UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

STATE OF INDIANA, et al., Plaintiffs, v. INTERNAL REVENUE SERVICE, et al., Defendants.	)	CASE NO. 1:13-cv-1612-WTL-TAB

AMENDED BRIEF IN SUPPORT OF PLAINTIFF SCHOOL CORPORATIONS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The federal government, by administrative rule, is extending the employer penalty provisions of the Patient Protection & Affordable Care Act ("ACA") to Indiana. Absent this administrative rule, those penalties, which can amount to millions of dollars depending on the size of the employer, would not apply in Indiana.

A stated purpose of the ACA is to provide near-universal, affordable health insurance coverage. But the ACA, through the methods employed to achieve that goal, is no stranger to controversy. On June 28, 2012, for example, the Supreme Court of the United States struck down part of the Medicaid expansion of the ACA, whereby the Federal Government could withdraw all Medicaid funding from non-participating states, as an unconstitutional extension of Congressional power under the Spending Clause. *See Nat'l Fed'n of Indep. Bus. v. Sebelius,* 132 S. Ct. 2566 at 2601-07 (2012) (opinion of Roberts, C.J).

The specific ACA controversy underlying this lawsuit emanates from the same legislative pool as the Medicaid expansion controversy. To facilitate the purchase of minimum-value, affordable coverage, the ACA created the concept of insurance "Exchanges." Specifically, the ACA provides that each of the 50 states "shall" establish an Exchange through which individuals may shop for, compare, and purchase health insurance, and that the Secretary of the Department of Health & Human Services shall establish the Exchange in any state that elects not to establish one. Importantly, in a provision added to the Internal Revenue Code by the ACA, premium assistance credits and cost-sharing reductions are available to offset certain costs of coverage, but only for insurance purchased through "an Exchange established by the State" under a certain section of the ACA (section 1311). Thus, although the goal of the ACA is near-universal coverage, Congress adopted a very specific delivery model: As with its assumption underlying the Medicaid expansion of universal participation by the states, Congress assumed that all 50

states would establish their own Exchanges, thereby making premium assistance credits and cost-sharing reductions available in all 50 states and keeping the federal government out of it.

This emphasis on state-established Exchanges was a necessary precondition to the passage of the ACA. In late 2009, the House of Representatives, under a Democrat majority, passed a health reform bill that put the responsibility for establishing and managing the Exchanges on the federal government. This fed-centric approach could not muster sufficient votes in the Senate to advance, and instead the Senate adopted an approach that sought to push the states into the lead on healthcare reform through a series of carrots and sticks. That is, although Congress sought to expand the depth and breadth of health insurance available to Americans through the ACA, it desired to limit as much as possible the federal government's direct involvement in managing those reforms by enticing the states, principally through tax credits to their citizens, to establish the Exchanges. In a surprise to many, 34 states elected not to establish their own Exchanges, thereby frustrating Congress's goal of keeping the federal government out of the Exchange business.

Even so, the Internal Revenue Service adopted a rule that makes the premium assistance credits and cost-sharing reductions available to any taxpayer who purchases insurance through any Exchange, whether state-established or federally-facilitated (generally, the "IRS Rule"). The only justification offered by the IRS for this rule in the Federal Register is that it is consistent with the text, structure, purpose, and legislative history of the ACA. In announcing this justification, the IRS did not attempt to explain why or how it was true. For example, even though the IRS asserted that its rule was supported by the text of the ACA, it did not cite any provision of the ACA in support of this assertion, because there is no such text.

The effect of this IRS Rule is at least two-fold. First, it allows a federal agency to appropriate potentially billions of dollars from the United States Treasury that Congress did not authorize. Second, and more germane to these plaintiffs, it triggers liability under the ACA's employer mandate. Under the law, an employer of 50 or more full-time equivalent employees that fails to offer minimum-value, affordable coverage and has at least one full-time employee (defined as 30-plus hours of service a week on average) who receives a premium assistance tax credit or a cost-sharing reduction is subject to the employer mandate penalties, which are fines that, depending on the number of full-time employees, could amount to millions of dollars.

But for the IRS Rule, the plaintiffs, as employers, would not be subject to the employer mandate penalties, because Indiana was one of the states that elected not to establish its own Exchange. Instead, its citizens and residents may choose from plans offered through the federally-facilitated Exchange (www.healthcare.gov). Now, because of the IRS Rule, the policy choice of the state of Indiana, the intent of Congress, and the plain, unambiguous language of the ACA have been thrust aside by the illegal, *ultra vires* actions of an unelected, unaccountable federal agency. For the reasons that follow, the IRS Rule should be invalidated under the Administrative Procedure Act. (And, for the reasons set forth in the State of Indiana's Motion for Summary Judgment and Memorandum in Support of Motion for Summary Judgment (which the Schools hereby incorporate by reference), the Employer Mandate (specifically, Sections 1513 and 1514 of the ACA), should be invalidated as to the Schools as well as the State as a violation of the Tenth Amendment and related intergovernmental immunity doctrines. Finally, also for the reasons set forth by the State, the Court should enter a decree estopping or enjoining the federal government from enforcing the penalty provisions of Section 1513 for violations of that section that occur in 2014.)

STATUTORY, REGULATORY, AND FACTUAL BACKGROUND

A. The ACA Presumes that States Will Establish New Insurance Exchanges, but Provides that the Federal Government Is the Back-up Plan.

The ACA provides, "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange ["Exchange"] . . . for the State that facilitates the purchase of qualified health plans." ACA, § 1311(b)(1); 42 U.S.C. § 18031(b)(1). The Exchange must "meet the requirements of subsection (d)" of Section 1311. *Id.* That subsection sets forth various requirements regarding the types of insurance Exchanges may offer, how Exchanges operate, and the type and categories of information the Exchanges must submit to the Secretary of the Department of Health & Human Services (the "Secretary") for purposes of enforcing the employer mandate to provide minimum essential coverage that satisfies the ACA's definition of "affordable." *See* ACA, § 1311(d); 42 U.S.C. § 18031(d).

Although the ACA provides that each state "shall" establish an Exchange, the federal government cannot impose that requirement on the sovereign states. *See Printz v. United States*, 521 U.S. 898, 925 (1997) ("The Federal Government may not compel the states to implement, by legislation or executive action, federal regulatory programs."); *see also Nat'l Fed'n of Indp. Bus.*, 132 S. Ct. at 2607 ("What Congress is not free to do is penalize the states that choose not to participate in that new program [*i.e.*, the Medicaid expansion program in the ACA] by taking away their existing Medicaid funding.") (Roberts, C.J.); *New York v. United States*, 505 U.S. 144, 162 (1992) ("The Constitution has never been understood to confer upon Congress the ability to require the states to govern according to Congress' instructions."). In the event a state did not elect to establish its own Exchange, or in the event an electing state failed to meet the requirements imposed by the Secretary, Congress directed the federal government to serve as the back-up plan; in such a case, Section 1321 provides that "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." ACA, § 1321(c); 18 U.S.C. § 18041(c).

In short, the ACA provides that two separate entities may establish the Exchanges: the states pursuant to § 1311 of the ACA, and the federal government pursuant to § 1321 of the ACA, with the latter existing only in states that decline to establish their own. Importantly, the ACA defines "State" as "each of the 50 states and the District of Columbia." ACA, § 1304; 42 U.S.C. § 18024(d). *Accord* 45 C.F.R. § 155.20 (defining "State" as "each of the 50 States and the District of Columbia"). Thus, while the Exchanges established by the states and the federal government fulfill the same function, they are established by separate constitutional sovereigns through distinct statutory sections.

B. Congress Entices the States to Establish the Exchanges through the Promise of Tax Credits and Cost-sharing Reductions.

Because Congress could not compel states to establish Exchanges, the ACA uses a variety of tools to encourage states to establish Exchanges voluntarily. These incentives to the States were important to Congress, because Congress could not muster support for an earlier proposal for comprehensive health insurance reform that embedded the exchanges in a new "Health Choices Administration," which was to be located in the Executive Branch. *See* Reconciliation Act of 2010, H.R. 4872 §§ 141(a), 201(a) (2010) (version reported in the House on March 17, 2010); *see also Halbig v. Sebelius*, 2014 WL 129023, 1:13-cv-00623-PLF, Dkt. 67 (D. D. C. Jan. 15, 2014) ("Halbig Slip Op.") at 36 ("Ultimately, however, [the Reconciliation Act of 2010] proved politically untenable and doomed to failure in the Senate, so the Senate passed a bill that provided 'flexibility' to each state as to whether it would operate the Exchange."). By contrast, the Senate bill, which ultimately became the ACA, passed only

because it contained provisions that shifted the focus to state-established exchanges. *See* Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO, Jan. 25, 2010 *at* http://www.politico.com/livepulse/0110/Nelson_National_exchange_a_dealbreaker.html (last visited on February 12, 2014) (Sen. Nelson: "The national exchange is unnecessary and I wouldn't support something that would start us down the road of federal regulation of insurance and a single-payerplan."). After Scott Brown won a special election in Massachusetts following the passing of Sen. Edward Kennedy, the Senate Democrats no longer possessed a filibuster-proof majority and the House of Representatives passed the Senate bill rather than have both houses attempt to reconcile the competing bills in conference committee.

