No. 14-114

In the Supreme Court of the United States

DAVID KING, ET AL., PETITIONERS

v.

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

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE RESPONDENTS

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QUESTION PRESENTED

Whether the Treasury Department permissibly interprets 26 U.S.C. 36B to make the Affordable Care Act's federal premium tax credits available to eligible taxpayers through the Exchanges in every State.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-41a) is reported at 759 F.3d 358. The opinion of the district court (Pet. App. 42a-74a) is reported at 997 F. Supp. 2d 415.

JURISDICTION

The judgment of the court of appeals was entered on July 22, 2014. The petition for a writ of certiorari was filed on July 31, 2014, and granted on November 7, 2014. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent provisions of the Patient Protection and Affordable Care Act (Affordable Care Act, ACA, or

Act), Pub. L. No. 111-148, 124 Stat. 119,[1] and other relevant statutes and regulations are set forth in the appendix to this brief. App., *infra*, 1a-79a.

STATEMENT

The Affordable Care Act was enacted to provide "Quality, Affordable Health Care for *All* Americans." Tit. I, 124 Stat. 130 (emphasis added). To achieve that national objective, the Act relies on three interdependent reforms: rules prohibiting insurers from denying coverage or increasing premiums because of a person's medical history; a tax penalty on people who fail to maintain health coverage; and federal tax credits subsidizing the purchase of insurance by people who otherwise could not afford it. The tax credits are made available through state-specific marketplaces called "Exchanges," which States may either establish for themselves or allow the federal government to establish in their stead.

In accordance with the Act, the Treasury Department has made tax credits available to eligible individuals in every State—just as the Act's other interlocking reforms apply nationwide. Millions of Americans have relied on an Exchange to obtain affordable coverage, and the percentage of Americans without insurance has fallen sharply.[2] More than 5 million of the people who obtained coverage through Exchanges in 2014 lived in one of the 34 States with an Exchange operated by the federal government, and the over-

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[1] Amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029.

[2] Ctrs. for Disease Control, *Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey* 5 (Dec. 16, 2014).

whelming majority of those people relied on tax credits to pay their premiums each month.

In this suit, petitioners seek to upend the Act and extinguish the coverage of millions of Americans by contending that tax credits are available only in States that establish Exchanges for themselves. The Act's text, structure, design, and history refute petitioners' argument. As Treasury correctly concluded, federal premium tax credits are available through the Exchanges in every State.

A. Statutory Background

Before the ACA, millions of Americans had inadequate health insurance or were forced to go without insurance at all because they could not afford it or because they were denied coverage based on their medical history. To solve those problems, the Act relies on a combination of reforms predicated upon the availability of tax credits subsidizing the purchase of insurance.

1. Before the Affordable Care Act, the individual market for insurance was characterized by high prices and widespread discrimination

Most Americans with private health coverage obtain it through an employer-sponsored plan. Congressional Budget Office (CBO), *Key Issues in Analyzing Major Health Insurance Proposals* xi (Dec. 2008) (*Key Issues*). Congress has long supported broad access to employer-based coverage through favorable tax treatment—a subsidy worth hundreds of billions of dollars—and rules prohibiting employer-sponsored plans from discriminating based on medical history. *Id.* at xi, 29-32, 79-80.

Previously, however, Congress's efforts to make affordable coverage widely available left a gap in the "individual market"—the market for people who do not receive coverage through an employer or a government program. Individual-market insurance generally did not receive favorable tax treatment. *Key Issues* 9. Moreover, federal law generally did not prevent insurers in that market from increasing premiums, or denying coverage altogether, based on a person's medical history. *Id.* at 80-81. As a result, millions of people were denied insurance or charged dramatically higher rates because of conditions as common as high blood pressure or asthma, and 80% of people without access to coverage through an employer or the government were uninsured. *Id.* at 9; *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the Senate Comm. on Finance*, 110th Cong., 2d Sess. 52 (2008) (Mark A. Hall, Wake Forest Univ.).

2. States that adopted stand-alone nondiscrimination rules suffered death spirals in their individual insurance markets

In the 1990s, several States attempted to address the failures of the individual market by adopting stand-alone nondiscrimination rules prohibiting insurers from denying coverage or increasing premiums based on medical history. "The results were disastrous." *National Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2614 (2012) (*NFIB*) (Ginsburg, J., concurring in part and dissenting in part). Stand-alone nondiscrimination rules encouraged people to "wait until they bec[a]me ill to buy insurance" because they could not be denied coverage or charged higher rates if they did so. *Ibid.* That well-understood phenomenon,

known as "adverse selection," caused insurers to increase premiums to account for risk pools skewed toward "those in need of immediate medical care—*i.e.*, those who cost insurers the most." *Ibid.* Higher premiums, in turn, encouraged still more people to defer purchasing coverage until they had an immediate medical need. *Ibid.*

That self-reinforcing cycle compelled insurers to "raise premiums dramatically" or to exit the market altogether, resulting in a "death spiral." *NFIB*, 132 S. Ct. at 2614 (Ginsburg, J., concurring in part and dissenting in part). "All seven states" that enacted stand-alone nondiscrimination rules in the 1990s "suffered from skyrocketing insurance premium[s]" and "reductions in individuals with coverage." *Ibid.* (citation omitted).

Massachusetts also adopted nondiscrimination rules in the 1990s, and like the other States, it suffered a cycle of higher premiums and reduced coverage. *Learning from the States: Hearing Before the Senate Comm. on Health, Education, Labor, & Pensions*, 111th Cong., 1st Sess. 45 (2009) (*Learning from the States*) (Jon Kingsdale, Commonwealth Health Ins. Connector). In 2006, however, Massachusetts enacted further reforms requiring individuals to pay a tax penalty if they failed to maintain health coverage and providing subsidies to make insurance affordable. *Id.* at 9-10. Those reforms reduced the State's uninsured rate to just 2.6%—by far the lowest in the Nation—and headed off adverse selection by encouraging people to obtain coverage *before* they became ill. *Ibid.*

3. The ACA's reforms are predicated on tax credits subsidizing the purchase of insurance

Congress drew on the States' experiences in crafting the ACA. Like prior state reforms, the Act adopts nondiscrimination rules prohibiting insurers from denying coverage or charging higher rates based on a person's medical condition or history. 42 U.S.C. 300gg to 300gg-4. But Congress expressly found that those rules, if enacted by themselves, would have triggered the same "adverse selection" the States suffered in the 1990s. 42 U.S.C. 18091(2)(I).

That finding reflected the consensus view of state regulators, industry participants, and outside experts. The National Association of Insurance Commissioners (NAIC) cautioned that, given the risk of "severe adverse selection," "[s]tate regulators c[ould] support" nondiscrimination rules *only* if they were "coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies." *Roundtable Discussions on Comprehensive Health Care Reform: Hearing Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-504 (2009) (Sandy Praeger, NAIC); see, *e.g.*, *Addressing Insurance Market Reform in National Health Reform: Hearing Before the Senate Comm. on Health, Education, Labor, & Pensions*, 111th Cong., 1st Sess. 33-34 (2009) (*Market Reform*) (Karen Ignagni, America's Health Ins. Plans). Economists likewise warned that nondiscrimination rules would "inexorably drive [the individual market] into extinction" unless they were paired with "a mandate on the individual to be insured" and "sufficient public subsidies toward the purchase of health insurance." *Health Reform in the 21st Century: Insurance Market Reforms: Hearing*

Before the House Comm. on Ways & Means, 111th Cong., 1st Sess. 13 (2009) (Uwe E. Reinhardt, Princeton Univ.) (emphasis omitted).

Citing Massachusetts as a model, Congress sought to "minimize this adverse selection and broaden the health insurance risk pool," 42 U.S.C. 18091(2)(I), by coupling nondiscrimination rules with an individual-coverage provision and tax credits subsidizing the purchase of insurance. See 42 U.S.C. 18091(2)(D). The individual-coverage provision generally requires individuals to pay a tax penalty if they do not maintain health coverage. 26 U.S.C. 5000A; see *NFIB*, 132 S. Ct. at 2580, 2600 & n.11. Congress deemed that requirement "essential to creating effective health insurance markets" under nondiscrimination rules, explaining that it would prevent adverse selection by achieving "near-universal coverage." 42 U.S.C. 18091(2)(D) and (I).

The individual-coverage provision could not serve that function without subsidies making coverage broadly affordable. Subsidies must go "hand in hand" with an individual mandate because Congress cannot "mandate people having something they can't afford." *Market Reform* 59 (Praeger, NAIC); see *Executive Comm. Meeting To Consider Health Care Reform: Hearing Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 19 (2009) (Sen. Grassley) ("[A] mandate to purchase coverage requires * * * Federal subsidies to make sure that coverage is affordable."). Indeed, a key reason why States had adopted standalone nondiscrimination rules without a mandate was that they "c[ould] not afford" the necessary subsidies. *Learning from the States* 44-45 (Susan Besio, Office of Vt. Health Access).

The ACA's structure and design are based on those principles. Congress provided refundable premium tax credits subsidizing the purchase of insurance by individuals with household incomes between 100% and 400% of the federal poverty level—up to approximately $95,000 for a family of four. 26 U.S.C. 36B.[3] The Act also provides payments subsidizing deductibles and other cost-sharing expenses for recipients of the credits with incomes in the lower half of that range. 42 U.S.C. 18071(c)(2). Together, those subsidies make health coverage affordable for millions of Americans. And in so doing, they allow the individual-coverage provision to create a large, diversified risk pool that will "dampen the chances" that the Act's nondiscrimination rules could trigger "a cycle of rising premiums and declining enrollment." CBO, *An Analysis of Health Insurance Premiums Under the ACA* 19-20 (Nov. 30, 2009) (*Premium Analysis*).

The Act directly links the individual-coverage provision to the tax credits. The individual-coverage provision's exemption for those who would have to spend more than 8% of their income to obtain coverage is based on the cost of insurance *after* "the credit allowable under section 36B." 26 U.S.C. 5000A(e)(1)(B)(ii). And because the nondiscrimination rules, individual-coverage provision, and tax credits were designed to function together, Congress provided that they would take effect on the same date, January 1, 2014. ACA §§ 1255, 1401(e), 1501(d), 10103(f)(1), 124 Stat. 162, 220, 249, 895.

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[3] The federal poverty level is currently $11,670 for an individual and $23,850 for a family of four. 79 Fed. Reg. 3593 (2014).

4. The ACA's tax credits are furnished through state-specific Exchanges operated by the States and by HHS

The Act provides for the creation of "Exchanges," which are state-specific marketplaces where consumers can compare and purchase private health insurance. 42 U.S.C. 18031(d). Exchanges are the Act's method for making tax credits available. Only individuals who buy insurance through the Exchange in their State are eligible for tax credits and cost-sharing subsidies. 26 U.S.C. 36B; 42 U.S.C. 18071. The Exchanges facilitate determinations regarding eligibility for credits and subsidies, 42 U.S.C. 18081, and also facilitate advance payments of the credits and subsidies directly to insurers, 42 U.S.C. 18082.

The Act provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State." 42 U.S.C. 18031(b)(1). But the Act affords "State flexibility" in the fulfillment of that requirement. 42 U.S.C. 18041. A State may "elect[]" to set up the Exchange for itself. 42 U.S.C. 18041(b). Alternatively, if a State does not elect to create the Exchange itself, or if the Secretary of Health and Human Services (HHS) determines that the State will not have the "required Exchange operational by January 1, 2014," then HHS "shall establish and operate such Exchange within the State." 42 U.S.C. 18041(c)(1).

An Exchange operated by HHS is known as a "[f]ederally-facilitated Exchange." 45 C.F.R. 155.20. Though run by HHS, each federally-facilitated Exchange is the same state-specific Exchange the State otherwise would have established. Insurers offering

coverage on the Exchange are regulated by the State in which the Exchange is located, see, *e.g.*, 42 U.S.C. 18021(a)(1)(C)(i), and premiums are based on rating areas and risk pools unique to the State, 42 U.S.C. 18021(a)(4), 18032(c).

The Act's tax credits are provided in 26 U.S.C. 36B. Section 36B(a) provides that a credit "shall be allowed" for any "applicable taxpayer," a term defined by income level and without regard to whether the State or HHS operates the Exchange in the taxpayer's State. 26 U.S.C. 36B(c)(1)(A). Section 36B(b) then provides that the amount of the credit available to a particular taxpayer is based in part on the premium paid for an insurance plan "offered in the individual market within a State" that was "enrolled in through an Exchange established by the State under [42 U.S.C. 18031]." 26 U.S.C. 36B(b)(2)(A). Another subclause of Section 36B cross-references Section 36B(b)(2)(A) and uses the same phrase in defining a "coverage month" for which a credit is to be calculated. 26 U.S.C. 36B(c)(2)(A)(i).

