffs' claims are not ripe. They complain of their potential liability for the tax penalty under the minimum coverage provision, 26 U.S.C. § 5000A. Their claims are not fit for resolution, however, because this Court could not determine that liability. If any of the plaintiffs are assessed with that penalty, they may bring a refund action for a federal court to determine whether they were properly so assessed. *See* 26 U.S.C. § 7422. That action will be adjudicated by the facts as they exist at that future time – not on the facts alleged in this proceeding. Likewise, to the extent that the plaintiffs seek a certificate of exemption, this Court is not empowered to award that exemption. Instead, the plaintiffs must apply to the Exchange for that certificate. *See* 42 U.S.C. § 18031(d)(4)(H); 45 C.F.R. §§ 155.605(g)(2); 155.615(f)(2). The Exchange cannot award the plaintiffs an exemption on the basis of the facts alleged here; instead, the Exchange must conduct its own verification process before determining whether an exemption is warranted. *See* 45 C.F.R. §§ 155.320(c);

155.615(f)(2). Thus, the plaintiffs' eligibility for an exemption, or their liability for the Section 5000A tax penalty, is not presented here "in clean-cut and concrete form." *Doe*, 713 F.3d at 758. The fitness prong therefore requires this court to defer adjudication, so that the federal courts will decide the plaintiffs' claims "only when they have to, and then, only once," *Am. Petroleum Inst. v. EPA*, 683 F.3d 382, 387 (D.C. Cir. 2012), after the administrative process is complete.

Nor do the plaintiffs suffer any hardship at all, let alone one that is "direct and immediate," *Regional Mgt. Corp.*, 186 F.3d at 466. As noted, although the plaintiffs contend that they would prefer to buy catastrophic coverage, a comprehensive plan offered through the Exchange will in fact be *cheaper* for them, after Section 36B tax credits are applied. And, as to the plaintiffs' potential liability under the minimum coverage provision, it should suffice to note that the most that any of the plaintiffs could owe under that provision for 2014 is $330 for the year.[4] Because that tax penalty is assessed on a monthly basis, *see* 26 U.S.C. § 5000A(c)(2), the plaintiffs, if they wished, could bring a test case in a refund action after incurring a single month's tax penalty of no more than $27.50. This hardly makes out a claim of hardship (particularly given that the plaintiffs' claimed injury is that they prefer to pay far more than these amounts for catastrophic coverage). In any event, claims like the plaintiffs', which seek pre-application review of rules governing the award of benefits, are categorically unripe. *See Reno v. Catholic Soc. Servs.*, 509 U.S. 43, 57-61 (1993).

D. The Plaintiffs Must Follow the Form of Proceeding That Congress Specified

Although the APA generally provides for judicial review of agency action, it does not

[4] For 2014, the assessment under 26 U.S.C. § 5000A will not be greater than 1.0% of the excess of the taxpayer's household income over the statutory exemption and standard deduction amounts. 26 U.S.C. § 5000A(c); 26 C.F.R. § 1.5000A-4(b); *see also* 26 U.S.C. §§ 63(c), 151(d), 6012(a)(1)(D) (defining exemption and deduction amounts); Rev. Proc. 2013-15, 2013-5 I.R.B. 444 (describing cost-of-living adjustments to these amounts). One percent of Ms. Levy's projected 2014 income, after application of these amounts, would be, at most, $330.

create a cause of action in cases where Congress has specified other judicial review procedures. In such cases, "[t]he form of proceeding for judicial review is the special statutory review proceeding relevant to the subject matter in a court specified by statute," unless the statutorily specified review proceeding is "inadequa[te]." 5 U.S.C. § 703. Similarly, the APA provides that "[a]gency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review." 5 U.S.C. § 704. Congress specified a separate and adequate judicial remedy for the plaintiffs here – an action for a tax refund. The plaintiffs must bring their claims in that proceeding, and not in this APA action.

The APA "does not provide additional judicial remedies in situations where the Congress has provided special and adequate review procedures." *Bowen v. Massachusetts*, 487 U.S. 879, 903 (1988) (internal quotation omitted). "When Congress enacted the APA to provide a general authorization for review of agency action in the district courts, it did not intend that general grant of jurisdiction to duplicate the previously established special statutory procedures relating to specific agencies." *Id*.

The plaintiffs seek relief that would declare that they have no potential 2014 liability for the tax penalty under Section 5000A of the Internal Revenue Code. But Congress has specified that a plaintiff must bring a tax refund suit to dispute his or her liability for such assessment. *See* 28 U.S.C. § 1346(a). Before bringing such a suit, the taxpayer "must comply with the tax refund scheme established in the Code," *United States v. Clintwood Elkhorn Mining Co*., 553 U.S. 1, 4 (2008), including the requirements that the tax has been assessed, that the taxpayer has fully paid the tax, and has filed an administrative claim before bringing suit. 26 U.S.C. § 7422; *see United States v. Dalm*, 494 U.S. 596, 609-10 (1990). Congress thus has specified the procedures for the taxpayer to follow "in an unusually emphatic form." *Clintwood Elkhorn*,

553 U.S. at 7. Indeed, the Supreme Court has observed that "we cannot imagine what language could more clearly state that taxpayers seeking refunds of unlawfully assessed taxes must comply with the Code's refund scheme before bringing suit[.]" *Id*. at 8.