One mechanism the ACA adopted to encourage states to establish Exchanges voluntarily was the use of federal grants to states for "activities (including planning activities) related to establishing an [Exchange]." ACA, § 1311(a); 42 U.S.C. § 18031(a). Based on its aversion to embedding the federal government too deeply in the insurance market, Congress did not appropriate any funds in the ACA for the federal government to establish Exchanges, even as it appropriated funds to help states establish theirs, *see* ACA, § 1311(a)(1); 42 U.S.C. § 18031(a)(1) ("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 . . . to States . . . for the uses described in paragraph (3)"), and (3) ("A State shall use amounts awarded under this subsection for activities . . . related to establishing an American Health Benefit Exchange as described in subsection (b)"). *See also* J. Lester Feder, *HHS May Have to Get 'Creative' on Exchange*, POLITICO, August 16, 2011 at *http://www.politico.com/news/stories/0811/61513.html* (last visited on February 24, 2014)

("While sorting out the policy kinks in setting up a federal exchange, HHS must tackle another problem: There is no money to pay for it.").

Conversely, the Act also created disincentives for the states to encourage them to establish their own Exchanges: The ACA penalizes states that do not create their own Exchanges by prohibiting them from tightening their Medicaid eligibility standards. *See* ACA, § 2001(b)(2); 42 U.S.C. § 1396a(gg) (requiring maintenance of eligibility standards until "the Secretary determines that an Exchange established by the State under section 1311 of the [ACA] is fully operational").

Most importantly, the ACA authorizes premium assistance subsidies for state residents who purchase individual health insurance coverage through state-established Exchanges. These subsidies take the form of refundable tax credits, which are paid directly from the federal treasury to the taxpayer's insurer, as an offset against the taxpayer's premiums. *See* ACA, §§ 1401, 1412; 26 U.S.C. § 36B; 42 U.S.C. § 18082. Targeted at low- and moderate-income Americans, the subsidy is available to households with incomes between 100 percent and 400 percent of the federal poverty level. *See* ACA, § 1401(c)(1)(a); 26 U.S.C. § 36B(c)(1)(a).

Critically, the subsidy is available only for individuals who purchase insurance through an Exchange established by a state under section 1311 of the ACA. Specifically, the ACA provides that a tax credit "shall be allowed" in a particular "premium assistance credit amount," 26 U.S.C. § 36B(a), with that amount calculated based on the number of "coverage months of the taxpayer occurring during the taxable year," *id.* § 36B(b)(1). The ACA then defines a "coverage month" as a month for which, "as of the first day of such month the taxpayer … is covered by a

qualified health plan[1]. . . that was enrolled in through an Exchange *established by the State under section 1311* of the [ACA]." ACA § 1401(c)(2)(A)(i); 26 U.S.C. § 36B(c)(2)(A)(i) (emphasis supplied). Under this structure, unless one buys insurance through a state-established Exchange, there are no "coverage months" and therefore no subsidies. In other words, purchasing insurance through a state-established Exchange is a precondition to receiving a subsidy.

Confirming this fact, the value of the subsidy, called the "premium assistance amount," for any particular "coverage month" is based on the monthly premium for a "qualified health pla[n] *offered in the individual market within a State* which cover[s] the taxpayer … *and which w[as] enrolled in through an Exchange established by the State under [§] 1311* of the [ACA]." *Id.* § 36B(b)(2)(A) (emphasis supplied); *see also id.*§ 36B(b)(3)(B)(i) (referring back to "same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered" for the purpose of calculating another value that bears upon amount of subsidy). That is, two conditions must be satisfied before a premium assistance credit is available: (1) the taxpayer must purchase a plan in the individual market within a state; and (2) the taxpayer must enroll in that plan through an Exchange established by the state. Thus, under the ACA, plans in the individual market may be offered through either the state or federal Exchanges, but only those enrolled in through an Exchange "established by the state" are eligible for premium assistance credits.

[1] A "qualified health plan" means a health plan that is certified or recognized by the Exchange through which it is offered, provides the coverage required under the ACA, and is offered through an issuer which meets certain requirements. ACA § 1301(a); 42 U.S.C. § 18021(a).

C. Thirty-Four States Decline to Establish an Exchange.

Despite the incentives provided by Congress, 34 states elected not to establish an Exchange under § 1311. *See State Decisions for Creating Health Insurance Marketplaces*, Kaiser State Health Facts, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ ("State Decisions") (last visited on February 25, 2014).[2] Twenty-seven states opted out of the Exchange regime completely, while another seven opted to assist the federal government with the operation of the federally-established Exchange in those states. *See id.*; *see also* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,325 (Mar. 27, 2012) ("A Partnership Exchange would be a variation of a Federally-facilitated Exchange . . . HHS would have ultimate responsibility for and authority over the Partnership Exchange.")

D. Undeterred, the IRS, through a Rule, Extends Tax Credits and Cost-sharing Reductions to Coverage Purchased Through the Federally-facilitated Exchange.

Notwithstanding the ACA's express limitation of premium assistance credits to qualified health plans purchased through an "Exchange established by the State under section 1311 of the [ACA]," the IRS, by rule, unilaterally extended these credits (and therefore disbursements from the United States Treasury) to qualified health plans purchased through HealthCare.gov, which was established by the federal government under § 1321 of the ACA.

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[2] The 34 states are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. *See State Decisions*, *supra*. The District of Columbia, statutorily defined as a "state" by the ACA, established a state-based Exchange. *Id.*

The IRS published a regulation (the "IRS Rule") that provides, "An applicable taxpayer . . . is allowed a premium assistance amount only for any month that one or more members of the applicable taxpayer's family . . . is enrolled in one or more qualified health plans through an Exchange." Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,387 (May 23, 2012). In defining "Exchange" for purposes of the IRS Rule, the IRS declared that it "has the same meaning as in 45 CFR 155.20, which provides that the term *Exchange* refers to a State Exchange, regional Exchange, subsidiary Exchange, *and Federally-facilitated Exchange*." *Id.* at 30,378 (emphasis supplied).[3] In effect, the IRS Rule eliminates the limiting language from the ACA that restricts premium assistance credits to qualified health plans purchased through Exchanges "established by the State under section 1311 of the [ACA]." Under the IRS Rule, those credits are available in all 50 states and the District of Columbia, even those 34 states that elected not to establish their own Exchanges and for which HealthCare.gov serves as the Exchange.

Commentators challenged the IRS's interpretation of 26 U.S.C. § 36B and the extension of premium assistance payments to those who purchased insurance through a federally-facilitated Exchange. In response, the IRS offered only the following justification:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

77 Fed. Reg. 30,378 (May 23, 2012); *see also* T.D. 9590, 2012-24 I.R.B. 1(g) (June 11, 2012).

[3] This, even though the Secretary separately defined a "Federally-facilitated Exchange" to mean "an Exchange established and operated *within* a State by the Secretary under section 1321(c)(1) of the [ACA]." 45 C.F.R. § 155.20 (emphasis supplied).

E. The IRS Rule Expands the Employer Mandate and Its Penalties to Employers in States that Elected not to Establish an Exchange.

The IRS Rule impacts employers directly because the ACA imposes a penalty under certain conditions on employers whose employees receive premium assistance credits. This is the ACA's "employer mandate." Under the heading "Shared responsibility for employers regarding health coverage," the ACA imposes a penalty on employers of more than 50 full-time equivalent employees if the employer fails to offer its full-time employees, defined as any employee who works more than 30 hours of service on average per week, "minimum essential coverage" for any month *and* at least one full-time employee enrolls for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to that employee. *See* ACA § 1513(a); 26 U.S.C. § 4980H(a), (c)(2), (c)(4).