Through notice-and-comment rulemaking, Treasury concluded that tax credits are equally available on both state-run and federally-facilitated Exchanges because an Exchange established by HHS for a particular State qualifies as an "Exchange established by the State under [Section 18031]" within the meaning of Section 36B. 26 C.F.R. 1.36B-1(k), 1.36B-2(a); see 77 Fed. Reg. 30,378 (2012). HHS has applied the same interpretation to the other provisions of the Act containing parallel language, including provisions addressing such central matters as who can purchase insurance on an Exchange. See pp. 27-31, *infra*.

B. The Operation Of The ACA's Exchanges

Thus far, 16 States and the District of Columbia have established Exchanges for themselves, while 34 States have opted to have HHS do so in their place.[4] In 2014, more than 5.3 million Americans selected an insurance plan through one of the 34 federally-facilitated Exchanges. HHS, *Summary Enrollment Report for the Initial Annual Open Enrollment Period* 34 (May 1, 2014). More than 85% of them were approved for advance payments of the tax credits, and the credits financed the lion's share of their premiums—an average of 76%. HHS, *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014*, at 5 (June 18, 2014) (*Premium Affordability*). Enrollment for 2015 is still in progress, but already nearly 7 million customers have selected or been reenrolled in a plan through a federally-facilitated Exchange,[5] and coverage through the Exchanges is expected to continue to increase substantially in the coming years.

C. Proceedings Below

Petitioners are four individuals who live in Virginia, which has a federally-facilitated Exchange. Pet. App. 1a, 9a. They do not wish to be eligible for tax credits, and they filed this suit asserting that Con-

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[4] HHS, *State Health Insurance Marketplaces* (Nov. 3, 2014), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html.

[5] HHS, *Open Enrollment Week 9* (Jan. 21, 2015), http://www.hhs.gov/healthcare/facts/blog/2015/01/open-enrollment-week-nine.html. HHS's statistics include three States (Nevada, New Mexico, and Oregon) that established their own Exchanges but are relying on HHS to make eligibility determinations. The 7 million figure includes only the 34 federally-facilitated Exchanges.

gress precluded Treasury from providing credits to all residents of States with federally-facilitated Exchanges. The district court dismissed the suit, holding that the Act unambiguously forecloses petitioners' claim. *Id.* at 42a-74a.

The court of appeals affirmed. Pet. App. 1a-41a. The court determined that the government has "the better of the statutory construction arguments." *Id.* at 18a. But it concluded that Section 36B is ambiguous and it therefore upheld Treasury's interpretation under *Chevron U.S.A. Inc.* v. *NRDC, Inc.*, 467 U.S. 837 (1984) (*Chevron*). Pet. App. 33a.

Judge Davis concurred. Pet. App. 34a-41a. He concluded that Treasury's interpretation is not merely permissible, but the only construction consistent with "a holistic reading of the Act's text and proper attention to its structure." *Id.* at 36a.

SUMMARY OF ARGUMENT

The court of appeals correctly held that the Affordable Care Act authorizes Treasury to make premium tax credits available on an equal basis to Americans in every State, as one would expect in a statute designed to provide "Affordable Coverage Choices for *All* Americans," Tit. I, Subtit. E, 124 Stat. 213 (emphasis added). Petitioners' contrary rendering of the Act—which rests on an acontextual misreading of a single phrase in two subclauses of Section 36B and an implausible account of the Act's design and history—would thwart the Act's core reforms in the 34 States that exercised their statutory prerogative to allow HHS to establish Exchanges for them. Those States would face the very death spirals the Act was structured to avoid, and insurance coverage for millions of their residents would be extinguished.

I. The Act's text, structure, and history demonstrate that tax credits are available through the Exchanges in every State.

Text. Section 36B(a) provides that a credit "shall be allowed" to an "applicable taxpayer." That term is defined by income and without regard to whether the State or HHS operates the Exchange in the taxpayer's State. In setting forth the formula used to calculate the credit available to a particular individual, two subclauses of Section 36B refer to insurance obtained through "an Exchange established by the State under [42 U.S.C. 18031]." Contrary to petitioners' claim, that phrase is a term of art that includes both an Exchange a State establishes for itself and an Exchange HHS establishes for the State. Section 36B therefore authorizes tax credits through the Exchanges in every State, not merely in States that establish Exchanges for themselves.

Section 18031(b)(1) expressly directs that "[e]ach State shall * * * establish an [Exchange]." But to afford "State flexibility," the Act further provides that if a State does not or cannot establish the "required Exchange" for itself, then HHS "shall * * * establish and operate *such Exchange* within the State." 42 U.S.C. 18041(c)(1) (emphasis added). The term "such Exchange" conveys that an Exchange HHS establishes as a statutory surrogate for a State fulfills Section 18031(b)(1)'s requirement that "[e]ach State" establish an Exchange. For purposes of the Act, therefore, such an Exchange is "an Exchange established by the State under Section 18031." The Act's definition of "Exchange" underscores that conclusion by defining the term to mean "an American Health Benefit Exchange established under section 18031."

42 U.S.C. 300gg-91(d)(21). Petitioners acknowledge that an Exchange HHS establishes for a State must be the "same Exchange" and function "just like" the Exchange the State would otherwise have established for itself. But a federally-facilitated Exchange could not function just like its state-run counterpart if tax credits were unavailable.

Numerous other textual references confirm that interpretation. Section 36B itself does so, in a provision (Section 36B(f)) that specifically requires federally-facilitated Exchanges to report information to Treasury for the express purpose of administering the tax credits—a requirement that would be pointless if tax credits were not available on those Exchanges. And other provisions of the Act use the phrase "Exchange established by the State" (or an equivalent formulation) in contexts that necessarily include federally-facilitated Exchanges. Most strikingly, the Act defines a "qualified individual" eligible to shop on an Exchange as a person who "resides in the State that established the Exchange." 42 U.S.C. 18032(f)(1)(A). Accordingly, if a federally-facilitated Exchange were not "established by the State," it would literally have no customers. Petitioners' reading of that phrase cannot be reconciled with this provision or with many others.

Structure and design. The Act's structure and design confirm that tax credits are available on the Exchanges in every State.

First, tax credits are essential to the Act's nationwide insurance-market reforms. Congress made an express legislative finding that the individual-coverage provision is "essential" to the effective implementation of the Act's nondiscrimination rules.

But, as Congress knew, the individual-coverage provision could not perform its market-stabilizing function in the absence of subsidies making coverage broadly affordable. The denial of tax credits and the resulting loss of customers would thus have disastrous consequences for the insurance markets in the affected States, which would remain subject to the Act's nondiscrimination rules but without the safeguards Congress deemed essential to preventing death spirals.

Second, the availability of tax credits in every State is essential to the Act's model of cooperative federalism. Petitioners' reading would transform Congress's promise of "State flexibility," 42 U.S.C. 18041, into a threat that a State would suffer severe consequences unless it established its own Exchange. To accept petitioners' account, moreover, the Court would have to accept that Congress adopted that scheme not in a provision giving States clear notice of the consequences of their choice, but instead by hiding it in isolated phrases in the formula for calculating an *individual's* tax credit. The Act should be interpreted to avoid the disrespect for State sovereignty inherent in petitioners' reading.

History. Petitioners do not deny that their interpretation of Section 36B would thwart the operation of the Act's central provisions in States with federally-facilitated Exchanges. Instead, they reverse-engineer a description of the Act's design and history to fit their misreading of Section 36B. Petitioners insist that Congress *intentionally* threatened to impose a dysfunctional regime on the States in order to pressure them to establish Exchanges for themselves, and that Congress assumed that every State would comply. That notion is baseless.

First, it was well understood when the Act was passed that some States would not establish Exchanges for themselves. The very fact that the Act provides for federally-facilitated Exchanges demonstrates that "Congress thought that some States might decline * * * to participate in the operation of an exchange." *NFIB* v. *Sebelius*, 132 S. Ct. 2566, 2665 (2012) (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

Second, the Act's tax credits are not structured as a conditional-spending program designed to induce the States to take action. They are *federal* tax credits provided to individual *federal* taxpayers as an integral part of *national* reforms that apply whether or not the States act. Had Congress actually intended to threaten States with death spirals if they declined to establish their own Exchanges, it would not have directed HHS to establish rump Exchanges that would be doomed to fail.

Third, the Act's legislative record confirms that tax credits are available in every State. During the time the Act was under consideration, no Member of Congress ever suggested that tax credits would be available only in States that established their own Exchanges—even though the language on which petitioners rely was in draft bills for months before the Act was enacted. Any such suggestion would have produced a firestorm of controversy, but there was none.

Absurd Results. Petitioners largely ignore the contradictions, anomalies, and absurdities their reading would create in other provisions of the Act. Their response to the one absurdity they do confront at any length—the fact that their reading would mean that

there would be no individuals "qualified" to shop on federally-facilitated Exchanges—further confirms their error, because they must invite the Court to ignore or rewrite the relevant provisions of the Act in stark derogation of the principles of textual interpretation to which they purport to adhere.

II. For the foregoing reasons, the Act clearly makes federal tax credits available through the Exchanges in every State. But even if there were some ambiguity on that question, it would be resolved by Treasury's authoritative interpretation. That interpretation was adopted in notice-and-comment rulemaking conducted pursuant to an express delegation of authority to implement Section 36B. It is thus entitled to the full measure of *Chevron* deference.

* * * * *

Petitioners invoke (Br. 17) "judicial fidelity to the rule of law and well-established interpretive principles." But it is petitioners, not the government, who seek to rewrite the Act. Determining the meaning of a statute duly enacted by Congress, particularly a statute as consequential as this one, by focusing on isolated phrases divorced from textual cross-references, definitions, and context—and with no regard for the statute's structure and design—does not respect the rule of law. It subverts the rule of law by denying appropriate respect to the choices Congress has made in the exercise of its democratically accountable authority.

ARGUMENT

The Treasury Department regulation providing tax credits to eligible Americans in every State is lawful and should be upheld. All the tools of statutory interpretation—text, structure and design, purpose, histo-

ry, and consequences—point to the same answer: tax credits are available on the Exchanges in every State.

The Act makes clear in myriad ways that all three essential pillars of the statutory scheme function the same way in every State. The nondiscrimination rules—the Act's core reforms eliminating restrictions that had denied coverage to millions of Americans—apply to insurers in every State. The individual-coverage provision—which Congress deemed an "essential" complement to the nondiscrimination rules, 42 U.S.C. 18091(2)(I)—applies to individuals in every State. And the tax credits necessary to enable the nondiscrimination rules and individual-coverage provision to function are likewise available to eligible individuals in every State—as one would expect given the interlocking, mutually reinforcing character of the Act's structure and design.

Seizing on isolated phrases in this complex and technical statute and giving them a meaning divorced from statutory context, petitioners advance a radically different conception of the Act's operation. They assert that Congress designed the Act principally to ensure that States set up the Exchanges that implement the Act's reforms—rather than to ensure that those reforms actually get implemented to give all Americans equal access to affordable coverage. To that end, petitioners claim, Congress threatened the States with an unworkable regime that would deny their residents tax credits and roil their insurance markets unless the States established Exchanges for themselves.

But Congress did not adopt such a self-defeating scheme. Nor did it engage the States in the high-stakes game of chicken that petitioners posit. Indeed,

it is implausible to think Congress would have done so, and there is no contemporaneous evidence that Congress sought to do anything of the kind. The Act was debated, evaluated, and passed under the universal understanding that tax credits would be available in every State—including States with federally-facilitated Exchanges. There is thus no basis in the Act's text, structure, or history for the result that petitioners seek.

I. THE AFFORDABLE CARE ACT MAKES FEDERAL TAX CREDITS AVAILABLE ON EXCHANGES IN EVERY STATE

A. The Text Of 26 U.S.C. 36B And The Other Directly Applicable Provisions Makes Clear That Tax Credits Are Available On Exchanges In Every State

In 26 U.S.C. 36B(a), Congress provided that a premium tax credit "shall be allowed" to any "applicable taxpayer." That term is defined as a taxpayer whose household income is between 100% and 400% of the federal poverty level. 26 U.S.C. 36B(c)(1)(A). Section 36B(a) thus defines *all* income-eligible taxpayers as potentially eligible to receive a credit—regardless of their State of residence or whether that State has elected to operate its own Exchange.