A tax refund action would afford the plaintiffs here adequate relief – payment in full, with interest, of any overpayment of their federal tax obligations, if they ultimately prevail. *See Bob Jones Univ. v. Simon*, 416 U.S. 725, 746-47 (1974) (tax refund suit offers adequate remedy); *see also Int'l Lotto Fund v. Virginia State Lottery Dep't*, 20 F.3d 589, 591 (4th Cir. 1994) (same). Because the plaintiffs have an available remedy under another statute, the plaintiffs must pursue that remedy, rather than bringing this APA action. *See Jersey Heights Neighborhood Ass'n v. Glendening*, 174 F.3d 180, 191-92 (4th Cir. 1999); *Randall v. United States*, 95 F.3d 339, 346 (4th Cir. 1996).[5]

III. The Plaintiffs Are Not Likely to Succeed on the Merits Because the Treasury Regulation Is Reasonable

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

The Treasury Department interprets 26 U.S.C. § 36B to provide that participants in any of the Exchanges, whether state-operated or federally-facilitated, may be eligible for federal premium tax credits. 26 C.F.R. § 1.36B-1(k). The regulation is entitled to deference so long as the Treasury Department did not exceed the expansive scope of its rulemaking authority. *See* 26 U.S.C. § 7805(a); *Mayo Found. for Med. Educ. & Research v. United States*, 131 S. Ct. 704, 714 (2011). The familiar two-step framework established in *Chevron U.S.A. Inc. v. Natural*

[5] Moreover, the plaintiffs may not litigate their eligibility for a certificate of exemption without, at a minimum, first following the procedures specified by statute, 42 U.S.C. § 18081, to present their request for an exemption to the Exchange, and to take an administrative appeal of any denial of their request, before proceeding in federal court on that claim. "'[N]o one is entitled to judicial relief for a supposed or threatened injury until the prescribed administrative remedy has been exhausted.'" *Volvo GM Heavy Truck Corp. v. U.S. Dep't of Labor*, 118 F.3d 205, 209 (4th Cir. 1997) (quoting *Myers v. Bethlehem Shipbuilding Corp*., 303 U.S. 41, 50-51 (1938)).

Resources Defense Council, 467 U.S. 837 (1984), governs the Court's resolution of this question.

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

B. The Affordable Care Act Is Best Read to Provide that Participants in Federally-Facilitated Exchanges Are Eligible for Premium Tax Credits

1. Section 36B, When Read Together with 42 U.S.C. §§ 18031 and 18041, Provides that Participants in Federally-Facilitated Exchanges Are Eligible for Premium Tax Credits

The plaintiffs argue that 26 U.S.C. § 36B conditions a taxpayer's eligibility for federal premium tax credits on whether his or her state's government has created a state-operated Exchange. In their view, residents of states with federally-facilitated Exchanges are ineligible for these federal tax credits. But, "in the absence of plain language to the contrary," it must be assumed "when Congress enacts a statute that it does not intend to make its application dependent on state law." *United States v. Midgett*, 198 F.3d 143, 145 (4th Cir. 1999) (internal quotation omitted). The courts presume that "federal statutes are generally intended to have uniform nationwide application," *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 43 (1989), so as to avert "the danger that the federal program would be impaired if state law were to control," *id.* at 44 (internal quotation omitted). This principle applies with special force

to federal taxation statutes such as Section 36B. "[T]he revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application." *United States v. Irvine*, 511 U.S. 224, 238 (1994) (internal quotation omitted). Thus, "[s]tate law may control only when the federal taxing act, by express language or necessary implication, makes its own operation dependent upon state law." *Burnet v. Harmel*, 287 U.S. 103, 110 (1932); *see also Irvine*, 511 U.S. at 238-39.

The plaintiffs purport to find "plain language" in support of their theory in 26 U.S.C. § 36B(b)(2)(A), which limits the amount of the credits to no more than the amount of premiums for a qualified health plan in which the taxpayer (or a spouse or family member) is "enrolled in through an Exchange established by the State under [42 U.S.C. § 18031, *i.e.*, Section] 1311 of the Patient Protection and Affordable Care Act." 26 U.S.C. § 36B(b)(2)(A); *see also* 26 U.S.C. § 36B(c)(2)(A). Because the federal government will operate the Exchange in Virginia, the plaintiffs reason, they will not enroll in an "Exchange established by the State," and the amount of their tax credits under the Section 36B(b)(2)(A) formula will necessarily be zero.