The "applicable premium tax credit" language relates to Section 36B of the Internal Revenue Code, which was added by ACA § 1401 and is discussed above. These credits, when applicable, provide premium assistance to individuals or families whose income is between 100 to 400 percent of the federal poverty level. The "cost sharing reduction" is set forth in ACA § 1402. It is designed to defray out-of-pocket costs—copays, deductibles, and coinsurance—for individuals or families with income up to 250 percent of the federal poverty level who enroll in a qualified health plan. Importantly, "no cost sharing reduction shall be allowed . . . with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B" of the Internal Revenue Code. ACA § 1402(f)(2); 42 U.S.C. § 18071(f)(2).

The monthly amount charged to the employer who fails to offer coverage to its full-time employees, called an assessable payment, is defined as the product of the number of full-time employees employed by the employer (minus 30) and 1/12 of $2,000. ACA § 1513(a), (c)(1),

and (c)(2)(D)(i); 26 U.S.C. § 4980H(a), 26 U.S.C. § 4980H(c)(1), and 26 U.S.C. § 4980H(c)(2)(D)(i). A large employer that fails to offer minimum essential coverage to at least 95 percent of its full-time employees is deemed not to offer coverage under the ACA.[4] 26 U.S.C. § 4980H(a); Treas. Reg. § 54-4980H-4(a). Thus, if a school employer of 130 full-time employees, for example, does not offer insurance to seven instructional aides who work 35 hours of service per week and one of those aides receives a premium assistance credit, the school employer's annual assessable payment is $200,000. If the school has 1,030 full-time employees and does not offer coverage to 53 of its full-time employees (average of 30 or more hours of service per week), the school employer's annual assessable payment is $2,000,000 if just one of those 53 full-time employees receives a premium assistance credit.

Similarly, if an employer offers minimum essential coverage to 95 percent of its full-time employees, but one or more of those full-time employees receives a premium tax credit or a cost-sharing reduction because the plan is not considered "affordable," or does not provide "minimum value," the employer is assessed a payment, which is also calculated monthly, that is based on the number of employees receiving the premium credit or the cost-sharing reduction multiplied by 1/12 of $3,000 (but this payment cannot be more than the amount that would be charged in the event the employer did not offer coverage). ACA § 1513(b); 26 U.S.C. § 4980H(b). Using a 1,000-employee school corporation as an example, and assuming that 25 full-time employees

[4] On February 10, 2014, the United States Treasury and the IRS issued final regulations implementing the shared responsibility provisions under the ACA. The preamble to the final regulations provides limited transition relief under Section 4980H(a). The preamble states, for each calendar month during 2015 and any calendar months during the 2015 plan year that fall in 2016, an applicable large employer member that offers coverage to at least 70 percent (or that fails to offer to no more than 30 percent) of its full-time employees (and, to the extent required, their dependents) will not be subject to an assessable payment under section 4980H(a). However, applicable large employers will continue to be subject to a potential assessable payment under 4980H(b). Shared Responsibility for Employers Regarding Health Coverage; Final Rule; 79 Fed. Reg. 8544, 8575 (Feb. 12, 2014).

receive a premium assistance credit or a cost-sharing reduction, the employer's annual assessable payment is $75,000. If 100 employees fall into this category, the assessable payment is $300,000.

F. The State of Indiana and 39 Public School Districts File Suit to Challenge the IRS Rule.

On October 8, 2013, the State of Indiana, both as a sovereign and as an applicable large employer, and 15 public school corporations, both as arms of the State of Indiana under the Tenth Amendment and as applicable large employers, sued to invalidate the IRS Rule. On December 9, 2013, the plaintiffs filed an amended complaint that added the Department of Labor and Secretary of Labor as defendants and 24 additional school corporations as plaintiffs. Through the Amended Complaint, the State of Indiana and the 39 public school corporations are asking the Court to declare the IRS Rule invalid and to enjoin its application.

Indiana elected not to establish an Exchange, which means that the federal HealthCare.gov is the Exchange for Indiana. By purporting to extend the availability of the tax credits and cost-sharing reductions to those states in which HealthCare.gov is the Exchange, the IRS Rule also expands the application of the employer mandate to the State of Indiana and the public school corporations, contrary to the express terms of the ACA and the policy choice of Indiana. Under the language of the ACA, these credits and cost-sharing reductions are available to a taxpayer only for qualified health plans offered in the individual market within a State *and* "which were enrolled in through an Exchange established by the State under [section] 1311 of the [ACA]." Thus, the question for summary judgment is whether this second condition—linking the eligibility for premium credits and cost reductions (and thereby linking liability for the employer mandate penalties) only to coverage purchased through a state-established Exchange—embodies the intent of Congress. The plaintiffs submit that it does.

STATEMENT OF UNDISPUTED MATERIAL FACTS

A. Schools Have Reduced the Hours of Several Essential Positions to Fewer Than 30 Hours Per Week.

1. Cloverdale Community Schools ("CCS") has reduced the hours of non-certified support staff, including bus drivers, food service staff, and instructional assistants to fewer than 30 hours per week so those employees are considered part-time under the ACA. Field trips and extracurricular trips remain a concern as CCS has a reduced pool of available drivers. New hires, for the most part, will be kept under 30 hours per week**.** CCS has had to severely limit the amount of time instructional assistants spend with special education students in order to keep them under 30 hours per week. Declaration of Dr. Carrie Milner ("Milner Decl.") ¶ 3.

2. North Lawrence Community Schools ("NLCS") has reduced the hours of all instructional assistants to 28 hours per week so those employees are considered part-time under the ACA. Declaration of Gary Conner ("Conner Decl.") ¶ 3; Conner Decl., Ex. 1 (March 20, 2013 Support Staff Meeting notes); Conner Decl., Ex. 2 (March 20, 2013 *Times Mail News* article); Conner Decl., Ex. 3 (March 31, 2013 *Times Mail News* Article). About 200 employees' hours have been reduced. Conner Decl., ¶ 3; Conner Decl., Ex. 2 (March 20, 2013 *Times Mail News* article). This change has made it especially difficult when NLCS is trying to provide consistency and stability with one-on-one aides. NLCS buildings have been creative with their schedules in order to make sure all school hours are covered by scheduling some members four-seven hour days and others are working five and a half hour days with staggered start times. Where NLCS used to have plenty of coverage, now the school buildings only have one or two staff members present for a longer period of time until the other shifts begin. Conner Decl. ¶ 4. The instructional assistants' reduction in hours has resulted in less instructional time with

NLCS' special education students. Conner Decl. ¶ 4; Conner Decl., Ex. 3 (March 31, 2013 *Times Mail News* Article).

3. The South Henry School Corporation Board adopted a resolution on May 13, 2013, which resolved that because the district "is not financially able to provide affordable, minimum value coverage to all of its employees who work at least thirty hours of service per week . . . the School Corporation shall limit the hours of nineteen classified employees (thirteen instructional assistants and six cafeteria staff) to twenty-nine hours per week effective June 1, 2013." Declaration of W. James Hamilton ("Hamilton Decl.") ¶ 3; Hamilton Decl., Ex. 1 (May 13, 2013 South Henry School Corporation Resolution).

4. Northwestern Consolidated School District of Shelby County ("NW-SC") has reduced the hours of 41 employees to fewer than 30 hours per week. Declaration of Dr. Shane Robbins ("Robbins Decl.") ¶ 3; Robbins Decl., Ex. 1 (April 10, 2013 NW-SC School Board meeting minutes).

5. Benton Community School Corporation ("BCSC") has limited 75 instructional aides and cafeteria staff to working under 30 hours per week. Declaration of Tracy Albertson ("Albertson Decl.") ¶ 3; Albertson Decl., Ex. 1 (September 16, 2013 BCSC School Board meeting minutes); Albertson Decl., Ex. 2 (November 18, 2013 BCSC School Board meeting minutes).

6. Vincennes Community School Corporation ("VCSC") has often been unable to cover classrooms adequately with qualified substitute teachers because of the 30-hour per week standard. Declaration of Greg Parsley ("Parsley Decl.") ¶ 3.

7. North Putnam Community School Corporation ("NPCSC") has reduced the hours of 42 employees to fewer than 30 hours per week so that those employees are considered part-

time. Declaration of Daniel Noel ("Noel Decl.") ¶ 3; Noel Decl., Ex. 1 (January 16, 2014 NPCSC School Board meeting minutes).

8. Perry Central Community Schools ("PCCS") has reduced the hours of 26 employees to under 30 hours per week. Declaration of Mary Roberson ("Roberson Decl.") ¶ 3.