Petitioners nevertheless insist that Congress denied credits to all residents of States with federally-facilitated Exchanges. They divine that categorical bar in a phrase—"established by the State under [Section 18031]"—contained in two subclauses setting forth the formula for calculating the amount of the credit available to a particular individual purchasing insurance on an Exchange. 26 U.S.C. 36B(b)(2)(A) and (c)(2)(A)(i). Petitioners assert (Br. 20) that be-

cause "HHS is not a 'State,'" the amount of the credit available to a taxpayer who uses a federally-facilitated Exchange is always zero.

It would be astonishing if Congress had buried a critically important statewide bar to the subsidies under this landmark legislation in subclauses setting forth the technical formula for calculating *how much* the subsidy should be. In fact, as demonstrated below, Congress did no such thing: The phrase "Exchange established by the State under Section 18031" is a term of art that includes an Exchange established for the State by HHS.

1. Tax credits are available on all Exchanges because the phrase "Exchange established by the State under Section 18031" is a term of art that includes a federally-facilitated Exchange

a. The relevant question in interpreting the language on which petitioners rely is not whether HHS is a "State." It is whether the statutory phrase "Exchange established by the State under Section 18031" includes an Exchange that HHS establishes as a surrogate for the State, as authorized by 42 U.S.C. 18041. That question cannot be answered by a myopic focus on that phrase alone: "The plain meaning that [courts] seek to discern is the plain meaning of the whole statute, not of isolated sentences." *Beecham* v. *United States*, 511 U.S. 368, 372 (1994).

That principle applies with special force to a comprehensive statute like the ACA. Given its many cross-references and interrelated provisions, the Act is not "a *chef d'oeuvre* of legislative draftsmanship." *Utility Air Regulatory Grp.* v. *EPA,* 134 S. Ct. 2427, 2441 (2014) (*UARG*). But that does not grant license to determine the meaning of statutory language in

isolation—particularly when the term is a technical one that defines how an interlocking system of reforms will operate. To the contrary, when interpreting statutes like this one, it is especially important to respect the "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (*Brown & Williamson*) (citation omitted). Indeed, the phrase on which petitioners seize itself includes a cross-reference and a defined term, making clear that it cannot be read in isolation. There is no such thing as a plain meaning of "an Exchange established by the State under Section 18031" that does not take into account Section 18031 and related provisions.

b. The three statutory provisions that together set forth how Exchanges will be established and operated—Section 18031, Section 18041, and the Act's definition of "Exchange"—demonstrate that an Exchange established by HHS for a particular State qualifies as "an Exchange established by the State under Section 18031." The phrase is a statutory term of art. As petitioners concede (Br. 26), Congress is "always" free to create a term of art or to give words used in a statute a "broader or different meaning" than they would ordinarily have. *Mohamad* v. *Palestinian Auth.*, 132 S. Ct. 1702, 1707 (2012). It has done so here.

Section 18031 expressly provides that every State will be served by an Exchange that is "established" by that State. It directs that "[*e*]*ach State* shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Ex-

change') for the State." 42 U.S.C. 18031(b)(1) (emphasis added). The requirement that each State establish an Exchange need not, however, be implemented by the State itself—a mandate that Congress could not have imposed, *Printz* v. *United States*, 521 U.S. 898, 926-927 (1997). Rather, Section 18041, which is entitled "State flexibility in operation and enforcement of Exchanges and related requirements," furnishes alternative means by which Section 18031(b)(1)'s requirement may be fulfilled. A State may "elect[]" under Section 18041(b) to establish the Exchange for itself if it does so by a date specified by HHS. See 45 C.F.R. 155.100, 155.105 (regulations governing HHS review and approval of state elections). But if a State opts not to do so, or if HHS determines that a State that attempted to set up an Exchange will not have the "required Exchange operational by January 1, 2014," then HHS "shall * * * establish and operate *such Exchange* within the State." 42 U.S.C. 18041(c)(1) (emphasis added).[6]

The use of the phrase "such Exchange" conveys that the Exchange to be established by HHS for the State *is* the "required Exchange" referenced earlier in the same sentence—that is, the Exchange "required" by Section 18031(b)(1), which provides that "each State shall * * * establish an [Exchange]." See *Black's Law Dictionary* 1570 (9th ed. 2009) ("such" means "[t]hat or those; having just been mentioned").

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[6] The Act also provides another means by which a State may be served by an Exchange that is "established by the State under Section 18031" even if the State does not "establish" that Exchange for itself: A State may "permit[]" a "[r]egional or other interstate Exchange" to "operate" within its borders. 42 U.S.C. 18031(f); see 77 Fed. Reg. at 30,378.

Section 18041(c)(1) empowers HHS, acting as the legislatively authorized surrogate of the State, to establish the Exchange that Section 18031(b)(1) requires "[e]ach State" to establish. For purposes of the Act, therefore, an Exchange created for a particular State by HHS *is* "an Exchange established by the State under Section 18031."

The applicable statutory definition reinforces that conclusion. "Exchange" is defined to mean "an American Health Benefit Exchange *established under section 18031*." 42 U.S.C. 300gg-91(d)(21) (emphasis added); see 42 U.S.C. 18111. Accordingly, when Section 18041(c)(1) directs HHS to establish an "Exchange" for a particular State, the resulting Exchange is, by definition, "established under section 18031." See *Western Union Tel. Co.* v. *Lenroot*, 323 U.S. 490, 502 (1945) ("[S]tatutory definitions of terms used therein prevail over colloquial meanings."). And an Exchange "established under section 18031" is necessarily an Exchange "established by the State," because Section 18031 provides for each State to establish an Exchange and does not contemplate any other sort of Exchange.[7]

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[7] Petitioners note (Br. 26-27) that Congress did not state that an Exchange created by HHS is "deemed" to be established by the State or provide, as it did with respect to federal territories, that HHS "shall be treated as a State" when it creates an Exchange. 42 U.S.C. 18043(a)(1). But Congress was not required to use petitioners' preferred formulations, and the fact that it "could have accomplished the same result by phrasing the statute differently" is no reason to disregard "the statute *as written*." *United States* v. *Aguilar*, 515 U.S. 593, 604 (1995). Petitioners' invocation of the provision addressing territories is particularly inapposite because that provision serves a different function: It makes territories eligible for federal grants available to "States," 42 U.S.C. 18031(a),

c. Notably, one thing Section 18041 does not do is provide any notice to a State that its residents will suffer the loss of tax credits if the State does not establish an Exchange for itself. Had Congress intended to impose that consequence, it would surely have spelled that out *in Section 18041*—which sets forth States' options for establishing Exchanges—so that States could evaluate the implications of their choice.

Instead, Section 18041 does the opposite. Consistent with Congress's statutorily-specified purpose to afford "State flexibility," Section 18041 informs a State that if it does not elect to establish the "required" Exchange, HHS will establish an equivalent Exchange (*i.e.*, "such Exchange") for it. Petitioners in fact concede (Br. 22) that Section 18041(c)(1) requires HHS to establish the "same Exchange" that would exist if the State established the Exchange for itself, and that an Exchange created by HHS must operate "just like the Exchange the state would otherwise have established." But a federally-facilitated Exchange could not be the "same Exchange" or function "just like" its state-run counterpart if tax credits were unavailable. The point of creating an Exchange is to provide a marketplace where consumers can use credits to obtain affordable coverage, as the overwhelming majority of people buying insurance on Exchanges have done. *Premium Affordability* 5. An Exchange without credits would be a rump Exchange bearing little resemblance to its state-run counterpart—if it could operate at all. See pp. 27-29, 36-38, 44, *infra*.

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but it does not authorize tax credits on territorial Exchanges or make such Exchanges equivalent to their state counterparts for all purposes. See 42 U.S.C. 18043(a).

Indeed, the terms of Section 18031 and other related provisions of the Act prescribe a central role for Exchanges in making credits available. Exchanges must provide information about credits and assist individuals in applying for them, including by making available a calculator to allow individuals to determine the cost of insurance "after the application of any premium tax credit" available under Section 36B. 42 U.S.C. 18031(d)(4)(G); see 42 U.S.C. 18031(c)(5) and (i)(3). Exchanges process applications for credits and cost-sharing subsidies and notify applicants of the results. 42 U.S.C. 18081(a), (b)(3) and (c)-(e). And Exchanges help administer the advance payment of credits and subsidies to insurers. 42 U.S.C. 18082. Accordingly, an Exchange without tax credits simply would not be an "Exchange" under the Act.

2. Section 36B(f) makes clear that tax credits are available to eligible taxpayers through the Exchanges in every State

Section 36B itself confirms that tax credits are available in States with federally-facilitated Exchanges. Subsection (f) of that Section, entitled "Reconciliation of credit and advance credit," provides for reduction of taxpayers' year-end tax credits by the amount of advance payments made during the year. To allow Treasury to make that reconciliation, Section 36B(f)(3) requires "each Exchange" to provide specified information to Treasury and to individuals who purchase insurance on the Exchange. All of the required information is used in administering the credits and accompanying subsidies. Among other things, each Exchange must report the "amount of any advance payment" of credits and subsidies; information "necessary to determine eligibility for, and the amount of,

[the] credit"; and "[i]nformation necessary to determine whether a taxpayer has received excess advance payments." 26 U.S.C. 36B(f)(3)(C), (E) and (F); see Treasury, *Form 1095-A*, http://www.irs.gov/pub/irs-pdf/f1095a.pdf (implementing Section 36B(f)(3)).

As petitioners concede (Br. 45), this reporting requirement applies to *all* Exchanges—indeed, Section 36B(f)(3) contains the Act's *only* direct reference to federally-facilitated Exchanges outside of Section 18041(c) itself.[8] But Congress would have had no reason specifically to require federally-facilitated Exchanges to report information for the express purpose of "[r]econciliation of credit and advance credit" if credits were categorically unavailable through those Exchanges. Subsection (f) thus confirms what Subsection (a) indicates—that tax credits are available to individuals through the Exchanges in *all* States.[9]

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[8] Section 36B(f)(3)'s reference to "each Exchange" encompasses federally-facilitated Exchanges, but the reporting obligation also specifically applies to "any person carrying out 1 or more responsibilities of an Exchange" under 42 U.S.C. 18041(c), a provision authorizing HHS to operate a federally-facilitated Exchange "through agreement with a not-for-profit entity."

[9] Straining to come up with an alternative explanation for these reporting requirements, petitioners speculate (Br. 45-47) that Congress intended the reported information to be used for *other* purposes, such as enforcing the individual-coverage provision. But there is no need to speculate. Section 36B(f) identifies the purpose for which the reports were required: to allow Treasury to "[r]econcil[e]" payments of the "credit" and the "advance credit." That some of the information required for that function can also be put to other uses is immaterial. And enforcement of the individual-coverage provision cannot explain Congress's inclusion of federally-facilitated Exchanges in Section 36B(f)(3) because another provision separately required *insurers* to provide the information necessary to enforce the individual-coverage provision,

3. Other provisions of the Act using equivalent language confirm that an Exchange established for a State by HHS qualifies as "an Exchange established by the State under Section 18031"

Other key provisions of Titles I and II of the ACA also contain the phrase "Exchange established by the State under Section 18031" or an equivalent formulation. As used in those provisions, that phrase plainly includes federally-facilitated Exchanges. Given the "standard principle of statutory construction" that "identical words and phrases within the same statute should normally be given the same meaning," *Powerex Corp.* v. *Reliant Energy Servs., Inc.*, 551 U.S. 224, 232 (2007), those provisions powerfully confirm that an Exchange established for a State by HHS qualifies as an "Exchange established by the State under [Section 18031]" within the meaning of Section 36B. See *United Sav. Ass'n of Tex.* v. *Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) ("A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme * * * because the same terminology is used elsewhere in a context that makes its meaning clear.").

a. Most notably, if petitioners were correct that a federally-facilitated Exchange is not an Exchange "established by the State," no individual would be eligible to purchase insurance on federally-facilitated Exchanges and no individual-market plans could be sold there.

Only "qualified individuals" may purchase individual-market policies sold on an Exchange.

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without all of the *additional* credit-specific information required by Section 36B(f)(3). 26 U.S.C. 6055.