But "[c]ourts have a duty to construe statutes, not isolated provisions." *Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 290 (2010) (internal quotation omitted). The plaintiffs err by reading Section 36B(b)(2)(A) in isolation. Section 36B, read in full and in conjunction with other provisions in the Affordable Care Act, leaves no doubt that federal premium tax credits are available both for state-operated Exchanges and for federally-facilitated Exchanges. The provision referenced in Section 36B(b)(2)(A), 42 U.S.C. § 18031, declares that "[e]ach State shall … establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State" that meets certain statutory requirements. 42 U.S.C. § 18031(b)(1). Despite this use of the term "shall," however, the Act

does not impose any sanction if a state elects not to establish an Exchange that complies with federal standards. Instead, the Act directs that, if a state will "not have any required Exchange operational by January 1, 2014, … the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate *such Exchange* within the State[.]" 42 U.S.C. § 18041(c)(1) (emphasis added). This language makes clear that Congress intended the federally-facilitated Exchange to constitute the referenced state-operated Exchange.

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

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

grammatically correct and it accommodates the purpose of the Act"); *United States v. Joseph*, 716 F.3d 1273, 1278 (9th Cir. 2013) ("'such' means 'the specific'"); *Alliance 3PL Corp. v. New Prime, Inc.*, 614 F.3d 703, 707 (7th Cir. 2010) ("such" is "legalese for the proposition that 'this use of the word "traffic" refers to the same "traffic" that this clause already mentioned'").

If there were any doubt on this score, the ACA's definitional provisions would resolve that doubt. For each use of the term "Exchange" in Title I of the ACA (which includes 42 U.S.C. § 18041), that term "means an American Health Benefit Exchange established under [42 U.S.C. § 18031]." 42 U.S.C. § 300gg-91(d)(21) (defining term for purpose of Public Health Services Act); *see* 42 U.S.C § 18111 (incorporating this definition for Title I of ACA). Thus, in light of the fact that "Exchange" is a defined term of art in the ACA, Section 18041(c)(1) reads, "the Secretary shall … establish and operate such [American Health Benefit Exchange established under 42 U.S.C. § 18031]." 42 U.S.C. § 18041(c)(1). The Exchange established by the federal government, then, *is* the Section 18031 Exchange. The plaintiffs' contrary reading fails to give effect either to the ACA's definitional provisions, or to Section 18041's use of the term "such," and that reading should be rejected. *See Joseph*, 716 F.3d at 1278 (rejecting interpretation that would render the term "such" superfluous).[6]

Further confirmation is provided within 26 U.S.C. § 36B itself. That provision directs "[e]ach Exchange (or any person carrying out 1 or more responsibilities of an Exchange under

[6] The plaintiffs rely entirely on the canon against surplusage. They contend that an isolated reading of Section 36B(b)(2)(A) is needed to give effect to the provision's use of the phrase "established by a State under [42 U.S.C. § 18031]." Mot. for S.J. (ECF 5) at 17. But, as the Supreme Court has noted with considerable understatement, "instances of surplusage are not unknown" in federal statutes. *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 299 n.1 (2006). In any event, "the canon against surplusage assists only where a competing interpretation gives effect to every clause and word of a statute." *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013) (internal quotation omitted). The plaintiffs do not offer such an interpretation, so the canon does not help their argument here. *See also* note 9, *infra*.

[42 U.S.C. § 18031(f)(3) or 42 U.S.C. § 18041(c)])" to provide certain information to the Treasury and to taxpayers, including "the aggregate amount of any advance payment" of tax credits or cost-sharing reductions that the taxpayer receives under the ACA, and "any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit." 26 U.S.C. § 36B(f)(3).[7] This provision's cross-reference to 42 U.S.C. § 18041(c) makes clear that Congress used the term "Exchange" to include the Exchange operated by the federal government under that provision, and that it intended that taxpayers would receive federal tax credits and cost-sharing reductions when purchasing insurance on that Exchange.

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

In sum, Section 36B must be read in its entirety, and also in conjunction with the

[7] 42 U.S.C. § 18031(f)(3), referenced in the text quoted above, permits a state-based Exchange to contract with an outside entity to perform one or more of the Exchange's responsibilities. Likewise, 42 U.S.C. § 18041(c) permits the Secretary of HHS to enter into an agreement with a non-profit entity to operate the Exchange.

provisions of the ACA describing the Exchange, 42 U.S.C. §§ 18031 and 18041. When these provisions are read together and as a whole, they make plain that Congress envisioned the federally-facilitated Exchange to be the same entity as the state-operated Exchange, and that it intended Section 36B "to establish a nationwide scheme of taxation uniform in its application," *Irvine*, 511 U.S. at 238 (internal quotation omitted), in which participants in any Exchange in any of the states would be eligible to receive federal premium tax credits.