9. East Porter County School Corporation ("EPCSC") has reduced the hours of 45 employees (25 instructional aides, 10 cafeteria personnel, and 10 custodians) to under 30 hours per week. Declaration of Rod Gardin ("Gardin Decl.") ¶ 3; Gardin Decl., Ex. 1 (October 14, 2013 EPCSC School Board meeting minutes and Board-approved plan); Gardin Decl., Ex. 2 (October 15, 2013 Superintendent's Memorandum).

B. Schools Have Incurred Costs to Provide Health Insurance For Newly-eligible Employees.

1. East Porter County School Corporation ("EPCSC") tried but was unable to reduce the hours of bus drivers, secretaries, school treasurers, technology aides, and full-time custodians. These employees therefore became eligible for health insurance benefits that will cost EPCSC approximately $96,000. Gardin Decl. ¶ 4; Gardin Decl., Ex. 3 (May 28, 2013 School Board meeting minutes and Board-approved plan); Gardin Decl., Ex. 1 (October 14, 2013 School Board meeting minutes and Board-approved plan).

2. Northwestern Consolidated School District of Shelby County ("NW-SC") had to treat 14 positions that used to be part-time as full-time, resulting in NW-SC's health insurance costs increasing by approximately $89,000 per year. Robbins Decl. ¶ 3.

3. North Putnam Community School Corporation ("NPCSC") has offered health insurance coverage to employees that work more than 30 hours per week and thus became eligible for health insurance at the cost of approximately $5,064 per employee. Noel Decl. ¶ 3.

4. Perry Central Community Schools ("PCCS") was unsuccessful in trying to split or reduce the responsibilities for three positions in order to reduce their hours, and therefore converted these positions to full-time. These employees became eligible for health insurance benefits that will cost PCCS approximately $10,000 per employee, or $30,000 total. Declaration of Mary Roberson ("Roberson Decl.") ¶ 3.

5. South Gibson School Corporation ("SGSC") has changed its group health insurance plan to a high-deductible plan in order to accommodate employees that are now eligible for health insurance because they work more than 30 hours per week. The estimated cost of adding these employee classes that were not previously eligible for coverage is between approximately $150,000 and $380,000. Declaration of Dr. Stacey Humbaugh ("Humbaugh Decl.") ¶ 3.

C. Schools Have Incurred Compliance Costs and Administrative Burdens.

1. East Porter County Community School Corporation ("EPCSC") has purchased a new time management tracking system to closely monitor employees' hours to ensure that they do not work more than 30 hours per week, at a cost of $30,000 and is spending an additional $2,400 per year under its software agreement. Gardin Decl. ¶ 5, Ex. 4 (May 31, 2013 Superintendent's Memorandum).

2. Western School Corporation ("WSC") has created a new position entitled "corporation receptionist," whose duties include tracking the hours of employees to ensure that they do not exceed 30 hours per week. Declaration of Randy McCracken ("McCracken Decl.") ¶ 3; McCracken Decl., Ex. 1 (September 11, 2013 Memorandum to the School Board); McCracken Decl., Ex. 2 (September 17, 2013 WSC School Board meeting minutes).

D. Schools Have Limited Their Staffs' Participation in Coaching and Other Extracurricular Activities.

1. Benton Community School Corporation ("BCSC") has limited 75 employees to working under 30 hours per week. BCSC has prevented 36 of these 75 employees from coaching sports or helping with other extracurricular activities because the extra hours would put them over 30 hours per week, and BCSC would not be able to afford health insurance coverage for these employees. Albertson Decl. ¶ 3.

2. Vincennes Community School Corporation ("VCSC") has limited the potential hiring pool of those coaching sports or helping with other extracurricular activities. As a general rule, VCSC does not permit part-time classified staff who work less than 30 hours per week to coach sports or help with other extracurricular activities because the extra hours would put them over 30 hours per week, and VCSC would not be able to afford health insurance coverage for these employees. Parsley Decl. ¶ 3.

3. Cloverdale Community Schools ("CCS") has reduced the hours of non-certified support staff, including bus drivers, to fewer than 30 hours per week so those employees are considered part-time under the ACA. Field trips and extracurricular trips remain a concern for CCS as there is now a reduced pool of available drivers. Milner Decl. ¶ 3.

E. Schools Have Eliminated Positions.

1. Northwestern Consolidated School District of Shelby County ("NW-SC") had to eliminate three positions. These positions were all classroom instructional aides. Robbins Decl. ¶ 3.

F. Schools Have Decided to Remain at Fewer Than 50 Employees.

1. Area 30 Career Education Interlocal ("Area 30") currently has 44 employees, and would like to add more employees in order to expand its class offerings. In order to minimize or

avoid Area 30's exposure to these assessable payment penalties once it has 50 or more employees, Area 30 has intentionally remained at less than 50 employees. Declaration of Lora Busch ("Busch Decl.") ¶ 3.

ARGUMENT

By tethering the premium assistance and cost-reduction subsidies to coverage purchased through an "Exchange established by the State," Congress, through plain and unambiguous language, foreclosed the concept embodied in the IRS Rule, namely, that these subsidies are available for coverage purchased through HealthCare.gov. The IRS Rule fails both phases of the *Chevron* two-step test: (1) it is contrary to the plain language of the ACA; and (2) it is entitled to no deference because it is not "based on a permissible construction of the [ACA]." *Chevron U.S.A. v. Natural Resource Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

A. Chevron Deference Does Not Apply to Unambiguous Statutes.

Under the Administrative Procedure Act, agency action must be "h[e]ld unlawful" and "set aside" if it is "in excess of statutory jurisdiction, authority, or limitations," or "otherwise not in accordance with law." 5 U.S.C. § 706(2)(A), (C). To evaluate the legality of an agency's regulation, a court must measure it against the statutory directive. This is a bifurcated process: first, applying the ordinary tools of statutory construction, the court must determine whether Congress has directly spoken to the precise question at issue. *City of Arlington v. FCC*, 133 S. Ct. 1863, 1868 (2013) (citing *Chevron*, 467 U.S. at 842). If the intent of Congress is clear, that is the end of the matter, because "the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* If the intent of Congress is not clear and one proceeds to the second step, "the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.*

The *Chevron* rule "is rooted in a background presumption of congressional intent: namely, 'that Congress, when it left ambiguity in a statute' administered by an agency, 'understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *Id.* (citing *Smiley v. Citibank (South Dakota), N.A.*, 517 U.S. 735, 740-41 (1996)). But the ambiguity is a necessary precondition to the agency's exercise of discretion: "Congress knows how to speak in plain terms when it wishes to circumscribe, and in capacious terms when it wishes to enlarge, agency discretion." *Id.* Because of this, it is improper to conclude that what Congress omitted from a statute is nevertheless within its scope. *Univ. of Texas S.W. Med. Ctr. v. Nassar*, 133 S. Ct. 2517, 2528 (2013).

Importantly, at the first step of the *Chevron* analysis, judges "owe the agency no deference on the existence of ambiguity." *Am. Bar Ass'n v. FTC*, 430 F.3d 457, 468 (D.C. Cir. 2005) ("*ABA*"). "Deference to the agency's interpretation under *Chevron* is warranted only where Congress has left a gap for the agency to fill pursuant to an express or implied delegation of authority to the agency." *Id.* (internal quotations omitted). Whether a gap exists is for the courts to determine *de novo*. This fresh-look by the court is intended to identify whether Congress intended an "implicit delegation of authority to the agency." *Sea-Land Serv., Inc. v. Dep't of Transp.*, 137 F.3d 640, 645 (D.C. Cir. 1998). Thus, finding an "ambiguity is not enough per se to warrant deference to the agency's interpretation. The ambiguity must be such as to make it appear that Congress either explicitly or implicitly delegated authority to cure that ambiguity." *ABA*, 430 F.3d at 469. Moreover, the type of ambiguity that is the object of *Chevron* deference "is a creature not of definitional possibilities, but of statutory context." *California Indep. Sys. Operator Corp. v. FERC*, 372 F.3d 395, 400 (D.C. Cir. 2004). *See also Kohler Co. v.*

Moen, Inc., 12 F.3d 632, 634 (7th Cir. 1993) (A reviewing court "must interpret the statute with little deference to the agency's interpretation, for the judiciary is the final authority on issues of statutory construction.").