42 U.S.C. 18031(d)(2)(A) ("An Exchange shall make available qualified health plans to qualified individuals and qualified employers.").[10] A "qualified individual" is one who, among other things, "*resides in the State that established the Exchange*." 42 U.S.C. 18032(f)(1)(A)(ii) (emphasis added). Because an Exchange established by HHS for a particular State qualifies as an "Exchange established by the State," HHS's regulations provide that otherwise-eligible individuals who reside in a State with a federally-facilitated Exchange are "qualified individuals" permitted to shop on that Exchange. 45 C.F.R. 155.20 (definitions of "qualified individual" and "Exchange"); 45 C.F.R. 155.305(a)(3) (eligibility for enrollment through an Exchange). That interpretation is not only reasonable and entitled to *Chevron* deference; it is essential to a viable construction of the Act. If an Exchange created by HHS for a State were not "established by the State" under the Act, there would be no qualified individuals in any State with a federally-facilitated Exchange—and Congress would have directed HHS to create Exchanges on which no one could lawfully shop.

The absence of qualified individuals in States with federally-facilitated Exchanges would yield a further impossibility: To certify a plan as a "qualified health plan" eligible to be sold, an Exchange must determine "that making available such health plan through such Exchange is in the interests of *qualified individuals* and qualified employers in the State." 42 U.S.C.

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[10] The Act's references to "qualified employers" are to small businesses eligible to purchase group coverage through a "SHOP Exchange," a distinct type of Exchange not at issue here. 42 U.S.C. 18031(b)(1)(B).

18031(e)(1)(B) (emphasis added). An Exchange could not make that determination with respect to an individual-market plan if there were no "qualified individuals" in its State. Accordingly, if a federally-facilitated Exchange were not an Exchange "established by the State," such an Exchange not only would have no customers; it also would have nothing to sell.

b. The Act's Medicaid maintenance-of-effort provision likewise confirms this reading. As a condition of receiving federal Medicaid funds, a State must maintain its Medicaid eligibility standards for adults from the date of the Act's passage until the date on which "an Exchange established by the State under section 18031" is "fully operational." 42 U.S.C. 1396a(gg)(1). Congress intended that provision to be a temporary one, expiring on January 1, 2014, when Exchanges—both state-run and federally-facilitated—would become operational in every State. See S. Rep. No. 89, 111th Cong., 1st Sess. 68 (2009) (Senate Finance Report) (requirement "would continue through December 31, 2013"); 42 U.S.C. 1396a(gg)(3) (an exception for States with budget deficits "end[ed] on December 31, 2013").

HHS informs this Office that since January 1, 2014, nine States with federally-facilitated Exchanges (including petitioners' amici Oklahoma, Indiana, and Nebraska) have relied on the expiration of the maintenance-of-effort requirement to tighten their Medicaid eligibility standards. HHS has approved those amendments to the States' Medicaid plans in actions entitled to *Chevron* deference. See *Douglas* v. *Independent Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1210 (2012). But if a federally-facilitated Exchange did not qualify as "an Exchange established by

the State under section 18031," the Act's temporary maintenance-of-effort provision would be transformed into a permanent freeze in States that decline to establish Exchanges for themselves—a freeze that nine of those States would have violated already.

c. Provisions requiring States to ensure coordination between Exchanges and their Medicaid and Children's Health Insurance Programs (CHIP) likewise support the government's reading. To help ensure that people eligible for Medicaid and CHIP receive benefits, Congress provided that Exchanges must accept applications for those programs and enroll people found to be eligible. 42 U.S.C. 18031(d)(4)(F), 18083(a). Those requirements apply in "each State." 42 U.S.C. 18083(a). To enable Exchanges to fulfill that responsibility, the Act provides that each State, as a condition of continued participation in Medicaid, "shall establish procedures" to ensure coordination and secure communication between its Medicaid program, its CHIP program, and "an Exchange established by the State under section 18031." 42 U.S.C. 1396w-3(b)(1), (2) and (4).

Consistent with this requirement, HHS informs this Office that the Medicaid and CHIP agencies in every State with a federally-facilitated Exchange have entered into coordination agreements with that Exchange. But if petitioners' reading were correct, it would be impossible for a State with a federally-facilitated Exchange to comply with the statutory coordination requirements because there would be no "Exchange established by the State under section 18031" with which to coordinate.

d. The same conclusion follows from the Act's provisions governing enrollment of CHIP-eligible chil-

dren through Exchanges. The Act provides that, in the event CHIP funding proves insufficient, a participating State "shall establish procedures" to enroll CHIP-eligible children in coverage "offered through an Exchange established by the State under section 18031." 42 U.S.C. 1397ee(d)(3)(B). Congress further directed that, "[w]ith respect to *each State*," HHS must review the insurance plans offered "through an Exchange established by the State under section 18031" and certify those plans that are suitable for enrollment of eligible children. 42 U.S.C. 1397ee(d)(3)(C) (emphasis added). If a federally-facilitated Exchange were not "an Exchange established by the State under section 18031," HHS and the States could not satisfy those requirements in States that did not establish their own Exchanges.

4. Petitioners' reading of the phrase "an Exchange established by the State under Section 18031" collapses under the cumulative weight of the myriad inconsistencies it creates

Petitioners' claim of fidelity to the statutory text is thus baseless. Indeed, to accept petitioners' reading, the Court would have to accept that Congress created a statute that:

- Requires federally-facilitated Exchanges to report information for a "[r]econciliation" of tax credits that could never occur, 26 U.S.C. 36B(f);

- Requires federally-facilitated Exchanges to establish processes for calculating and distributing tax credits that would never be available,

42 U.S.C. 18031(d)(4)(G), (c)(5) and (i)(3), 18081, 18082;

- Requires the creation of federally-facilitated Exchanges on which there would quite literally be no "qualified individuals" eligible to shop, 42 U.S.C. 18032(f)(1)(A)(ii);

- Requires the creation of federally-facilitated Exchanges on which there would be no "qualified health plans" eligible to be sold, 42 U.S.C. 18031(e)(1)(B);

- Imposes a permanent freeze on Medicaid eligibility in States that decline to operate Exchanges for themselves, in the guise of a transitional "[m]aintenance of effort" provision designed to expire at the end of 2013, 42 U.S.C. 1396a(gg)(1);

- Directs States, as a condition of continued participation in Medicaid, to satisfy coordination requirements that could not be met in States with federally-facilitated Exchanges, 42 U.S.C. 1396w-3(b);

- Directs HHS and States participating in the CHIP program to take steps that could not be accomplished in States with federally-facilitated Exchanges, 42 U.S.C. 1397ee(d)(3).

In short, to make their reading of "established by the State under Section 18031" fit with the rest of the Act, petitioners must rewrite so many of the Act's provisions, and explain away or ignore so many textu-

al incongruities and contradictions, that their argument collapses under its own weight—wholly apart from the havoc it would wreak on the Act's structure and design, see pp. 35-41, *infra*. The government's interpretation, in contrast, allows the Act to function as a "symmetrical and coherent regulatory scheme," *Brown & Williamson*, 529 U.S. at 133 (citation omitted), with no need to rewrite, explain away, or ignore any of its provisions.

5. The phrase "established by the State under Section 18031" serves to identify the Exchange in a particular State, not to exclude a federally-facilitated Exchange

Petitioners contend (Br. 20, 27-28) that the government's interpretation renders the phrase "established by the State under Section 18031" superfluous. They are mistaken. As the use of that phrase in Section 36B and throughout the Act demonstrates, it serves to identify the Exchange in a particular State. Its presence or absence in the Act's provisions reflects style and grammar—not a substantive limitation on the type of Exchange at issue.

An Exchange is a state-specific marketplace, and Section 36B(b)(2)(A) uses the phrase "Exchange established by the State under [Section 18031]" because it is referring to the Exchange in the specific State mentioned earlier in the same sentence: The formula for tax credits depends on the cost of one or more insurance plans "offered in the individual market within *a State* * * * which were enrolled in through an Exchange established by *the State* under [Section 18031]." 26 U.S.C. 36B(b)(2)(A) (emphasis added); see 26 U.S.C. 36B(c)(2)(A) (cross-referencing Section 36B(b)(2)(A)). In like manner, the other ref-

erences to an "Exchange established by the State" in the relevant Titles of the Act refer to the Exchange in a specific State, typically one identified elsewhere in the same provision.[11]

In contrast, when a provision of Section 36B addressing Exchanges does not refer to the Exchange in an earlier-referenced State, the phrase "established by the State under [Section 18031]" is omitted. 26 U.S.C. 36B(d)(3), (e)(3) and (f)(3). That phrase is also missing from numerous other provisions of the Act addressing the tax credits and subsidies available through Exchanges. See, *e.g.*, 29 U.S.C. 218b(a)(2); 42 U.S.C. 18032(e)(2), 18033(a)(6)(A), 18051(d)(3)(A)(i), 18052(a)(3), 18071(b)(1), (d)(1) and (e)(3), 18082. All of those provisions concern tax credits and the accompanying subsidies, and on petitioners' reading they should apply only to an "Exchange established by a State under Section 18031." Yet none of them contain that limitation—they refer to credits and subsidies available

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[11] 42 U.S.C. 1396a(gg)(1) ("*a State*" must maintain Medicaid eligibility standards until "an Exchange established by *the State*" is operational); 42 U.S.C. 1396w-3(b) ("[*a*] *State*" must coordinate its Medicaid and CHIP programs with "an Exchange established by *the State*"); 42 U.S.C. 1397ee(d)(3)(B) and (C) ("[w]ith respect to *each State*," HHS must certify health plans "offered through an Exchange established by *the State*" and "*the State*" must establish procedures for enrolling eligible children in such plans); 42 U.S.C. 18031(f)(3)(A) ("[*a*] *State* may elect to authorize an Exchange established by *the State*" to contract with third parties to carry out Exchange functions); 42 U.S.C. 18032(f)(1)(A) (a "qualified individual" is one who "resides in *the State* that established the Exchange") (all emphases added). One provision in Title VI of the Act, § 6005, 124 Stat. 698, which is otherwise unrelated to Exchanges, refers more generally to "an exchange established by *a* State under section 18031." 42 U.S.C. 1320b-23(a)(2) (emphasis added).

through "Exchanges," and some of them actually use other formulations that even petitioners concede (Br. 13) "clearly encompass HHS Exchanges." See 42 U.S.C. 18051(d)(3)(A)(i), 18052(a)(3).

It strains credulity to insist, as petitioners must, that Congress limited tax credits to States that establish Exchanges for themselves by including the modifier "established by the State under [Section 18031]" in two subclauses of Section 36B, yet omitted that purportedly crucial limiting language from *all* of the Act's myriad other references to the credits and subsidies available on Exchanges. That pattern raises no such difficulty if—as the text of the relevant provisions makes clear—the modifier serves not to exclude federally-facilitated Exchanges, but merely to refer to the Exchange in a particular State identified elsewhere in the same provision.

B. The ACA's Structure And Design Confirm That Tax Credits Are Available Through The Exchanges In Every State

Interpreting Section 36B to make tax credits available through the Exchanges in every State is essential to the effective operation of the Act's insurance-market reforms and to its framework of cooperative federalism. That interpretation harmonizes the relevant provisions of the Act, "allowing them to accomplish their manifest objects." *Abramski* v. *United States*, 134 S. Ct. 2259, 2269 (2014). Petitioners' reading, in contrast, would "deny effect to the regulatory scheme" by subverting the Act's structure and design. *Ibid.*

1. The availability of tax credits on Exchanges in every State is essential to the Act's insurance-market reforms

The structure and design of the Act's insurance-market reforms require that tax credits be available on Exchanges in every State. The Act's nondiscrimination rules apply in every State, whether or not the State establishes an Exchange for itself. 42 U.S.C. 300gg to 300gg-4. The individual-coverage provision likewise applies nationwide. 26 U.S.C. 5000A. Congress found that the individual-coverage provision is "essential" to preserving "effective health insurance markets" under the Act's nondiscrimination rules. 42 U.S.C. 18091(2)(I). Tax credits are in turn indispensable to the operation of the individual-coverage provision, because that provision cannot perform its "essential" market-stabilizing function without them. See pp. 6-8, *supra*.