2. The Larger Structure of the Act Confirms This Reading

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

First, under the plaintiffs' theory, no individual could meet the statutory definition for eligibility to buy insurance offered on the federally-facilitated Exchange. The ACA provides that "[a] qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible." 42 U.S.C. § 18032(a)(1). For this purpose, however, a "qualified individual" is defined as an individual "who resides in the State that

established the Exchange." 42 U.S.C. § 18032(f)(1)(A)(ii).[8] Under the plaintiffs' reading, then, nobody would be a "qualified individual" in a state with a federally-facilitated Exchange. Obviously, Congress did not intend this result. It designed the Exchange, after all, to serve "as an organized and transparent marketplace for the purchase of health insurance." H.R. REP. NO. 111-443, pt. II, at 976 (2010). Congress certainly would not have gone to the trouble of creating a federally-facilitated Exchange that could serve only as a Potemkin marketplace.[9] "[C]ourts presume that Congress has used its scarce legislative time to enact statutes that have some legal consequence." *Fund for Animals*, 472 F.3d at 877; *see also Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 216 (1995) (interpretation that would leave a statutory provision "utterly without effect" is "a result to be avoided if possible").[10]

Second, even if it were to be assumed that health coverage could be purchased by qualified individuals on the federally-facilitated Exchange, under the plaintiffs' theory, that Exchange still would not be able to perform a number of the functions that Congress charged it with. The ACA sets forth a number of responsibilities that Exchanges must fulfill, and a number of those functions would be meaningless under the plaintiffs' reading. Under 42 U.S.C.

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

[9] It would follow, moreover, that the language in Section 36B that the plaintiffs rely upon is surplusage even under their theory. If residents of a state with a federally-facilitated Exchange could not enroll for coverage in their Exchange, they could not obtain tax credits for that coverage, and it would be unnecessary to specify also that the applicant must enroll in a plan on an Exchange "established by the State under [42 U.S.C. § 18031]." An interpretation that compounds, rather than resolves, any surplusages in the Act is not a reading that is compelled by the Act's plain language. *See* note 6, *supra*.

[10] Moreover, the plaintiffs could enroll in catastrophic coverage in Virginia's federally-facilitated Exchange only if they were "qualified individual[s]." 42 U.S.C. § 18032(d)(3)(C). They thus could not obtain the relief they seek even under their own theory, further demonstrating (if any further proof is needed) that they lack standing to bring this suit.

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

Third, the plaintiffs' theory would upset the careful compromise that Congress reached regarding the availability of coverage for abortions on the Exchanges. The ACA provides that "[a] State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition." 42 U.S.C. § 18023(a)(1). This authorization would not apply in states where a federally-facilitated Exchange operates, under the plaintiffs' theory, given that their claim depends on the premise that the term "Exchange" refers only to state-operated Exchanges. Given the close attention

that was paid to the issue of abortion coverage during the enactment of the ACA, it is unlikely that Congress intended to carve out an implicit exemption for federally-facilitated Exchanges on this issue.

Fourth, the plaintiffs' reading would create an unanticipated obligation for states in the operation of their Medicaid plans. The ACA expands the scope of eligibility for the Medicaid program, beginning January 1, 2014. *E.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).[11] As a bridge until that date, the ACA provides, as a condition of continued federal funding, that participating states shall maintain their then-existing eligibility standards, until the effective date of the ACA's Medicaid eligibility expansion provisions. In particular, this "maintenance of effort" provision directs states, as a condition for the receipt of federal Medicaid funds, not to impose any "eligibility standards, methodologies, or procedures" under their Medicaid state plan, or any applicable waiver, that are "more restrictive" than the standards that the state had in place as of the date the ACA was enacted. 42 U.S.C. § 1396a(gg)(1). This condition applies until "the date on which the Secretary determines that an Exchange established by the State under [42 U.S.C. § 18031] is fully operational." *Id.* As the plaintiffs acknowledge, Mot. for S.J. (ECF 5) at 6, under their theory, a state with a federally-facilitated Exchange would *never* be relieved of this maintenance-of-effort requirement. It is not plausible that Congress intended this result; if it had so intended, it certainly would have stated so more directly.

Fifth, the plaintiffs' theory would undermine the ACA's process for state innovation waivers. The ACA enacts a procedure for a state to seek a waiver from some of the Act's provisions. 42 U.S.C. § 18052. Beginning in 2017, if a state has enacted legislation that

[11] The Supreme Court has held that HHS may not withdraw existing Medicaid funds for a state's failure to comply with this eligibility expansion provision. *Nat'l Fed'n of Indep. Business v. Sebelius*, 132 S. Ct. 2566, 2607 (2012) (plurality opinion).

provides coverage that is "at least as comprehensive," "at least as affordable," and "that reaches at least a comparable number of its residents" as does the coverage provided for under the ACA, and if that legislation would not increase the federal deficit, that state may seek a waiver of certain provisions of the Act. 42 U.S.C. § 18052(a), (b)(1). In particular, the state could seek to opt out of provisions relating to Exchanges, the distribution of premium tax credits and cost-sharing subsidies, and the large employer tax provision (26 U.S.C. § 4980H) and the minimum coverage provision (26 U.S.C. § 5000A). *Id.* The amount of any foregone premium tax credits would then be distributed directly to the state to administer its alternative plan. 42 U.S.C. § 18052(a)(3). Under the plaintiffs' theory, however, for a state that has not established its own Exchange, the amount of this funding would always be zero. Moreover, this waiver procedure would be an empty formality if, as the plaintiffs would have it, a state already had the power to prevent the application of significant portions of the ACA within its borders, simply by declining to establish its own Exchange. Congress intended a state to be eligible for a waiver only after a showing that the state could provide alternative comprehensive and affordable health coverage. Congress certainly did not intend, then, that a state could prevent the application of central provisions of the Act simply by declining to operate an Exchange.[12]