Under this standard, the government must convince this Court first, that the phrase "Exchange established by the State" is ambiguous as to whether it includes the HealthCare.gov Exchanges established by the federal government; and second, that Congress, through this ambiguity, was implicitly directing the IRS to exercise its discretion as to whether to make subsidies available from the United States Treasury in the federal Exchanges without any specific appropriations language. Neither conclusion is a plausible construction of the statute. In fact, the plaintiffs submit that the IRS Rule turns the *Chevron* inquiry upside down. The government attempted to justify the IRS Rule on the ground that "the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges." Fed. Reg. 30,378 (May 23, 2012); T.D. 9590, 2012-24 I.R.B. 1(g) (June 11, 2012). But the real inquiry should be whether Congress intended "Exchanges established by the State under section 1311 of the [ACA]" to be an ambiguity of such a character that Congress delegated to the IRS the authority to interpret the specifically defined term "states" to include the Department of Health & Human Services, which is conspicuously absent from the ACA's definition of "states." Rules of statutory construction demonstrate that Congress left no such ambiguity.

B. The ACA Is Unambiguous

Here, Congress spoke plainly, in unadorned language, when it declared under the ACA that premium assistance credits were available, and therefore the employer mandate applied, only with respect to qualified health plans purchased through an Exchange established by the State

under Section 1311 of the ACA. If the ACA means what it says, this should be the end of the matter. *See Chevron*, 467 U.S. at 842-43.

There is no ambiguity in the ACA that supports the IRS Rule. The ACA provides that an eligible taxpayer shall be entitled to a refundable tax credit in "an amount equal to the premium assistance credit amount of the taxpayer for the taxable year." 26 U.S.C. § 36B(a). That "premium assistance credit amount" is then defined as the sum of the monthly premium assistance amounts "with respect to all coverage months of the taxpayer occurring during the taxable year." *Id.* § 36B(b)(1). A "coverage month" is defined as a month for which, "as of the first day of such month the taxpayer … is covered by a qualified health plan … that was enrolled in through an Exchange *established by the State under section 1311 of the Patient Protection and Affordable Care Act*." *Id.* § 36B(c)(2)(A)(i) (emphasis supplied). These provisions are not open to interpretation: Unless a taxpayer enrolls in insurance "through an Exchange established by the State under section 1311 of the [ACA]," he has no "coverage months" and therefore no "premium assistance credit amounts." Eligibility for a subsidy is thus based on whether the individual is enrolled in insurance obtained through a state-established Exchange during the relevant month. If the taxpayer's state is served, instead, by HealthCare.gov, as Indiana is, then no premium assistance subsidies are available to that taxpayer. Period.

Reinforcing this point, the ACA specifies that the premium assistance amount for a given coverage month is equal to the lesser of two values: First, "the monthly premiums for such month for [a] qualified health pla[n] offered in the individual market within a State which cover[s] the taxpayer … and which w[as] enrolled in through *an Exchange established by the State under section 1311*" of the Act. *Id.* § 36B(b)(2)(A) (emphasis supplied); and second, the excess, over a specified percentage of the taxpayer's average monthly household income, of the

"adjusted monthly premium for such month for the applicable second lowest cost silver plan" that is "offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered"—namely, the Exchange "established by the State under section 1311 of the Patient Protection and Affordable Care Act." *Id.* § 36B(b)(2)(B), (3)(B). For both amounts, the starting point is an Exchange established by a state which qualifier takes on added significance because the "individual market" referenced above exists in both federal and state Exchanges. Congress did not refer to qualified plans purchased in the individual market through "any Exchange," "an Exchange established under this Act," or "an Exchange established by the State under section 1311 or the Secretary under section 1321," as it has in other sections of the ACA. *See e.g.*, ACA § 1421(a); 26 U.S.C. § 45R(b)(1); ACA, § 1312(d)(3)(D)(i)(II); 42 U.S.C. § 18032(d)(3)(D)(i)(II). Congress said only "an Exchange established by the State under section 1311" of the ACA, and only through a breezy indifference to the written word can one interpret these provisions of 26 U.S.C. § 36B(b) to encompass "an Exchange established by the Secretary."

The Congressional Research Service agrees. It reasons that "a strictly textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS's authority to issue the premium tax credits is limited only to situations in which the taxpayer is enrolled in a state-established exchange. Therefore, the IRS interpretation that extends tax credits to those enrolled in federally facilitated exchanges would be contrary to clear congressional intent, receive no *Chevron* deference, and likely be deemed invalid." Cong. Res. Serv., *Legal Analysis of Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act* at 8 (Jul. 23, 2012).

C. The Government's Reading of the ACA Is Unsupportable.

In stark contrast to the language of the ACA, the IRS Rule provides that a taxpayer is eligible for premium assistance tax credits so long as he "[i]s enrolled in one or more qualified health plans through an Exchange," with no qualification based on the entity that established the Exchange. 26 C.F.R. § 1.36B-2(a)(1). The IRS regulations then adopt a definition of "Exchange" from an HHS regulation that defines "Exchange" to include "State Exchanges, regional Exchanges, subsidiary Exchanges, *and a Federally-facilitated Exchange*." 26 C.F.R. § 1.36B-1(k); 45 C.F.R. § 155.20 (emphasis added). Under these regulations, every individual who buys insurance in the individual market through an Exchange, including a federally-established one, is potentially eligible for a federal subsidy. The regulations, again in contrast to the ACA, also adopt a broad definition of "coverage month," defining it to include any month if, "[a]s of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange" (not just a state-established one). 26 C.F.R. § 1.36B-3(c)(1)(i); *cf.* 26 U.S.C. § 36B(c)(2)(A)(i) (The term "coverage month' means . . . any month [in which] the taxpayer . . . is covered by [insurance] that was enrolled in through an Exchange established by the state under Section 1311 of the [ACA].")

The IRS Rule contradicts the plain and unambiguous text of the ACA. The ACA restricts premium assistance subsidies to coverage obtained through "an Exchange established by the State under section 1311" of the Act, but the IRS Rule expands the availability of those subsidies to coverage obtained through *any* Exchange, including an Exchange "establish[ed] and operat[ed]" by the Secretary. The state- and federally-established Exchanges are not both "established by the State under section 1311." The ACA's implementing regulations acknowledge as much when they separately define "federally-facilitated Exchange" as one that is

"established and operated … by *the Secretary* under *section 1321(c)(1)* of the [ACA]," 45 C.F.R. § 155.20 (emphases supplied). This underscores another self-evident truth: the federal government is not a "state."

If there were any doubt, the ACA removes it: "In this title, the term 'State' means each of the 50 States and the District of Columbia." ACA, § 1304(d); 42 U.S.C. § 18024. Strikingly, the District of Columbia is not a state either, but Congress declared that it should be treated as one for purposes of the ACA. The territories of the United States also are not states, but Congress declared them as equivalents for purposes of the ACA. Specifically, the ACA provides that any territory that elects to establish an Exchange "in accordance with part II of this subtitle and establishes such an Exchange . . . shall be treated as a State for purpose of such part." Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 § 1323(a)(1), 124 Stat. 1029 (2010); 42 U.S.C. § 18043(a)(1). There is no similar equivalency language for the federal government anywhere in the ACA. Indeed, but for the IRS Rule, HealthCare.gov would not be treated as an Exchange "established by the state," would not be a vehicle through which premium assistance credits would be available, and would not be a basis upon which to invoke the employer mandate penalties. In short, the Secretary of the Department of Health & Human Services is not one of the 50 states, whether in fact or by operation of law, and no ukase by the Internal Revenue Service or the Treasury Department can change that.

D. Canons of Statutory Construction Foreclose the Government's Reading of the ACA.

The most fundamental canons of construction foreclose the IRS Rule, to the extent that it purports to be an interpretation of the ACA's text. Canons of construction are rules of thumb, which are designed to "help courts determine the meaning of legislation, and in interpreting a statute a court should always turn first to one, cardinal canon before all others." *Connecticut Nat.*

Bank v. Germain, 503 U.S. 249, 253-54 (1992). The Supreme Court has stated "time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Id.* "When the words of a statute are unambiguous, then, this first canon is also the last: 'judicial inquiry is complete.'" *Id.* at 254 (citing *Rubin v. United States*, 449 U.S. 424, 430 (1981)).