If tax credits were no longer available in States with federally-facilitated Exchanges, the vast majority of the millions of people currently relying on them to pay for insurance would be exempt from the individual-coverage provision because they would not be able to afford insurance. Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell* 6 (Jan. 2015) (*Implications*); see 26 U.S.C. 5000A(e)(1).[12] In those circumstances, the individual-coverage provision would not produce a risk pool broad enough to avoid adverse selection and ensure "effective health insurance mar-

[12] A small percentage of people denied subsidies would remain subject to the individual-coverage provision because the cost of coverage would be less than 8% of their income. *Implications* 6.

kets." Too few people would be able to afford coverage, and too few would be subject to the incentivizing effect of the tax penalty.

With neither subsidies nor an effective individual-coverage provision, States with federally-facilitated Exchanges would face the same death spirals experienced by States that enacted stand-alone nondiscrimination rules in the 1990s—the very thing the Act was designed to avoid. Recent studies confirm that elimination of tax credits "would result in sharp premium increases and enrollment declines," "causing significant instability and threatening the viability of the market[s]." Evan Saltzman & Christine Eibner, *The Effect of Eliminating the ACA's Tax Credits In Federally Facilitated Marketplaces* 5-6 (Jan. 2015) (47% premium increases and 70% reductions in individual-market enrollment); *Implications* 1 (35% premium increases and 69% enrollment reductions). And those harms would not be confined to the Exchanges. Because the entirety of the affected States' individual markets would be subject to the nondiscrimination rules and the resulting adverse-selection pressure, everyone purchasing coverage—even those not currently shopping on Exchanges or relying on credits—would face skyrocketing premiums. *Ibid.*

Accordingly, petitioners' reading "would throw a debilitating wrench into the Act's internal economic machinery." Pet. App. 29a. And contrary to petitioners' suggestion (Br. 31), that objection cannot be brushed aside as an appeal to generalized statutory purpose or vague notions of congressional intent. Rather, it reflects a bedrock principle of statutory interpretation: Where, as here, a proffered interpretation of one provision of a statute "would be incon-

sistent with—in fact, would overthrow—the Act's structure and design," it must be rejected. *UARG*, 134 S. Ct. at 2443.

2. The availability of tax credits on Exchanges in every State is essential to the Act's model of cooperative federalism

Petitioners' interpretation would also subvert the cooperative-federalism design of the Act's insurance market reforms. As Section 18041 reflects, the Act offers States a real choice. Congress authorized States to establish their own Exchanges and provided federal grants to help them do so. 42 U.S.C. 18031(a), 18041(b). But out of the same desire to provide "State flexibility," Congress gave each State the option of allowing HHS to establish the required Exchange in its stead, while preserving state regulation of insurers. 42 U.S.C. 18041; see ACA Tit. I, Subtit. D, Pt. 3 ("State Flexibility Relating To Exchanges"). Thus, like many other cooperative-federalism statutes, the Act permits state implementation of federal requirements in the first instance, but directs the federal government to step into a State's shoes if the State fails to act. See, *e.g.*, 42 U.S.C. 300gg-22 (insurance reforms in the Public Health Service Act (PHSA), 42 U.S.C. 201 *et seq.*, including amendments made by the ACA); 42 U.S.C. 7410(c)(1) (Clean Air Act). And like those statutes, the Act provides that when HHS steps in, it meets the federal requirements that the State would otherwise have been required to meet: A federally-facilitated Exchange is the same as, and functions just like, an Exchange the State establishes for itself—including by performing the central function of making tax credits available.

Petitioners' reading, in contrast, would transform the "flexibility" promised by Section 18041 into a threat. On petitioners' reading, a State may decline to participate in the implementation of the Act's regulatory scheme only at the price of depriving its citizens of the tax credits at the heart of the Act and crippling its insurance market. And petitioners would impose that result even on a State that attempted to establish an Exchange for itself and was merely unable to have the Exchange "operational" by the statutory deadline. 42 U.S.C. 18041(c)(1). The scheme petitioners posit bears no relation to the normal operation of cooperative-federalism programs.

To accept petitioners' account, moreover, the Court would have to conclude that Congress sneaked these consequences into isolated phrases in subclauses of Section 36B, rather than giving States clear notice in Section 18041 itself of what would follow if they did not establish their own Exchanges. But Congress "does not * * * hide elephants in mouseholes." *Whitman* v. *American Trucking Ass'ns*, 531 U.S. 457, 468 (2001). It would display considerable disrespect for state sovereignty for Congress to hide the ramifications of a *State's* election in subclauses setting forth the technical formula for calculating the amount of an eligible *individual's* tax credit. And it makes little sense to conclude that Congress would have communicated these consequences in so oblique a manner if—as petitioners insist—its purpose was to ensure that every State got the message that it needed to establish its own Exchange to avoid harms to its citizens and its insurance market. Had Congress intended what petitioners claim, it surely would have spoken "with a clear voice" directly to the States to allow

them "to exercise their choice knowingly." Va. Amicus Br. at 12, *Halbig* v. *Burwell*, No. 14-5018 (D.C. Cir. Nov. 3, 2014) (quoting *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981)).[13]

"Among the background principles of construction that [the Court's] cases have recognized are those grounded in the relationship between the Federal Government and the States under our Constitution." *Bond* v. *United States*, 134 S. Ct. 2077, 2088 (2014). Those principles bear directly on the interpretive question in this case. Rather than assuming that Congress subjected States (with only the most obscure notice) to the onerous regime that would be required by petitioners' interpretation of the Act, cf. *NFIB* v. *Sebelius*, 132 S. Ct. 2566, 2601-2602 (2012) (opinion of Roberts, C.J.); *Gregory* v. *Ashcroft*, 501 U.S. 452, 460-461 (1991); *Pennhurst*, 451 U.S. at 17, the Court should interpret the Act in a manner that advances the respect for state sovereignty reflected in its express promise of "State flexibility" and its cooperative federalism design. See *Wisconsin Dep't of Health & Family Servs.* v. *Blumer*, 534 U.S. 473, 495 (2002); see also *New York Tel. Co.* v. *New York State Dep't of Labor*, 440 U.S. 519, 539 n.31 (1979) (plurality opinion) ("presumption in favor of 'cooperative feder-

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[13] Petitioners note (Br. 29) that the formula in Section 36B contains a different limitation on the credits: the fact that insurance must be purchased on an Exchange in order to be subsidized. But that limitation does not establish severe consequences for *state* decisionmaking or categorically deny credits based on a taxpayer's State of residence. Moreover, the fact that credits are available only through Exchanges is not buried solely in Section 36B's subclauses—it is reflected throughout the Act. See, *e.g.*, 26 U.S.C. 36B(f); 29 U.S.C. 218b(a)(2); 42 U.S.C. 18032(e)(2), 18051(d)(3)(A)(i), 18052(a)(3), 18082(a)(1).

alism'" in interpreting statutes); *Batterton* v. *Francis*, 432 U.S. 416, 431-432 (1977) (same).

C. Petitioners' Alternative Account Of The Act's Design Is Baseless

Petitioners do not dispute that denying tax credits in States that opt not to establish Exchanges for themselves would torpedo the insurance markets in those States—a result that would be particularly disrespectful of state sovereignty. But they assert (Br. 32-39) that Congress *intended* to threaten States with that result, and that it believed federally-facilitated Exchanges would never come into existence because it assumed every State would yield to the pressure and establish its own Exchange.

Petitioners' rendering of the Act lacks credibility. It is implausible that Congress would have risked the collapse of the statutory scheme in non-electing States—and the denial of affordable coverage to millions of Americans—as a means to ensure that the Act's express offer of "State flexibility" would never be accepted. Petitioners have identified nothing in the Act's legislative record, in contemporaneous statements of government officials (federal or state), or in contemporaneous public commentary that substantiates their reverse-engineered account of the Act's design. If the text of the Act were as clear as petitioners claim, there would be no need for them to strain so hard to invent such a narrative.

1. Congress understood that some States would not establish Exchanges for themselves

The linchpin of petitioners' account is their assertion (Br. 5, 40-41, 43) that Congress assumed every State would establish an Exchange for itself. But the

very fact that the Act includes a "backup scheme" in the form of federally-facilitated Exchanges demonstrates that "Congress thought that some States might decline * * * to participate in the operation of an exchange." *NFIB*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).[14]

The historical record confirms what the text makes clear. While supporters of the Act hoped that most States would establish Exchanges for themselves, it was well understood that the Act gave "States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges." 155 Cong. Rec. S13,832 (Dec. 23, 2009) (Sen. Baucus). And it was abundantly clear that some States would not establish their own Exchanges. See *e.g.*, 156 Cong. Rec. H2207 (Mar. 22, 2010) (Rep. Burgess) (up to 37 States "may not set up the State-based exchange"); 155 Cong. Rec. S12,543-S12,544 (Dec. 6, 2009) (Sen. Coburn) (Oklahoma was unlikely to create an Exchange); David D. Kirkpatrick, *At State Level, Health Lobby Fights Change*, N.Y. Times, Dec. 29, 2009, at A1 (describing state proposals to "opt out" of exchanges); *Don't Trust States To Create Health Care Exchanges*, USA Today, Jan. 4, 2010, at 8A ("Some state officials hostile to reform are already trying to block implementation.").

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[14] Although petitioners suggest otherwise (Br. 5), Congress also provided funding for federally-facilitated Exchanges. HCERA § 1005, 124 Stat. 1029 (appropriating $1 billion for "Federal administrative expenses to carry out" the ACA).

2. The Act's tax credits are unlike a conditional spending program

Petitioners attempt (Br. 14-15, 32-34) to analogize their view of Section 36B to conditional-spending programs such as the Act's Medicaid expansion, but that analogy is fundamentally flawed. Congress may, of course, "grant federal funds to the States, and may condition such a grant upon the States' taking certain actions that Congress could not require them to take." *NFIB*, 132 S. Ct. at 2601 (opinion of Roberts, C.J.) (citation and internal quotation marks omitted). The ACA followed that model in its provisions addressing Medicaid, a longstanding conditional-spending program. To provide coverage for low-income individuals—including those with incomes too low to qualify for tax credits—the Act provided that, as a condition of continued receipt of federal Medicaid funds, States were required to expand Medicaid eligibility substantially. *Id.* at 2581-2582. Congress expected that every State would continue to participate in Medicaid, and it thus provided no alternative in the event that a State declined to do so. *Id.* at 2665 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

Congress took an entirely different approach to Exchanges and tax credits. The Act does offer grants to provide "[a]ssistance to States" in establishing Exchanges. 42 U.S.C. 18031(a). But unlike those conditional grants, the "premium assistance" made available by Section 36B is a *federal* tax credit awarded to individual *federal* taxpayers. The credits are also part of an integrated set of national reforms that apply whether or not a State elects to establish its own Exchange. Section 36B thus bears no resem-

blance to the conditional-spending programs on which petitioners rely.[15]

Critically, moreover, the Exchanges that Congress directed HHS to set up for States that declined or were unable to do so for themselves would be a futile gesture absent tax credits. "Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges," and insurers would likely "be unwilling to offer insurance inside of exchanges" if they were no longer the exclusive means of reaching subsidized customers. *NFIB*, 132 S. Ct. at 2674 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting). "With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all." *Ibid.* Petitioners cannot explain why, if Congress meant to use the threat of withholding tax credits to induce the States to act on a conditional-spending model, it would have bothered to require HHS to expend substantial time, resources, and taxpayer dollars establishing rump Exchanges that would be doomed to fail.[16]

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[15] Petitioners assert (Br. 30) that 26 U.S.C. 35 provided a precedent for their reading of Section 36B. They are mistaken. Section 35 provided credits subsidizing the purchase of insurance by certain narrow categories of people. 26 U.S.C. 35(a)-(c). Those credits were available nationwide because several forms of qualifying insurance did not require action by the States. 26 U.S.C. 35(e)(1)(A), (I) and (J). And although other forms of qualifying coverage had to be offered by state governments, Section 35(e)(2) set forth the "[r]equirements for State-based coverage" in a provision expressly directed to the States.