[12] This list of anomalies in the plaintiffs' theory is far from exhaustive. Other examples abound. *See, e.g.*, 42 U.S.C. § 1320b-23(a)(2) (pharmacy benefits managers must provide certain pricing information to HHS if the plan is offered on a state-operated Exchange, but not on a federally-facilitated Exchange); 42 U.S.C. § 1396w-3(b)(1)(D) (federally-facilitated Exchange would not be subject to provisions concerning coordination of Medicaid and CHIP benefits); 42 U.S.C. § 1397ee(d)(3)(B) (federally-facilitated Exchange would not be obligated to enroll children in CHIP program in the Exchange, as states would in certain circumstances); 42 U.S.C. § 1397ee(d)(3)(C) ("[w]ith respect to *each State*," HHS must review and certify whether qualified health plans offer benefits for children that are at least comparable to those offered in the state's CHIP plan, but this review extends only to plans "offered through an Exchange established by the State under [42 U.S.C. § 18031]"; thus, HHS could not fulfill this obligation in "each State" with a federally-facilitated Exchange) (emphasis added); 42 U.S.C. § 18054(c)(3)(A) (individual enrolled in a multi-state health plan in a federally-facilitated

In sum, the "statutory scheme," *Adoptive Couple*, 133 S. Ct. at 2563, confirms further that Congress intended the federally-facilitated Exchange and the state-operated Exchange to be the same entity, and that federal premium tax credits would be available under either version of the Exchange. The plaintiffs' contrary theory is fundamentally inconsistent with the intended operation of the Exchanges and with numerous other features of the Act. Treasury's interpretation avoids the incongruities that the plaintiffs' reading would create. That interpretation is the better reading of the Act, and it is certainly, at minimum, a permissible one.

3. The Legislative History of the Act Confirms This Reading

If Congress had intended to prohibit participants in the federally-facilitated Exchange from receiving federal premium tax credits, presumably one or more members of Congress would have stated that intent at some point during the legislative deliberations. After all, this condition on the availability of federal premium tax credits would have been a central feature of Congress's reform legislation. But there is not a word in the legislative history that anybody in Congress contemplated such a result. "Congress' silence in this regard can be likened to the dog that did not bark." *Chisom v. Roemer*, 501 U.S. 380, 396 n.23 (1991).

Instead, the legislative history consistently points to the conclusion that Congress meant federal premium tax credits to be available in every state. *First*, the House passed a bill that explicitly so provided. Its bill created a federal Exchange that would operate as the default Exchange, unless a state received a waiver to operate its own Exchange. H.R. 3962, 111th Cong., §§ 301, 308 (2009). The bill provided for federal premium tax credits for participants in

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Exchange would not be eligible for premium tax credit, contrary to statutory direction that such individual "shall be eligible for credits under section 36B of Title 26 … in the same manner as an individual who is enrolled in a qualified health plan"); 42 U.S.C. § 18081(a) (directing HHS to create program to collect information needed to determine an applicant's eligibility for federal premium tax credits, without including state of residence among relevant factors).

any of the Exchanges. *Id.*, §§ 308(b)(1)(A)(iv), 341(a). If the bill that eventually became the ACA had changed this scheme to provide for tax credits in some states but not others, one would expect members of the House to have noticed this change. There is no indication, however, that any member of Congress believed that the two bills differed with respect to this issue.

Indeed, the House paid careful attention to the amount of federal premium tax credits that would be available under the ACA. As a condition to the enactment of the ACA, the Senate accepted the House's amendments to Section 36B in contemporaneously-enacted legislation, the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No, 111-152, 124 Stat. 1029. HCERA increased the income cut-off for eligibility for federal premium tax credits to 400 percent of the federal poverty level, in the amount that the House had initially provided for but that had been reduced in the Senate's version of the legislation. *Id.*, § 1001(a), 124 Stat. at 1030-31. It is doubtful that the House would have paid such close attention to the *amount* of federal premium tax credits, while at the same time silently acceding to legislation that would have foreclosed federal premium tax credits *entirely* in some states.

Second, although the language that became 26 U.S.C. § 36B was developed in the Senate Finance Committee, that Committee did not at any time express any intent to condition the availability of federal premium tax credits on the existence of a state-operated Exchange. To the contrary, to the extent that the issue arose at all, the Finance Committee expressed its understanding that the federally-facilitated Exchange would be the *same entity* as the state-operated Exchange. Its bill provided that, if a state did not establish an operational Exchange (in the bill's parlance, an "interim exchange") within the time contemplated in the bill, then "*the Secretary* would be required to contract with a nongovernmental entity to establish *state exchanges* during this interim period." S. Rep. No. 111-89, at 19 (2009) (emphasis

added). The Senate Finance Committee would not have used such language in its report if it believed the Secretary-established Exchange was a different entity from the "state exchange."