Under the "one, cardinal canon that precedes all others," namely what does the statute say, the ACA conjoins the premium assistance credits and cost-sharing reductions (and by extension, the employer mandate) to the Exchange established by the "State" under section 1311. The IRS Rule, however, under the guise of statutory interpretation, entirely deletes the statutory modifiers "established by the State" and "under section 1311 of the [ACA]" from the eligibility requirement for premium assistance credit. Of course, this approach violates another "cardinal principle of statutory construction" that "no clause, sentence, or word [of a statute] shall be superfluous, void, or insignificant." *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (internal quotation marks omitted). Even more, the IRS Rule conflates "an Exchange established *by the State*" with a broader phrase found elsewhere in the Act—"an Exchange established *under this Act*." ACA, § 1312(d)(3)(D)(i)(II) (emphasis added); 42 U.S.C. § 18032(d)(3)(D)(i)(II). Consequently, the IRS Rule thus violates still another basic canon that "differing language" in "two subsections" of a statute should not be treated by the courts as having "the same meaning in each." *Russello v. United States*, 464 U.S. 16, 23 (1983). Under this canon of construction, if an "Exchange established by the State" were the same thing as an "Exchange established under this Act," Congress would not have used different language.

Moreover, the fact that Congress referred elsewhere in the ACA to this broader category of Exchanges proves that Congress understood the differences between them and, when

Congress wanted to refer to *all* Exchanges (including federally-established ones), it "knew how to do so." *Custis v. United States*, 511 U.S. 485, 492 (1994); *see also Sebelius v. Cloer*, 133 S. Ct. 1886, 1894 (2013) ("We have long held that '[w]here Congress includes particular language in one section of a statute but omits it in another of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.'"); *United States v. Carr*, 965 F.2d 176, 178 (7th Cir. 1992) ("Because Congress placed the limiting clause only in certain portions of the statute, we presume that the clause restricts the reach only of those portions."). In short, "Congress did not write the statute" in a way that supports the IRS Rule's assumption that an Exchange established by the Secretary was also established by the State. *See Russello*, 464 U.S. at 23.

E. The Government's Reading of the ACA Unlawfully Appropriates Money from the Federal Treasury.

It is, of course, always impermissible for an executive agency to exceed its statutory authority. But the IRS Rule's departure from the ACA's text is especially forbidden because of its profound effect on the federal treasury. Under the Appropriations Clause of the Constitution, "[n]o Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." U.S. CONST. Art. I, § 9, cl. 7. This means, as the Supreme Court has explained, that "the payment of money from the Treasury must be authorized by a statute" and that "no money can be paid out of the Treasury unless it has been appropriated by an act of Congress." *Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414, 424 (1990). Executive agencies are simply not empowered to disburse federal funds absent such statutory authority, even if the agency officials "were displeased with a new restriction on benefits imposed by Congress." *See id.* at 428.

Yet, by promulgating the IRS Rule, the IRS has appropriated potentially *billions* of dollars of premium assistance subsidies that Congress never authorized. The Rule "would

impose a potentially burdensome enough impact on the federal treasury that it should be supported by a clear expression of legislative intent in either the statute itself or in the accompanying legislative history." *Norton v. United States*, 581 F.2d 390, 397 (4th Cir.), *cert. den.*, 439 U.S. 1003 (1978). As shown above, however, not only is the Rule not supported by clear expression of legislative intent, it is actually squarely foreclosed by clear statutory text and structure. It cannot stand.

This conclusion is based on yet another canon of statutory construction. The authority to expansively interpret a statute, which the IRS has done here through adoption of the IRS Rule, is not available if other canons of construction require narrowly construing the statute to extend no further than its plain language. Specifically, where established principles of statutory construction require a clear or unambiguous statement of congressional intent to infer certain results, an agency cannot construe statutory text as ambiguous to achieve those results. Indeed, a contrary rule would eliminate these canons of construction entirely in the agency context. *See* Cass Sunstein, *Nondelegation Canons*, 67 U. CHI. L. REV. 315, 316 (2000) (explaining that these canons "forbid administrative agencies from making decisions on their own" by depriving them of their "ordinary discretion" to construe an "ambiguous statutory provision").

Thus, for example, if a statute is ambiguous but one construction "would raise serious constitutional problems" while another construction would not, there is no deference to an agency adopting the construction of dubious constitutionality. *See, e.g., Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 574-75 (1988); *Nat'l Mining Ass'n v. Kempthorne*, 512 F.3d 702, 711 (D.C. Cir.), *cert. den.*, 555 U.S. 1062 (2008) (holding that "canon of constitutional avoidance trumps *Chevron* deference"). For example, in *INS v. St. Cyr*, 533 U.S. 289 (2001), the Supreme Court held that the presumption against

retroactivity means that "a statute that is ambiguous with respect to retroactive application is construed . . . to be unambiguously prospective," such that "there is, for *Chevron* purposes, no ambiguity in such a statute for an agency to resolve." *Id.* at 320 n.45.

As relevant here, a venerable canon of construction recognized by the Supreme Court holds that tax credits (and deductions and exemptions) "must be expressed in clear and unambiguous terms." *Yazoo & Miss. Valley R.R. Co. v. Thomas*, 132 U.S. 174, 183 (1889). A statute must "unquestionably and conclusively" establish such a credit or exemption. *Stichting Pensioenfonds Voor de Gezondheid v. United States*, 129 F.3d 195, 198 (D.C. Cir. 1997), *cert. den.*, 525 U.S. 811 (1998). Because "taxation is the rule, and exemption [and credits and deductions] the exception, the intention to create an exemption [or a credit or deduction] must be expressed in clear and unambiguous terms." *Id.* (quoting *Yazoo*, 132 U.S. at 183). Critically, such tax benefits "are not to be implied; they must be unambiguously proved," *United States v. Wells Fargo Bank*, 485 U.S. 351, 354 (1988); and "must rest … on more than a doubt or ambiguity," *United States v. Stewart*, 311 U.S. 60, 71 (1940). The Supreme Court has ruled that if "doubts are nicely balanced," then this balance defeats the claimed tax exemption. *Trotter v. Tennessee*, 290 U.S. 354, 356 (1933); *accord Of Course, Inc. v. Comm'r*, 499 F.2d 754, 758 (4th Cir. 1974) (en banc). Only that "extremely high standard" properly respects "the importance of taxation" to the national revenue. *Stichting*, 129 F.3d at 197-98; *see also Comm'r v. Swent*, 155 F.2d 513, 517 (4th Cir. 1946), *cert. den.*, 329 U.S. 801 (1947) (invoking this canon).[5]

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

Given this—namely, allowing money to be drawn from the Treasury only when the custodian of the federal purse has unambiguously authorized it—*Chevron* deference does not exist with respect to 26 U.S.C. § 36B and the IRS Rule. The clear statement rule embodied in *Yazoo* and *Stichting* prevents agencies from granting a tax credit unless Congress unambiguously allows it. The availability of § 36B tax credits in federal Exchanges "must be unambiguously proved," *Wells Fargo Bank*, 485 U.S. at 354; the IRS cannot by regulation extend the credits by resting on "doubt or ambiguity" in the ACA, *Stewart*, 311 U.S. at 71. As such, any ambiguity in § 36B must as a matter of law be construed against the availability of the tax credit, and so "there is, for *Chevron* purposes, no ambiguity in [the] statute for [the IRS] to resolve." *St. Cyr*, 533 U.S. at 320 n.45. Put another way, if § 36B "can reasonably be construed" to restrict the ACA's premium tax credit to state-established Exchanges, "it must be construed that way." *See Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1445 (D.C. Cir. 1988), *cert. den.*, 488 U.S. 1010 (1989).

F. The IRS Cannot Defend Its Rule.

Despite the obvious conflict between the IRS Rule and the ACA's text, the IRS defends its regulation with only a single, brief, vague paragraph, invoking (in general terms) the Act's "language," "structure," "legislative history," and "purpose." 77 Fed. Reg. 30,377-78. None of these appeals is even remotely convincing.

1. The Language of the ACA Does Not Support the IRS Rule.

As to the statutory language, the IRS claims that it "support[s] the interpretation that credits are available to taxpayers who obtain coverage through a . . . Federally-facilitated Exchange." *Id.* Understandably, the agency does not quote or cite any such purportedly supportive language, because there simply is none. *See* Part I.A, *supra*.