[16] Petitioners err in asserting (Br. 37) that the government argued in *NFIB* that Exchanges could function without tax credits. The question in *NFIB* was whether the other provisions of the Act were severable from the individual-coverage provision; the gov-

The Act's provision for federally-facilitated Exchanges thus makes clear that Congress did not condition tax credits on state action. That is the understanding expressed by the 26 States that successfully argued to this Court that the Act's Medicaid expansion was unconstitutionally coercive. *NFIB*, 132 S. Ct. at 2606-2607 (opinion of Roberts, C.J.). Those States emphasized the differences between the Medicaid expansion and the Exchange provisions, correctly explaining that the Act gave States a "real choice * * * to create exchanges or have the federal government do so" in their stead. State Pet. Br. on Medicaid at 51, *NFIB*, *supra* (No. 11-400); see *id.* at 22. And petitioners' amicus Senator Hatch expressed a similar view while the Act was under consideration, emphasizing that establishing an Exchange was "not a condition for receiving federal funds" and that if the States declined to create Exchanges for themselves, HHS would "step in and do it for them." 156 Cong. Rec. H179 (Jan. 19, 2010) (Rep. Foxx) (quoting Orrin G. Hatch et al., *Why the Health-Care Bills Are Unconstitutional*, Wall St. J., Jan. 2-3, 2010, at A11); see 155 Cong. Rec. S13,726 (Dec. 22, 2009) (Sen. Hatch).

3. The legislative record demonstrates that Congress understood that tax credits would be available through federally-facilitated Exchanges

The ACA was the subject of months of intense public debate. The resulting record reinforces what the Act's text and structure make clear: Congress under-

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ernment had no occasion to address the very different question whether Exchanges could meaningfully function without tax credits. Gov't Br. on Severability at 33, *NFIB*, *supra* (Nos. 11-393 & 11-400).

stood that tax credits would be available in every State, including those with federally-facilitated Exchanges.

a. The Act's Exchange and tax credit provisions originated in a bill drafted by the Senate Finance Committee. The earliest version of that bill, a narrative summary used for the Committee's markup, provided that "States must establish an exchange" and directed HHS to establish an Exchange for a State if the State did not do so for itself. *Chairman's Mark: America's Healthy Future Act of 2009*, at 11 (Sept. 22, 2009). The draft provided for tax credits subsidizing insurance purchased through "state exchanges," but it expressly described an exchange established by HHS as a "state exchange"—*i.e.*, an exchange on which credits were available. *Id.* at 11, 20.

All of those features were preserved in the bill approved by the Committee in October 2009. S. 1796, 111th Cong. 1st Sess. §§ 1001, 1101 (proposing to add Sections 2225(b)(1)(B) and 2235 to the Social Security Act (SSA), 42 U.S.C. 301 *et seq.*). Notably, the formula for tax credits introduced language materially identical to the language on which petitioners rely, providing that the credit would be based on the cost of insurance "enrolled in through an exchange established by the State" under the provisions of the bill corresponding to Section 18031. *Id.* § 1205 (proposing 26 U.S.C. 36B(b)(2)(A)). Confirming that this language did not exclude an Exchange established by HHS, the bill stated that credits were available to "individuals enrolling in a health benefits plan through an exchange," without limitation. *Id.* § 1001 (proposing to add Section 2200(3) to the SSA).

The bill that ultimately became the ACA was a combination of the Finance Committee bill and a bill drafted by the Senate Committee on Health, Education, Labor, and Pensions (HELP). See H.R. 3590, 111th Cong., 1st Sess. (as amended by Senate Nov. 19, 2009). That combined bill continued to provide for state Exchanges with a federal fallback, and it continued to provide that the amount of the tax credit would be based on the cost of insurance obtained through "an Exchange established by the State." *Id.* § 1401 (proposing 26 U.S.C. 36B(b)(2)(A)).[17] That language remained in the bill until it was passed by the Senate in December 2009. H.R. 3590, 111th Cong., 1st Sess. § 1401 (as passed by Senate, Dec. 24, 2009). The House passed the Senate bill without amendment several months later, and the Act was signed into law on March 23, 2010.

b. During the months this language was under consideration, Members of Congress consistently expressed their understanding that credits would be available through "exchanges," without limitation. 155 Cong. Rec. S13,205 (Dec. 15, 2009) (Sen. Baucus). There is no evidence that any Member suggested that credits might be limited to States that established Exchanges for themselves. To the contrary, it was understood that credits would be available through the Exchange in "each State." *Id.* at S12,358 (Dec. 4, 2009) (Sen. Bingaman); accord, *e.g.*, *id.* at S13,375 (Dec. 17, 2009) (Sen. Johnson) ("exchanges in every State" will "provide tax credits"); see Senate Finance Report 9, 18-19, 37 (providing that tax credits would

[17] The combined bill also substituted a second use of that phrase for a cross-reference that had appeared in the Finance Committee bill. H.R. 3590 § 1401 (proposing 26 U.S.C. 36B(c)(2)(A)(i)).

be available on "state exchanges" and contemplating that HHS could "establish state exchanges"); *id.* at 39 (tax credits are "available for any plan purchased through the Exchange").

That was also the basis on which the CBO and the Joint Committee on Taxation (JCT) assessed the Act's tax and budgetary consequences. *Premium Analysis* 3-4, 19-20; JCT, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination with the ACA* 12 (Mar. 21, 2010). Those assessments were critical to the Act's passage, and were referenced in the text of the Act itself. ACA § 1563(a), 124 Stat. 270-271. They were prepared on the understanding that credits "would be available in every state, including states where the insurance exchanges would be established by the federal government." Letter from Douglas W. Elmendorf, Dir., CBO, to Rep. Darrell E. Issa, Chairman, Comm. on Oversight & Gov't Reform (Dec. 6, 2012) (Elmendorf Letter). And that was so even though it was clear that some States would not establish Exchanges for themselves. See pp. 41-42, *supra*. Indeed, "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." Elmendorf Letter.[18]

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[18] Petitioners contend (Br. 41) that the Senate HELP Committee bill made tax credits conditional on state action in certain respects. But that bill provides no support for their position because it did not condition credits on a State establishing its own Exchange, and because the condition was set forth in a provision expressly directed to the States—not buried in the formula for the credit

The absence of any suggestion that the Senate bill restricted tax credits to Exchanges that States establish for themselves is particularly striking because the House's version of the Act provided for credits nationwide. H.R. 3962, 111th Cong., 1st Sess. §§ 301, 308, 341 (2009). Had any Member believed that the Senate version adopted the radically different approach petitioners urge, "surely this would have been mentioned somewhere in the legislative history." *Taylor* v. *United States*, 495 U.S. 575, 601 (1990). But there was not a hint of such a controversy. Just the opposite: A comprehensive analysis of the differences between the House and Senate bills, including the "[k]ey differences" on tax credits, made no mention of this purported feature of the Senate bill. Tri-Committee House Staff, *House-Senate Comparison of Key Provisions* 2 (Dec. 29, 2009). Nor did the House seek to alter the language on which petitioners rely when, a few days after the Act was signed, Congress amended Section 36B in a separate law revising the Act to address the House's objections to the original Senate version of the Act. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1001, 1004, 124 Stat. 1031-1032, 1034.

Even after the Act was passed, moreover, there was no intimation of the critical restriction that petitioners now purport to discern. To the contrary, that purported limitation apparently was not "discover[ed]" until "[m]onths after the ACA became law," Stephanie Armour, *Lawyer's Eye Helped Spark Health-Care Suits*, Wall St. J., July 25, 2014, at A4, and the amici who first developed petitioners' inter-

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available to a particular individual. S. 1679, 111th Cong., 1st Sess. § 142 (2009) (proposing to add Section 3104(d) to the PHSA).

pretation characterized it as a "glitch" rather than a core feature of the Act's design, Jonathan H. Adler & Michael F. Cannon, *Another ObamaCare Glitch*, Wall St. J., Nov. 16, 2011, at A15. As this Court is well aware, the ACA was one of the most intensely debated pieces of legislation in our history. The notion that a critical and controversial feature of the Act went unnoticed and unmentioned until months after the Act's passage is not credible.[19]

c. Petitioners imply (Br. 4, 42) that this purported feature of the Act went unnoticed because it was added late in the legislative process, to secure the support of Senator Ben Nelson or other unnamed "centrist Senators" whose votes were needed for final passage. Not so. As demonstrated, the language on which petitioners rely had been in the Senate Finance Committee bill for months and was in the combined Senate bill from the beginning. And although Senator Nelson opposed a single *nationwide* Exchange like the one proposed in the House bill, petitioners do not identify

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[19] Petitioners rely heavily (Br. 4-5, 42-43) on statements made by Jonathan Gruber, an economist, consultant, and supporter of the Act. But those statements were made two years after the Act was passed, and Gruber has clarified that they were taken out of context. Jonathan Gruber, *Written Testimony Before the House Comm. on Oversight & Gov't Reform* 2 (Dec. 9, 2014). Petitioners also cite (Br. 41) an earlier academic paper noting that Congress *could* limit tax credits to States that set up Exchanges. Timothy S. Jost, *Health Insurance Exchanges: Legal Issues* 7 (2009). But there is no indication any Member of Congress saw that paper, and in any event the Act actually corresponds to a *different* option described in the same paper: It "invite[s] state participation in a federal program, and provide[s] a federal fallback program to administer exchanges in states that refuse[] to establish complying exchanges." *Ibid.*

any evidence that he (or anyone else) objected to *state-specific* Exchanges run by HHS—much less that anyone sought to *pressure* States to establish Exchanges for themselves.[20] In fact, the Senators who opposed a national Exchange were echoing state regulators who *wanted* Exchanges to be "based at the State level." *Healthcare Reform Roundtable (Part I): Hearing Before the Senate Comm. on Health, Education, Labor, & Pensions*, 111th Cong., 1st Sess. 70 (2009) (Praeger, NAIC). And it would have been perverse for Senators concerned about federalism to insist on pressuring States to participate in the implementation of a federal statute.

D. Petitioners Cannot Escape The Absurd Consequences Of Their Reading

1. Petitioners do not acknowledge, much less address, most of the textual absurdities, impossibilities and incongruities their reading of "established by the State under Section 18031" produces. They do concede (Br. 48) that it would "surely be absurd" if their reading meant that there were no "qualified individuals" eligible to shop on federally-facilitated Exchanges. But as we explain above, that is indeed the consequence of their reading. See pp. 27-29, *supra*. Petitioners labor to explain away that result, but each of

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[20] Senator Nelson "oppose[d] any health care reform bill with a national insurance exchange." Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, Politico, Jan. 25, 2010. That describes the House bill, which would have established a nationwide Exchange subject to a limited state opt-out. H.R. 3692 § 301. The Act's federally-facilitated Exchanges do not raise that concern because, like their state-run counterparts, each is a state-specific marketplace.

their rationalizations violates the "plain text" principles they invoke.

Petitioners posit (Br. 48, 50) that the Act's qualified-individual provisions simply do not apply to federally-facilitated Exchanges. But their only textual basis for that claim is the untenable suggestion (Br. 48) that the requirements in Section 18031 do not apply to an Exchange created by HHS because such an Exchange is not an "Exchange" as that term is defined and used in the Act. That assertion contradicts both the definition of "Exchange" and the express directive in Section 18041(c)(1) for HHS to establish an "Exchange"—a directive petitioners elsewhere concede (Br. 22) requires HHS to create "the same Exchange that the state would have established had it elected to do so."

Alternatively, petitioners try to read the word "qualified" out of the Act (Br. 49-50) by insisting that "enrollment through Exchanges is not *limited* to 'qualified individuals.'" That argument disregards the meaning of the word "qualified," which defines a class of persons who are eligible and by necessary implication excludes from eligibility those who do not possess the necessary qualifications. Unsurprisingly, therefore, the Act expressly equates "a qualified individual" with a person "eligible for enrollment in a qualified health plan offered through an Exchange." 42 U.S.C. 18051(e)(1) and (2).[21]

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[21] Other provisions confirm that Exchanges are open only to qualified individuals. See, *e.g.*, 42 U.S.C. 18031(c)(1)(F) (providing for an enrollment form that "qualified individuals" may use to enroll on Exchanges); 42 U.S.C. 18031(c)(5)(B) (same for an Internet portal facilitating enrollment); 42 U.S.C. 18031(i)(4)(A)(ii) (prohibiting payment of kickbacks for enrolling "any qualified

Petitioners' reading would also make a hash of other congressional judgments reflected in the text. The only people who are not "qualified individuals" are those who do not "reside[] in the State that established the Exchange," 42 U.S.C. 18032(f)(1)(A)(ii); those who are "incarcerated, other than incarceration pending the disposition of charges," 42 U.S.C. 18032(f)(1)(B); and those who are not "lawfully present in the United States," 42 U.S.C. 18032(f)(3). Petitioners identify no plausible reason why Congress would have fashioned the Act's qualified-individual architecture to permit an Exchange to offer coverage to those classes of people. To the contrary, opening the Exchange to residents of other States would contradict Congress's considered judgment that interstate sales of insurance should be restricted.[22] And Congress would have had no reason to authorize prisoners, who are entitled to medical care from their custodians, cf. *Estelle* v. *Gamble*, 429 U.S. 97, 103 (1976), to obtain coverage on an Exchange. Still less does it make sense to posit, as petitioners must, that Congress intended to place *all* residents of States with federally-facilitated Exchanges in the same statutory category as the incarcerated and people seeking to buy insurance across state lines.