Third, the Congressional Budget Office's ("CBO") cost analyses provide further proof that Congress understood that the federal premium tax credits would apply nationwide. CBO played a central role in Congress's deliberations on the ACA. CBO, along with the Joint Committee on Taxation ("JCT"), prepared analyses that estimated the cost of premiums in the Exchanges and the numbers of individuals who would enroll in the Exchanges; these analyses assumed that tax credits would be available in every state. *See, e.g.*, CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 6-7 (Nov. 30, 2009).[13] Congress relied heavily on these estimates in debating the merits of the ACA; indeed, the Act itself recites that Congress adopted CBO's findings. Pub. L. No. 111-148, § 1563(a), 124 Stat. 119, 270-71 (2010). There is no indication anywhere in the legislative record, however, that any member of Congress took issue with CBO's assumption that tax credits would be available nationwide. *See* 155 Cong. Rec. S12,764 (Dec. 9, 2009) (Sen. Baucus) (discussing CBO's finding that most participants in "the exchange" would receive federal premium tax credits, reducing their overall costs); 155 Cong. Rec. S13,559 (Dec. 20, 2009) (Sen. Durbin) (describing comprehensive availability of federal tax credits).

To the contrary, members of Congress consistently affirmed that tax credits would be available in every state. Senator Landrieu quoted a poll question describing the ACA as

[13] *See also* Letter from Douglas W. Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives at 1 (Dec. 6, 2012) ("To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state."), available at http://www.cbo.gov/publication/43752.

legislation in which "[l]ower and middle income people would receive subsidies to help them afford" insurance bought on a "[n]ational [i]nsurance Exchange," and declared that description to be "very accurate." 155 Cong. Rec. S13,733 (Dec. 22, 2009). Senator Johnson noted that the ACA would "form health insurance exchanges in every State" and would "provide tax credits to significantly reduce the cost of purchasing" coverage on the Exchanges. 155 Cong. Rec. S13,375 (Dec. 17, 2009). Similarly, Senator Bingaman noted that the ACA would create "a new health insurance exchange in each State which will provide Americans … refundable tax credits to ensure that coverage is affordable." 155 Cong. Rec. S12,358 (Dec. 4, 2009).[14]

Fourth, the JCT prepared a report on the ACA's tax provisions. That report further confirms that Congress intended federal premium tax credits to be available for the purchase of insurance on the federally-facilitated Exchange. The JCT stated that the Section 36B premium tax credit "subsidizes the purchase of certain health insurance plans through an exchange," without specifying that the entity that operates the exchange would be relevant in any way. JCT, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the "Patient Protection and Affordable Care Act"* 12 (Mar. 21, 2010). To be sure, a JCT report is prepared by committee staff, not legislators. But, because that staff is closely involved in the formulation of taxing provisions such as Section 36B, the courts have recognized that the JCT's reports are "highly indicative of what Congress did, in fact, intend." *Miller v. United States*, 65 F.3d 687, 690 (8th Cir. 1995) (internal quotation

[14] Nor could these statements be explained away by asserting that Congress assumed that every state would establish an Exchange. It was well known that some states would not do so. *See* 156 Cong. Rec. H2207 (Mar. 22, 2010) (Rep. Burgess) (as many as 37 states "may not set up the State-based exchange"); 155 Cong. Rec. S12,543 (Dec. 6, 2009) (Sen. Coburn) (submitting letter from Oklahoma official stating that his state was unlikely to create an Exchange); *see also* Editorial, *Don't Trust States to Create Health Care Exchanges*, USA Today, Jan. 4, 2010, available at 2010 WLNR 148256 (noting that "[s]ome state officials hostile to reform are already trying to block implementation," and would likely not create their own Exchanges).

omitted). *See also Fed. Power Comm'n v. Memphis Light, Gas & Water Div.*, 411 U.S. 458, 472 (1973) (JCT report is a "compelling contemporary indication" of Congressional intent); *Capital One Fin. Corp. v. Commissioner*, 659 F.3d 316, 325 (4th Cir. 2011) (relying on JCT report). If Congress had intended federal premium tax credits to be available only in states with state-operated Exchanges, the JCT report would have made note of that fact.

In sum, all of the legislative history points to the same conclusion; Congress intended that the federal premium tax credits would be available for the participants in every Exchange, as part of "a nationwide scheme of taxation uniform in its application," *Irvine*, 511 U.S. at 238. Nothing in the legislative history supports the plaintiffs' contrary theory. But if Congress had intended such a result, surely some member of Congress would have made note of that fact during at some point during the legislative deliberations. Some dog, somewhere, would have barked. That silence is a powerful indication that the plaintiffs' reading of the Act is incorrect.