The government has argued to Congress that § 1321 of the ACA, which directs the Secretary, where a state "will not have any required Exchange operational by January 1, 2014," to "establish and operate *such Exchange* within the State," ACA, § 1321(c)(1); 42 U.S.C. § 18041(c)(1) (emphasis added), implies that a federal-fallback Exchange is equivalent in all material senses to a state-established Exchange. Joint Staff Report, U. S. House of Representatives, Committee on Oversight and Government Reform & Committee on Ways and Means at 12 (February 5, 2014) ("Joint Staff Report") (Letter from Mark J. Mazur, Assistant Secretary for Tax Policy, U. S. Treasury Department, to Rep. Darrell Issa, Chairman, Committee on Oversight & Government Reform, U. S. House of Representatives (Oct. 12, 2012)). According to this logic, the ACA's reference to Exchanges "established by the State under section 1311" of the Act must necessarily also include Exchanges established by the federal government under § 1321 of the Act. *Id.*

Not so. It is the identity of the establishing entity that makes all the difference for purposes of the premium assistance credits. Indeed, the text of 26 U.S.C. § 36B contains two separate requirements that limit the availability of premium assistance credits to state-established Exchanges. First, the Exchange must be established by "the State," which is defined to include any of the 50 states, the District of Columbia, and U. S. territories that elect to establish their own Exchanges. Second, the Exchange must be established under § 1311 of the ACA. By default, an Exchange established by the Secretary under § 1321 is neither established by the state nor established under § 1311. The reference to "such Exchange" in section 1321 relates only to the nature and function of the Exchange the federal government will establish and operate, *i.e.*, with the nature and function described in section 1311. A federal Exchange with the same nature and function as a state Exchange is still a federal Exchange; it was not established by a state.

Nor does anything else in the ACA suggest that the subsidy provisions' identification of "state" Exchanges was somehow intended to connote "any sort of Exchange" or "federally-established Exchange." If Congress intended to refer to both types of Exchanges in § 36B, it would have omitted the phrase "established by the State under section 1311" altogether, and referred, as it did elsewhere in the Act, generically to "an Exchange" (*e.g.*, ACA, § 1421(a); 26 U.S.C. § 45R(b)(1)), or an Exchange "established under this Act" (*e.g.*, ACA, § 1312(d)(3)(D)(i)(II); 42 U.S.C. § 18032(d)(3)(D)(i)(II)). *See Russello*, 464 U.S. at 23 (upholding the basic canon that "differing language" in "two subsections" of a statute should not be treated by the courts as having "the same meaning in each"); *Carr*, 965 F.2d at 178 (same).

More generally, other sections of the ACA further confirm that Congress viewed state-run and federally-run Exchanges as distinct. For example, another section of the subsidy provisions expressly lists state-established Exchanges and federally-established Exchanges *separately*, confirming that Congress did not view the two types as one. *See* ACA, § 1401(f)(3); 26 U.S.C. § 36B(f)(3) (imposing information sharing mandate on "any person carrying out . . . responsibilities of an Exchange under *section 1311(f)(3) or 1321(c)* of the [ACA]"). There is no provision adopting any type of equivalence language for federal Exchanges.[6]

2. The Structure of the ACA Does Not Support the IRS Rule.

In equally vague and conclusory terms, the IRS invokes the "structure of section 36B and the Affordable Care Act as a whole" to support its Rule. 77 Fed. Reg. at 30,377-78. The IRS assumes that simply stating the conclusion makes it true; in fact, nothing in the ACA's structure supports the IRS Rule's evisceration of the Act's language.

[6] According to the Joint Staff Report, documents from the Treasury Department show that at the end of March, 2011, Treasury and IRS officials expressed concern that there was no direct statutory authority to interpret federal exchanges as an Exchange established by a state. *See* Joint Staff Report at 12-13.

Some have suggested that the structure of the subsidy provision supports the IRS Rule in that it requires all Exchanges—including federal ones—to share certain information with HHS and enrollees, including the "total premium for the coverage without regard to the credit under this section" and the "aggregate amount of any advance payment of such credit" by the federal treasury. 26 U.S.C. § 36B(f)(3). Under this argument, the state- and federally-established Exchanges must not be treated differently because otherwise, the "aggregate amount of any advance payment of such credit" would always be zero, thereby requiring the federal Exchanges to perform a useless or redundant act.

The information-sharing requirements, however, apply equally to all Exchanges, even though some of the information sought is relevant only to the state-established Exchanges. Several other pieces of information are equally relevant to federal Exchanges, including the "total premium" and the "name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy." *Id.* § 36B(f)(3)(B), (D). The information-sharing provision thus contains no empty words if federal subsidies are limited to coverage from state-established Exchanges; indeed, it causes no harm for the federal Exchanges to answer, simply, "not applicable" where appropriate. In fact, consolidating the information required from state- and federally-established Exchanges makes as much, if not more, sense than having separate and mostly redundant statutory provisions outlining the information sought by Congress from each type of Exchange. (If anything, this approach demonstrates yet again that Congress understood the difference between state and federal Exchanges, and expressly enumerated both when it so desired.)

3. The Legislative History of the ACA Does Not Support the IRS Rule.

The IRS further defends its Rule by observing, rather obscurely, that "the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges." 77 Fed. Reg. at 30,378. In other words, according to the IRS, the *plain text* of a statute is somehow insufficient to establish congressional "intent" unless it is accompanied by legislative history confirming that the plain text means what it unequivocally says.

This gets it backwards. If, as here, the plain language of the statute settles the question before the court, a court may look to the legislative history to determine "only whether there is 'clearly expressed legislative intention' contrary to that language, which would require [the court] to question the strong presumption that Congress expresses its intent through the language it chooses." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 432 n.12 (1987) (citations omitted)). Thus, even if legislative history affirmatively demonstrated that Congress contemplated that subsidies could be available in federal Exchanges, this history would have to be specific and authoritative to surmount the "strong presumption" that Congressional intent is expressed in the language Congress chose to use. *See Ardestani v. INS*, 502 U.S. 129, 135-36 (1991) ("The 'strong presumption' that the plain language of the statute expresses congressional intent is rebutted only in 'rare and exceptional circumstances' . . . when a contrary legislative intent is clearly expressed." (citations omitted)).

There is no direct legislative history that suggests Congress meaningfully discussed the question of whether or not premium assistance credits could be available for coverage purchased through a federally-facilitated Exchange, and the IRS does not claim otherwise. In fact, one court has described the relevant legislative history on this question as "scant." *Halbig*, Halbig Slip Op. at 35. However, early proposals for comprehensive health insurance reform were premised on a

model in which the federal government would establish and run the Exchanges, but this proved politically untenable. *Id.* at 36. As the ACA took shape, it was described as giving 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." *Id.* (citing 155 Cong. Rec. S13,832 (Dec. 23, 2009 (Sen. Baucus)). But this is precisely the point. Congress did not want a system dominated by federal Exchanges—indeed, the Senate overtly rejected the concept of the Executive Branch running all exchanges set forth in the bill passed by the House of Representatives at a time when the Senate Democrats possessed a filibuster-proof majority. Consequently, Congress incentivized the states by offering tax credits to the citizens of those states that established their own Exchanges. This "scant" history falls woefully short of the legislative history necessary to overcome the strong presumption that Congress meant what it said. *See Germain*, 503 U.S. at 253-54 (As the Supreme Court has "stated time and again," courts "must presume that a legislature says in a statute what it means and means in a statute what it says there."). If anything, this history confirms that the ACA means what it says.

4. The Purpose of the ACA Does Not Support the IRS Rule.

In defense of its Rule, the IRS also obliquely invokes the statute's "purpose." 77 Fed. Reg. at 30,378. By this, the agency presumably means that Congress would have "wanted" residents of states that declined to establish Exchanges to be able to afford insurance, and therefore Congress would have "wanted" to subsidize these individuals' insurance, too.

Neither the premise nor its conclusion is sound. Even well-supported conclusions about general legislative purpose do not authorize departure from plain statutory text. As Justice Holmes once wrote, "It is a delicate business to base speculations about the purposes or construction of a statute upon the vicissitudes of its passage." *Monterey Coal Co. v. Fed. Mine*

Safety & Health Rev. Comm'n, 743 F.2d 589, 597 (7th Cir. 1984) (quoting *Pine Hill Coal Co. v. United States*, 259 U.S. 191, 196 (1922)). Since neither the ACA's language nor its structure (nor even its legislative history) manifests a purpose at odds with the plain language of § 36B, the judiciary may not examine Congress's stated general goal of near universal coverage in ascribing meaning to that provision.