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individuals" in qualified health plans but omitting any similar prohibition for other individuals).

[22] Congress considered and rejected broad proposals to authorize cross-state sales, see, *e.g.*, 155 Cong. Rec. S13,490 (Dec. 19, 2009) (amendment offered by Sen. Coburn), and instead adopted narrow provisions permitting cross-state purchases of insurance and operation of Exchanges only with HHS approval, 42 U.S.C. 18031(f)(1), 18053(a).

2. Petitioners' reading of Section 36B yields a further absurdity in another provision of the Act—the employer-responsibility provision. That provision imposes a tax on large employers that fail to offer affordable health coverage to their workers. 26 U.S.C. 4980H. The tax is triggered when one or more full-time employees receive a tax credit through an Exchange. 26 U.S.C. 4980H(a) and (b)(1)(B). Accordingly, under petitioners' reading, the employer-responsibility provision would no longer apply uniformly because employees who reside in States served by federally-facilitated Exchanges would no longer be eligible for tax credits.

But Section 4980H would not cease to apply altogether in States that declined to establish their own Exchanges. Instead, employers in such a State (*e.g.*, New Jersey or Virginia) could still face the tax based on their *total* number of employees if they hired even a single worker living in a neighboring State that had established an Exchange for itself (*e.g.*, New York or Maryland). 26 U.S.C. 4980H(a). Thus, within a single State, some employers would be subject to the tax while others would not, depending wholly on the fortuity of whether they hired across state lines. Petitioners identify no reason why Congress would have provided for such bizarre application of Section 4980H.[23]

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[23] Petitioners' amici States contend that Congress *intended* to authorize them to prevent the application of Section 4980H by declining to establish their own Exchanges. Okla. Amicus Br. 5-16; Ind. Amicus Br. 23-34. But they assume their reading would allow them to render Section 4980H entirely inapplicable within their borders; they do not defend the bizarre regime it would actually yield. The States' position is also irreconcilable with the structure of the Act in another respect. Beginning in 2017, a State may obtain a waiver of the Act's central provisions—including the tax

II. AT A MINIMUM, TREASURY'S INTERPRETATION IS A PERMISSIBLE ONE WARRANTING DEFERENCE

A. Section 36B authorizes Treasury to "prescribe such regulations as may be necessary" to implement the Act's tax credits. 26 U.S.C. 36B(g); see 26 U.S.C. 7805(a). An interpretation adopted in a notice-and-comment regulation promulgated pursuant to that authority "falls squarely within the bounds of, and is properly analyzed under, *Chevron*." *Mayo Found. for Med. Educ. & Research* v. *United States*, 131 S. Ct. 704, 714 (2011) (*Mayo Found.*). Even if the phrase "established by the State under [Section 18031]" in Section 36B could plausibly bear the restrictive meaning petitioners ascribe to it, that is not its only plausible meaning. To the contrary, the traditional tools of statutory interpretation confirm that Treasury's reading is at least a reasonable one warranting deference under *Chevron*. Pet. App. 26a-33a.

As a textual matter, petitioners' reading raises so many conflicts with other provisions of the Act that the phrase "established by the State" cannot be read to unambiguously *bar* tax credits in States with federally-facilitated Exchanges. For example, petitioners are surely incorrect that Section 36B unambiguously *denies* credits to individuals in such States, given the explicit and directly contrary text in

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credits, individual-coverage provision, and employer-responsibility provision—if it adopts alternative reforms satisfying specific criteria. 42 U.S.C. 18052(a). Given that carefully crafted waiver authority, it is untenable to assert that Congress allowed States immediately to wholly or partially nullify the Act's central provisions by declining to establish Exchanges for themselves—particularly given Congress's awareness that some States would resist the Act's implementation, see pp. 41-42, *supra*.

Section 36B itself, which requires those Exchanges to report information needed to reconcile tax credits. 26 U.S.C. 36B(f); see pp. 25-26, *supra*. In like manner, petitioners' reading cannot be unambiguously correct because it would mean that HHS could not possibly fulfill the statutory command in Section 18041(c)(1) that federally-facilitated Exchanges operate just like their state counterparts. See pp. 24-25, *supra*. And petitioners' reading cannot be unambiguously correct because it would mean that literally no one would be qualified to shop on federally-facilitated Exchanges and no insurance plans would be qualified to be sold there. See pp. 27-29, 51-53, *supra*. That petitioners are forced into so many textual contortions to avoid that outcome amply demonstrates that Section 36B does not unambiguously mean what they claim it means. See *Brown & Williamson*, 529 U.S. at 132 ("[T]he meaning—or ambiguity—of certain words or phrases may only become evident when placed in context.").

As demonstrated in Part I, all of these textual and structural tensions are readily resolved in favor of Treasury's interpretation by recognizing that the phrase "established by the State under Section 18031" is a term of art that encompasses an Exchange established for a particular State by HHS. That is why Treasury's interpretation is not merely reasonable, but the only plausible reading of the Act. But even where—unlike here—a statute contains "internal tension" because different provisions point "in divergent ways" and cannot readily be reconciled, "*Chevron* dictates that a court defer to the agency's * * * expert judgment about which interpretation fits best with, and makes most sense of, the statutory scheme."

Scialabba v. *Cuellar de Osorio*, 134 S. Ct. 2191, 2203 (2014) (plurality opinion); accord *id.* at 2219-2220 & n.3 (Sotomayor, J., dissenting). The Court should resolve any ambiguity in Section 36B by deferring to the expert agency charged with implementing that provision through notice-and-comment regulations.

B. Petitioners contend that *Chevron* is inapplicable for three reasons. All lack merit.

1. Petitioners first assert (Br. 52) that the question whether tax credits are available nationwide is too important to be left to an administrative agency. But *Chevron* applies as much to "big, important" matters as to "humdrum, run-of-the-mill stuff." *City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1868 (2013). The decisions on which petitioners rely did not hold that the *Chevron* framework is inapplicable to major questions; only that the statutes at issue in those cases were unambiguous because Congress would have spoken clearly had it intended to grant the agencies the authority they claimed. *UARG*, 134 S. Ct. at 2444; *Brown & Williamson*, 529 U.S. at 159. That principle provides no aid to petitioners. They contend that Congress would have spoken clearly had it intended to make tax credits available in every State, but there is far greater reason to think that it would have spoken clearly had it intended to *deny* credits to residents of States that opt not to set up Exchanges for themselves—thereby threatening those States with the destruction of their insurance markets and their residents with the denial of billions of dollars of tax credits.

2. Petitioners next assert (Br. 53-55) that *Chevron* is displaced in tax law by the canon that "exemptions from taxation are to be construed narrowly," *Mayo*

Found., 131 S. Ct. at 715 (citation omitted). But this Court has held that "*Chevron* appl[ies] with full force in the tax context," finding "no reason why * * * review of tax regulations should not be guided by agency expertise pursuant to *Chevron* to the same extent as * * * review of other regulations." *Id.* at 713.

In any event, the narrow-construction canon does not help petitioners because their interpretation of Section 36B would expand exceptions to other tax provisions. 26 U.S.C. 4980H, 5000A(e)(1); see Pet. Br. 8-9. And Treasury's interpretation is the only one consistent with the even more fundamental canon that federal tax laws are "to be interpreted so as to give a uniform application to a nationwide scheme of taxation" rather than in a manner "dependent upon state law." *Burnet* v. *Harmel*, 287 U.S. 103, 110 (1932); accord *United States* v. *Irvine*, 511 U.S. 224, 238 (1994); *Lyeth* v. *Hoey*, 305 U.S. 188, 194 (1938).

3. Finally, petitioners argue (Br. 55-56) that Treasury's interpretation of Section 36B is not entitled to deference because HHS has authority to implement other ACA provisions related to Exchanges. But Treasury's regulation remains an exercise of its expressly conferred authority to interpret Section 36B, even though that interpretation was properly informed by the Act as a whole. In any event, *Chevron* applies where two agencies jointly charged with implementing a statute adopt a common interpretation. See *Coeur Alaska, Inc.* v. *Southeast Alaska Conservation Council*, 557 U.S. 261, 277-278 (2009); *National Ass'n of Home Builders* v. *Defenders of Wildlife*, 551 U.S. 644, 664-666 (2007).

Petitioners' contrary argument turns Congress's delegation of authority on its head. Congress vested HHS and Treasury with responsibility to administer related provisions of the Act, and directed the Departments to coordinate their implementation. See, *e.g.*, 26 U.S.C. 36B(g)(1) (authorizing Treasury to make regulations for "coordination" of tax credits with HHS's "program for advance payment of the credit"). The Departments have done exactly that: As shown above, the shared understanding that an Exchange established by HHS qualifies as one "established by the State under Section 18031" undergirds the Departments' implementation of a number of provisions within their respective spheres of authority. The fact that petitioners' reading would upend not only the administration of the tax credits but also a host of the Act's other reforms only confirms that the Departments' shared interpretation harmonizing the Act's provisions warrants deference.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

1. 42 U.S.C. 18031 (ACA § 1311) provides in pertinent part:

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—

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[1] See References in Text note below.

(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-l(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 re-

quire, 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[2] 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—

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[2] See References in Text note below.

(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 cost-sharing 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 self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds

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

(6) Consultation

An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

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

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

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

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs

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

(e) Certification

(1) In general

An Exchange may certify a health plan as a qualified health plan if—

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

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

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

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

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

(2) Premium considerations

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1)[3] 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.

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[3] See References in Text note below.

(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.

(ii) 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.[3]

(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, in-

cluding 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.].

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(i) Navigators

(1) In general

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

(2) Eligibility

(A) In general

To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing

relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) Types

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

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

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

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

(3) Duties

An entity that serves as a navigator under a grant under this subsection shall—

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

(B) distribute fair and impartial information concerning enrollment in qualified health plans,

and the availability of premium tax credits under section 36B of 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.

2. 42 U.S.C. 18032 (ACA § 1312) provides:

Consumer choice

(a) Choice

(1) Qualified individuals

A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) Qualified employers

(A) Employer may specify level

A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 18022(d) of this title to be made available to employees through an Exchange.

(B) Employee may choose plans within a level

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

(b) Payment of premiums by qualified individuals

A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) Single risk pool

(1) Individual market

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

(2) Small group market

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

(3) Merger of markets

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

(4) State law

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

(d) Empowering consumer choice

(1) Continued operation of market outside Exchanges

Nothing in this title[1] shall be construed to prohibit—

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

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

(2) Continued operation of State benefit requirements

Nothing in this title[1] shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) Voluntary nature of an Exchange

(A) Choice to enroll or not to enroll

Nothing in this title[1] shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) Prohibition against compelled enrollment

Nothing in this title[1] shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

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[1] See References in Text note below.

(C) Individuals allowed to enroll in any plan

A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 18022(e) of this title, a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 18022(e)(2) of this title.

(D) Members of Congress in the Exchange

(i) Requirement

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

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

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

(ii) Definitions

In this section:

(I) Member of Congress

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

(II) Congressional staff

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

(4) No penalty for transferring to minimum essential coverage outside Exchange

An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of title 26 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such title).

(e) Enrollment through agents or brokers

The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals and employers in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

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

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

(1) Qualified individuals

In this title:[1]

(A) In general

The term "qualified individual" means, with respect to an Exchange, an individual who—

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

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

(B) Incarcerated individuals excluded

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

(2) Qualified employer

In this title:[1]

(A) In general

The term "qualified employer" means a small employer that elects to make all fulltime employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

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[1] See References in Text note below.

(B) Extension to large groups

(i) In general

Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) Large employers eligible

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

(3) Access limited to lawful residents

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

3. 42 U.S.C. 18041 (ACA § 1321) provides:

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,[1] and the amendments made by this title,[1] 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.].

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[1] See References in Text note below.

[1] See References in Text note below.

(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[1] shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[1]

(e) Presumption for certain State-operated Exchanges

(1) In general

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[1] See References in Text note below.