4. The Purpose of the Affordable Care Act Confirms This Reading

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

When it enacted the ACA, Congress "'intended to solve a national problem on a national

scale.'" *Id.* (quoting *NLRB v. Hearst Publ'ns, Inc.*, 322 U.S. 111, 123 (1944)). Congress's basic goal in enacting Section 36B was "[t]o ensure that health coverage is affordable," and "to help offset the cost of private health insurance premiums." S. REP. NO. 111-89, at 4 (2009); *see also* H.R. REP. NO. 111-443, vol. II, at 977 (2010). Indeed, Congress recognized that the Section 36B tax credits "are *key* to ensuring people affordable health coverage." H.R. REP. NO. 111-443, vol. I, at 250 (emphasis added). Congress's goal would be undermined if the plaintiffs were to prevail here; many individuals would find it difficult (if not impossible) to obtain affordable health coverage if they were to be deprived of tax credits worth, on average, more than $5,000 annually.[15] But the effects would be even broader. A substantial adverse selection effect would arise, because healthier individuals would lose a powerful incentive to purchase coverage. According to the calculations of one health care economist, without the minimum coverage provision and subsidized insurance coverage, premiums for single individuals would be *double* the amount anticipated under the ACA.[16] The result would be "essentially no increase" in the number of persons enrolled in individual coverage. *Id.*

Indeed, Congress heard testimony that this adverse selection effect would undermine the ability of the Exchanges to offer affordable coverage. As CBO put the issue, "[i]f no subsidies were provided, the total premiums charged to nonfederal enrollees would probably be much higher than those observed in the program today – so the number of new enrollees would probably be limited." CBO, *Expanding Health Insurance Coverage and Controlling Costs for*

[15] *See* CBO, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act: May 2013 Baseline*, tbl. 1 (May 14, 2013) (estimating that federal premium tax credits will average $5,290 per person in 2014, rising to $7,900 in 2023).

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

Health Care: Testimony Before the S. Comm. on the Budget, at 19 (Feb. 10, 2009) (written testimony of Douglas W. Elmendof, Director, CBO) (discussing proposal to allow uninsured persons to enroll in federal employees' plans without subsidies), available at http://www.cbo.gov/publication/41761.[17]

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

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

H.R. 4872, the Reconciliation Act of 2010: Hearing Before the H. Comm. on Rules 71 (Mar. 20, 2010) (statement of Rep. Andrews) (commercial transcript of hearing) (attached as Exhibit 2).

When Congress enacted the ACA, it did not enact a statute that would be at war with itself. It did not enact comprehensive reform legislation for the purpose of expanding the availability of affordable health insurance, and at the same time hide a provision in the text that would undermine the possibility that that goal could be achieved. The plaintiffs' reading of the ACA to allow for affordable health insurance in some states but not others is implausible. At the very least, it is not a reading that is compelled under *Chevron* Step One.

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

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

It follows from the foregoing that 26 C.F.R. § 1.36B-1(k) "is based on a permissible construction of the statute" under *Chevron* Step Two. *City of Arlington*, 133 S. Ct. at 1868. Given Congress's instruction in the ACA to treat the federally-facilitated Exchange and the state-operated Exchange as the same entity, and its instruction in Section 36B itself that the federally-facilitated Exchange is to administer premium tax credits; the long list of anomalies that a contrary reading would create in the operation of the ACA's provisions; the absence of any legislative history that would support that contrary reading; and the Congressional purpose to expand the availability of affordable health coverage, the Treasury Department reasonably concluded that Section 36B premium tax credits are available for participants in federally-facilitated Exchanges.

IV. The Plaintiffs Suffer No Irreparable Injury from the Treasury Regulation

As noted above, the plaintiffs have a heavy burden; they must make a "clear showing" that they will likely suffer irreparable harm if an injunction is not granted. *United States v. South Carolina*, 720 F.3d at 533. The harm shown "must be neither remote nor speculative, but actual and imminent." *Manning v. Hunt*, 119 F.3d 254, 263 (4th Cir. 1997) (internal quotation omitted). A harm is not irreparable if there is a "possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation." *Hughes Network Sys. v. InterDigital Comm'ns Corp.*, 17 F.3d 691, 694 (4th Cir. 1994).

The plaintiffs argue that they would suffer irreparable injury if they could purchase only comprehensive coverage, such as a bronze-level plan in the Exchange, instead of the less generous catastrophic coverage that they assert they would prefer to purchase. Mot. for Prelim. Inj. at 9. As discussed above, however, (subsidized) bronze-level coverage would be cheaper

for them than (unsubsidized) catastrophic coverage. They therefore do not suffer any harm at all from the Treasury regulation, let alone an irreparable one. But even if they had shown some injury, it is well settled that economic losses, standing alone, do not qualify as irreparable harm. *See Virginia Carolina Tools, Inc. v. Int'l Tool Supply, Inc*., 984 F.2d 113, 120 (4th Cir. 1993) ("largely economic injuries" were not irreparable harm); *see also Taylor v. Resolution Trust Corp.*, 56 F.3d 1497, 1507 (D.C. Cir. 1995) ("in the absence of special circumstances, ... recoverable economic losses are not considered irreparable").