[2] So in original. Probably should be "Service".

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.

4. 26 U.S.C. 36B (ACA § 1401) provides:

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.

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[1] So in original. Probably should be preceded by "section".

(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

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[2] See References in Text note below.

(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 appli-

cable 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 meaning 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 l(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.

5. 42 U.S.C. 18083 (ACA § 1413) provides:

Streamlining of procedures for enrollment through an Exchange and State medicaid, CHIP, and health subsidy programs

(a) In general

The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX[1] [42 U.S.C. 1396 et seq.], or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act [42 U.S.C. 1397aa et seq.], the individual is enrolled for assistance under such plan or program.

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[1] So in original. Probably should be followed by "of the Social Security Act".

(b) Requirements relating to forms and notice

(1) Requirements relating to forms

(A) In general

The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) State authority to establish form

A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) Supplemental eligibility forms

The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not deter-

mined on the basis of the household income (as defined in section 36B of title 26).

(2) Notice

The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) Requirements relating to eligibility based on data exchanges

(1) Development of secure interfaces

Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 18081(c)(4) of this title.

(2) Data matching program

Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent[2] with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act [42 U.S.C. 1396w-2] or that are otherwise applicable to such programs.

(3) Determination of eligibility

(A) In general

Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

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[2] So in original. Probably should be preceded by "is".

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act [42 U.S.C. 1320b-7, 653(i), 1396w-2(a)], obtained through such arrangement.

(B) Exception

This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) Secretarial standards

The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) Administrative authority

(1) Agreements

Subject to section 18081 of this title and section 6103(*l*)(21) of title 26 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and

enter into agreements, for the sharing of data under this section.

(2) Authority of exchange to contract out

Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX[1] that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) Applicable State health subsidy program

In this section, the term "applicable State health subsidy program" means—

(1) the program under this title[3] for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(2) a State medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.];

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[3] See References in Text note below.

(3) a State children's health insurance program (CHIP) under title XXI of such Act [42 U.S.C. 1397aa et seq.]; and

(4) a State program under section 18051 of this title establishing qualified basic health plans.

6. 42 U.S.C. 300gg-91 (as amended by ACA § 1563) provides in pertinent part:

Definitions

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(d) Other definitions

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(21) Exchange

The term "Exchange" means an American Health Benefit Exchange established under section 18031 of this title.

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7. 42 U.S.C. 1396a (as amended by ACA § 2001) provides in pertinent part:

State plans for medical assistance

* * * * *

(gg) Maintenance of effort

(1) General requirement to maintain eligibility standards until State exchange is fully operational

Subject to the succeeding paragraphs of this subsection, during the period that begins on March 23, 2010, and ends on the date on which the Secretary determines that an Exchange established by the State under section 18031 of this title is fully operational, as a condition for receiving any Federal payments under section 1396b(a) of this title for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on March 23, 2010.

(2) Continuation of eligibility standards for children until October 1, 2019

The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this subchapter or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

(3) Nonapplication

During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State

with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4) Determination of compliance

(A) States shall apply modified adjusted gross income

A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(B) States may expand eligibility or move waivered populations into coverage under the State plan

With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on March 23, 2010, or that makes individuals who, on March 23, 2010, are eligible for medical assistance under a waiver of the State plan, after March 23, 2010, eligible for medical 'assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of subsection (a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

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8. 42 U.S.C. 1397ee (as amended by ACA § 2101) provides in pertinent part:

Payments to States

* * * * *

(d) Maintenance of effort

* * * * *

(3) Continuation of eligibility standards for children until October 1, 2019

(A) In general

During the period that begins on March 23, 2010, and ends on September 30, 2019, as a condition of receiving payments under section 1396b(a) of this title, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 1397ee(a)(1)(A) of this title) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on March 23, 2010. The preceding sentence shall not be construed as preventing a State during such period from—

(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children un-

der the plan or waiver that are in effect on March 23, 2010;

(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or

(iii) imposing a limitation described in section 1397*ll*(b)(7) of this title for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

(B) Assurance of exchange coverage for targeted low-income children unable to be provided child health assistance as a result of funding shortfalls

In the event that allotments provided under section 1397dd of this title are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this subchapter, a State shall establish procedures to ensure that such children are screened for eligibility for medical assistance under the State plan under subchapter XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under subchapter XIX, the State shall

establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange established by the State under section 18031 of this title. For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 18071 of this title, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.

(C) Certification of comparability of pediatric coverage offered by qualified health plans

With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 18031 of this title and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.

* * * * *

9. 42 U.S.C. 1396w-3 (ACA § 2201) provides:

Enrollment simplification and coordination with State health insurance exchanges

(a) Condition for participation in Medicaid

As a condition of the State plan under this subchapter and receipt of any Federal financial assistance under section 1396b(a) of this title for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is[1] met.

(b) Enrollment simplification and coordination with State health insurance exchanges and CHIP

(1) In general

A State shall establish procedures for—

(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 18031 of this title as being eligible for—

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[1] So in original. Probably should be "are".

(i) medical assistance under the State plan or under a waiver of the plan; or

(ii) child health assistance under the State child health plan under subchapter XXI;

(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under subchapter XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 18071 of this title, and any other assistance or subsidies available for coverage obtained through the Exchange;

(D) ensuring that the State agency responsible for administering the State plan under this subchapter (in this section referred to as the "State Medicaid agency"), the State agency responsible for administering the State child health plan under subchapter XXI (in this section referred to as the "State CHIP agency") and an Exchange established by the State under section 18031 of this title utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such

medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this subchapter, subchapter XXI, or a qualified health plan, as appropriate;

(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under subchapter XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with the requirements of section 1396a(a)(43) of this title; and

(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this subchapter or for child health assistance under subchapter XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(2) Agreements with State health insurance exchanges

The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 18031 of this title under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

(3) Streamlined enrollment system

The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 18083 of this title (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

(4) Enrollment website requirements

The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 18031 of this title and to the State CHIP agency (if different from the State Medicaid agency) and allows

an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

(5) Continued need for assessment for home and community-based services

Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).[2]

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[2] Probably means subsection (a)(10)(A)(ii)(VI) of section 1396a of this title.

10. 26 U.S.C. 35 provides in pertinent part:

Health insurance costs of eligible individuals

(a) In general

In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A an amount equal to 72.5 percent of the amount paid by the taxpayer for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

(b) Eligible coverage month

For purposes of this section—

(1) In general

The term "eligible coverage month" means any month if—

(A) as of the first day of such month, the taxpayer—

(i) is an eligible individual,

(ii) is covered by qualified health insurance, the premium for which is paid by the taxpayer,

(iii) does not have other specified coverage, and

(iv) is not imprisoned under Federal, State, or local authority, and

(B) such month begins more than 90 days after the date of the enactment of the Trade Act of 2002, and before January 1, 2014.

(2) Joint returns

In the case of a joint return, the requirements of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirements.

(c) Eligible individual

For purposes of this section—

(1) In general

The term "eligible individual" means—

(A) an eligible TAA recipient,

(B) an eligible alternative TAA recipient, and

(C) an eligible PBGC pension recipient.

(2) Eligible TAA recipient

(A) In general

Except as provided in subparagraph (B), the term "eligible TAA recipient" means, with respect to any month, any individual who is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974 or who would be eligible to receive such allowance if section 231 of such Act were applied without regard to subsection (a)(3)(B) of such section. An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(B) Special rule

In the case of any eligible coverage month beginning after the date of the enactment of this paragraph, the term "eligible TAA recipient" means, with respect to any month, any individual who—

(i) is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974,

(ii) would be eligible to receive such allowance except that such individual is in a break in training provided under a training program approved under section 236 of such Act that exceeds the period specified in section 233(e) of such Act, but is within the period for receiving such allowances provided under section 233(a) of such Act, or

(iii) is receiving unemployment compensation (as defined in section 85(b)) for any day of such month and who would be eligible to receive such allowance for such month if section 231 of such Act were applied without regard to subsections (a)(3)(B) and (a)(5) thereof.

An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(3) Eligible alternative TAA recipient

The term "eligible alternative TAA recipient" means, with respect to any month, any individual who—

(A) is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and

(B) is receiving a benefit for such month under section 246(a)(2) of such Act.

An individual shall continue to be treated as an eligible alternative TAA recipient during the first month that such individual would otherwise cease to be an eligible alternative TAA recipient by reason of the preceding sentence.

(4) Eligible PBGC pension recipient

The term "eligible PBGC pension recipient" means, with respect to any month, any individual who—

(A) has attained age 55 as of the first day of such month, and

(B) is receiving a benefit for such month any portion of which is paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974.

(d) Qualifying family member

For purposes of this section—

(1) In general

The term "qualifying family member" means—

(A) the taxpayer's spouse, and

(B) any dependent of the taxpayer with respect to whom the taxpayer is entitled to a deduction under section 151(c).

Such term does not include any individual who has other specified coverage.

(2) Special dependency test in case of divorced parents, etc.

If section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (as defined in section 152(e)(4)(A)) and not with respect to the noncustodial parent.

(e) Qualified health insurance

For purposes of this section—

(1) In general

The term "qualified health insurance" means any of the following:

(A) Coverage under a COBRA continuation provision (as defined in section 9832(d)(1)).

(B) State-based continuation coverage provided by the State under a State law that requires such coverage.

(C) Coverage offered through a qualified State high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

(D) Coverage under a health insurance program offered for State employees.

(E) Coverage under a State-based health insurance program that is comparable to the health insurance program offered for State employees.

(F) Coverage through an arrangement entered into by a State and—

(i) a group health plan (including such a plan which is a multiemployer plan as defined in section 3(37) of the Employee Retirement Income Security Act of 1974),

(ii) an issuer of health insurance coverage,

(iii) an administrator, or

(iv) an employer.

(G) Coverage offered through a State arrangement with a private sector health care coverage purchasing pool.

(H) Coverage under a State-operated health plan that does not receive any Federal financial participation.

(I) Coverage under a group health plan that is available through the employment of the eligible individual's spouse.

(J) In the case of any eligible individual and such individual's qualifying family members, coverage under individual health insurance if the eligible individual was covered under individual health insurance during the entire 30-day period that ends on the date that such individual became separated from the employment which qualified such individual for—

(i) in the case of an eligible TAA recipient, the allowance described in subsection (c)(2),

(ii) in the case of an eligible alternative TAA recipient, the benefit described in subsection (c)(3)(B), or

(iii) in the case of any eligible PBGC pension recipient, the benefit described in subsection (c)(4)(B).

For purposes of this subparagraph, the term "individual health insurance" means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

(K) Coverage under an employee benefit plan funded by a voluntary employees' beneficiary association (as defined in section 501(c)(9)) established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, as provided in section 1114 of title 11, United States Code.

(2) Requirements for state-based coverage

(A) In general

The term "qualified health insurance" does not include any coverage described in subparagraphs (B) through (H) of paragraph (1) unless the State involved has elected to have such coverage treated as qualified health insurance under this section and such coverage meets the following requirements:

(i) Guaranteed issue

Each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs credit eligibility certificate described in section 7527 and pays the remainder of such premium.

(ii) No imposition of preexisting condition exclusion

No pre-existing condition limitations are imposed with respect to any qualifying individual.

(iii) Nondiscriminatory premium

The total premium (as determined without regard to any subsidies) with respect to a qualifying individual may not be greater than the total premium (as so determined) for a similarly situated individual who is not a qualifying individual.

(iv) Same benefits

Benefits under the coverage are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

(B) Qualifying individual

For purposes of this paragraph, the term "qualifying individual" means—

(i) an eligible individual for whom, as of the date on which the individual seeks to enroll in the coverage described in subparagraphs (B) through (H) of paragraph (1), the aggregate of the periods of creditable coverage (as defined in section 9801(c)) is 3 months or longer and who, with respect to any month, meets the requirements of clauses (iii) and (iv) of subsection (b)(1)(A); and

(ii) the qualifying family members of such eligible individual.

(3) Exception

The term "qualified health insurance" shall not include—

(A) a flexible spending or similar arrangement, and

(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

* * * * *

11. 26 C.F.R. 1.36B-1 provides in pertinent part:

Premium tax credit definitions.

* * * * *

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

* * * * *

12. 26 C.F.R. 1.36B-2 provides in pertinent part:

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).

* * * * *

13. 45 C.F.R. 155.20 provides in pertinent part:

Definitions.

* * * * *

Exchange means a governmental agency or nonprofit 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.

* * * * *

Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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