The plaintiffs argue that their (non-existent) economic injury is irreparable because they could not gain a monetary recovery from the government. Mot. for Prelim. Inj. at 9. This is simply wrong. They have a readily available remedy. They contend that they should not face potential liability under the minimum coverage provision, 26 U.S.C. § 5000A. They may test that theory by paying the assessment – which, as discussed above, could be no more than $330 for 2014, and could be substantially less – and then bringing a tax refund action for the recovery of the assessment. *See* 26 U.S.C. § 7422. The availability of an adequate tax refund remedy, by itself, disposes of the request for an injunction because "general equitable principles disfavor[] the issuance of federal injunctions against taxes, absent clear proof that available remedies at law [are] inadequate." *Bob Jones Univ.*, 416 U.S. at 742 n.16. The plaintiffs may prefer not to follow this course, but "[a] taxpayer cannot render an available review procedure an inadequate remedy at law by voluntarily forgoing it." *Alexander v. Americans United, Inc.*, 416 U.S. 752, 762 n.13 (1974).

The plaintiffs also argue that they have lost their (supposed) statutory right to buy coverage under a catastrophic plan, and that the loss of such a right is irreparable harm *per se*. This is not the law. "A federal judge sitting as chancellor is not mechanically obligated to grant

an injunction for every violation of law." *Winter*, 555 U.S. at 32. "Instead, courts must look to traditional principles of equity to determine what form of injunctive relief, if any, is appropriate to remedy a statutory violation. These equitable principles have always required irreparable injury and the inadequacy of legal remedies before an injunction is warranted." *Nat'l Audubon Soc. v. Dep't of Navy*, 422 F.3d 174, 200 (4th Cir. 2005).

The plaintiffs cannot show that they suffer an irreparable injury from the Treasury regulation; indeed, they are not harmed at all. They cannot meet their burden, then, to show "that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis in original).

V. The Public Interest and the Balancing of the Equities Weigh Heavily Against Issuing a Preliminary Injunction

Finally, the public interest and the equities weigh strongly against the plaintiffs' claim for injunctive relief. Congress has charged the Treasury Department with implementing the ACA's taxation-related provisions, and the public interest and the equities weigh strongly against interference with Treasury's performance of its duties to apply its understanding of Section 36B and the rest of the ACA to the plaintiffs' circumstances. "[T]here is inherent harm to an agency in preventing it from enforcing regulations that Congress found it in the public interest to direct that agency to develop and enforce." *Cornish v. Dudas*, 540 F. Supp. 2d 61, 65 (D.D.C. 2008).

The plaintiffs seek a broader injunction that would preclude Treasury from applying its interpretation of Section 36B in *any* circumstance, not only their own. No such injunction may issue. "[I]njunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). Thus, any injunction in this case could be no broader than what would be needed to address the plaintiffs' particular injuries. *See Virginia Soc'y for Human Life v. FEC*, 263 F.3d 379, 393-94

(4th Cir. 2001), *overruled in part on other grounds by The Real Truth About Abortion, Inc. v. FEC*, 681 F.3d 544, 550 n.2 (4th Cir. 2012). This Court, then, could not address the tax circumstances of parties who are not present in this proceeding.

But even if a broader injunction could issue, the public interest and the equities would weigh strongly against such relief. The plaintiffs argue that it would be a "recipe for chaos" if a preliminary injunction does not issue here, given that a court might later adopt their theory. Mot. for Prelim. Inj. at 10.[18] To the contrary, it is the plaintiffs who would throw the process of tax administration into disarray. Any attempt to adjudicate the tax liabilities of parties not present here, as the plaintiffs request, would "seriously disrupt the entire revenue collection process." *Apache Bend Apartments, Ltd. v. United States*, 987 F.2d 1174, 1177 (5th Cir. 1993). Injunctive relief – and particularly *preliminary* injunctive relief – in the plaintiffs' favor could not settle the issue, then. Instead, the public interest and the equities weigh heavily in favor of the uniform operation of a central feature of the Affordable Care Act that will enable millions of Americans to receive the substantial tax relief to which they are entitled under the statute.[19]

Conclusion

For the foregoing reasons, the motion for a preliminary injunction should be denied.

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[18] This premise is wrong, in any event. In the highly unlikely event that the Treasury regulation is later invalidated, the Treasury Department would have the discretion to apply such a ruling prospectively. *See* 26 U.S.C. § 7805(b)(8).

[19] The plaintiffs argue that "potentially millions of American employees" will lose employer-sponsored coverage under Treasury's reading of Section 36B. Mot. for Prelim. Inj. at 11. This assertion is wildly overblown. More careful studies estimate that the ACA as a whole (let alone the Treasury regulation at issue here) will have relatively "modest effects" on employer-sponsored coverage, ranging from an estimated 1.8% decrease in persons covered at the workplace to an estimated 2.9% *increase*. *See* Thomas Buchmueller, et al., *Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?*, 32 Health Affairs 1522, 1526-27 (Sept. 2013) (criticizing methodology of researchers who predict greater effects).

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CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of October, 2013, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send a notification of such filing (NEF) to the following:

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