Even if it were proper for the judiciary to speculate about general legislative purpose to alter the ACA's plain text, it is clear that limiting subsidies to state-run Exchanges is consistent with that purpose. In crafting the subsidy provisions, Congress had to balance two competing purposes—to subsidize the purchase of insurance by lower-income Americans, but also to encourage states to establish Exchanges, because, as noted, a single-payer federal system was a non-starter. *See Halbig*, Halbig Slip Op. at 36. Limiting subsidies to the state-established Exchanges might have undermined the former objective, but it promoted the latter. Moreover, as the now defunct coercive Medicaid expansion provisions demonstrate, Congress was willing to deprive the states of the Medicaid funding that is so critical to an important piece of the healthcare policy for the poor—a result decidedly at odds with the goal of expanding the availability of healthcare. Given the Supreme Court's treatment of the Medicaid expansion, the Congressional "purpose" of extending healthcare to all was undermined by its own miscalculation of the states' willingness to simply go along with being commandeered to expand that program. Congress again miscalculated the states' receptiveness to running the Exchanges, even with the carrot of tax credits to its citizens (but with the considerable weight of the employer mandate). *See* Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule To Expand Tax Credits Under the PPACA*, 23 HEALTH

MATRIX 119, 142 (2013). Saving Congress from its political miscalculations is not the role of the judiciary. Fealty to the text of the laws as passed by Congress is.

Thus, the "purpose" argument simply asks the judiciary, improperly, to substitute its policy judgment about how to balance these objectives for the Legislature's judgment. *See Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam) ("Deciding what competing values will or not be sacrificed to the achievement of a particular objective is the very essence of legislative choice—and it frustrates rather than effectuates legislative intent simplistically to assume that whatever furthers the statute's primary objective must be the law."). One cannot change the meaning of "an Exchange established by a State under section 1311" of the ACA or expand the scope of the employer mandate to coverage purchased through the federally-facilitated Exchange by resorting generally to the "purpose" of the ACA. Even when the purpose of a statute is laudable, words still have meaning, and those meanings have their limits.

G. The *Halbig* Decision.

On January 15, 2014, the United States District Court for the District of Columbia, in the case *Halbig v. Sebelius*, 1:13-cv-00623-PLF, Dkt. 67 (D. D.C), granted the government's motion for summary judgment on the validity of the IRS Rule. The court stated that "Congress expressly delegated to the Secretary of the Treasury to resolve any ambiguities in Section 36B," *Halbig*, Halbig Slip Op. at 23, but found no ambiguity in the ACA. Instead, the court determined that while, "[o]n its face, the plain language of 26 U.S.C. § 36B(b)-(c), viewed in isolation, appears to support plaintiffs' interpretation," Halbig Slip Op. at 26, the government's defense of the IRS Rule was "plausible and persuasive," *id.* at 28. The court then looked at the structure of the ACA, its purpose, and its legislative history, *id.* at 28-37, to justify the conclusion that "Congress

intended to make premium tax credits available on both state-run and federally-facilitated Exchanges," *id.* at 37.[7] The plaintiffs here disagree.

The court started by recognizing that the "federal government, after all, is not a 'State,'" and that the "phrase 'Exchange established by the State under [42 U.S.C. § 18031]' therefore, standing alone, could be read to refer only to state-run Exchanges." *Id.* at 26. In looking at the other ACA provisions referenced by 26 U.S.C. § 36B, the court concluded that the reference to an "American Health Benefit Exchange" or "Exchange" in section 1311 was definitional and that Congress "describe[d] an 'Exchange' as necessarily being established by a State." *Id.* at 27. It is true that the definitional section of the ACA relied upon by the court provides that the term Exchange "means American Health Benefit Exchange established under [42 U.S.C. § 18031]." *Id.* (citing ACA § 1563(b)(21), *codified at* 42 U.S.C. § 300gg-91(d)(21)). It is also clear that section 1311 (42 U.S.C. § 18031, which was cited by the court) is the ACA section that establishes what an Exchange is and does. Yet none of this addresses the truth that when a state elects not to establish an Exchange, the federal government steps in and establishes it under section 1321 of the ACA (42 U.S.C. § 18041), not section 1311 (42 U.S.C. § 18031). The acknowledgment that the federally-facilitated Exchange authorized by Section 1321 is functionally established and described "under" and "in" section 1311 does not also convert the federal government into one of the 50 states or the District of Columbia when it establishes an Exchange.

[7] On February 18, 2014, the United States District Court for the Eastern District of Virginia issued a decision on the IRS Rule that agreed with the *Halbig* decision. *See King v. Sebelius*, 2014 WL 637365, 3:13-cv-630-JRS, Dkt. 52 ("King Slip Op.") (E.D. Va. February 18, 2014). The court in *King* generally adopted or applied the reasoning of the court in *Halbig*. *Compare* King Slip Op. at 15-23, *with* Halbig Slip Op. at 22-33.

The court described the plaintiffs' reading of 26 U.S.C. § 36B(b)-(c) and its "Exchange established by the State" language as "the more intuitive one"—"Why would Congress have inserted the phrase 'established *by the State* under [42 U.S.C. § 18031]' if it intended to refer to Exchanges created by a state *or* by HHS?," Halbig Slip Op. at 28 (emphasis original)—but found the government's rejoinder to be "plausible and persuasive": The ACA "takes a state-established Exchange as a given" and "even where a state does not actually establish an Exchange, the federal government can create 'an Exchange established by the State under [42 U.S.C. § 18031]' *on behalf of* that state." Halbig Slip Op. at 28-29 (emphasis original). Really? An Exchange is established either by the "State" or by the "Secretary," and even if the Exchange is established by the Secretary "on behalf of" a State, it is still not "established by the State." There is nothing "plausible or persuasive" about the government's reinvention of words.

The court then turned to other provisions of the ACA, so as not to read the operative text in isolation. Halbig Slip Op. at 29. The court characterized other provisions of the ACA as "appear[ing] to reflect an intent by Congress to make tax credits available to taxpayers purchasing insurance from the federally-facilitated Exchanges" and others that, "if construed consistently with plaintiffs' proposed definition, would create numerous anomalies within the statute that Congress could not have intended." Halbig Slip Op. at 30. But a review of these provisions relied upon by the court exposes the fallacy in the court's conclusion. Indeed, there is nothing anomalous with ascribing the words chosen by Congress their plain meaning and allowing the effect of those words, and therefore the intent of the ACA, to be realized.

First, the court cited 26 U.S.C. § 36B(f)(3). The court explained that subsection (f) provides that the premium tax credit received by a taxpayer must be reduced by the amount of any advance payment check. 26 U.S.C. § 36B(f)(1). Slip. Op. at 30-31. The text of section

36B(f)(1) provides, "The amount of the credit allowed under this section [i.e., ACA § 1402; 26 U.S.C. § 36B] 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 ACA]." 26 U.S.C. § 36B(f)(1). For the IRS to track these advance payments, according to the court, "the statute mandates that '[e]ach Exchange (or any person carrying out 1 or more responsibilities of an Exchange under [42 U.S.C. § 18031] *or* [*42 U.S.C. § 18041*])' provide certain information to the Secretary of the Treasury and to the taxpayer 'with respect to any health plan provided through the Exchange.'" Halbig Slip Op. at 30-31 (citing 26 U.S.C. § 36B(f)(3) (emphasis and brackets by court)).[8] The court concluded that by invoking both section 18031 (ACA § 1311) and section 18041 (ACA § 1321) in this reporting requirement, Congress meant to extend the premium assistance credits to all Exchanges, both state-established and federally-facilitated, because otherwise Congress is asking the federal Exchanges to do something that serves no purpose by reporting on tax credits that are not available. Halbig Slip Op. at 31.

The court's conclusion that the purpose of the reporting requirement is limited to reconciling the advance payments with the final amount of premium credits is not supported or supportable by a review of the entirety of section 36B(f). The Treasury Secretary certainly is responsible for reconciling the advance payments of the credit allowed under 26 U.S.C. § 36B(b)—which expressly and only allows those credits for coverage months in which coverage was purchased through an Exchange established by the state under ACA § 1311. To aid Treasury in that obligation, those charged with running the Exchanges are required to report designated categories of information to the Treasury Department, but the reporting obligation extends well beyond reporting just on tax credits and advance payments. Specifically, section

[8] This provision is discussed briefly in § II.B, *supra*.

36B(f)(3), which was not part of the ACA when it was signed by the President,[9] has six categories of information that must be reported "with respect to *any health plan provided through the Exchange*": (1) the level of coverage under the ACA and the period it was in effect; (2) the total premium without any premium assistance credits or cost-sharing reductions; (3) the aggregate amount of advance credits or cost-sharing payments; (4) the name, address, and taxpayer identification number of those insured; (5) any information provided to the Exchange necessary to determine eligibility for the credit; and (6) information necessary to determine whether a taxpayer received excess advance payments. 26 U.S.C. § 36B(f)(3) (emphasis supplied).

The court in *Halbig* determined that based on this provision, "an Exchange established by the state" really cannot mean what it says, because if it did this reporting requirement would require the federal Exchanges to report "not applicable" with respect to the aggregate amount of advance credits or cost-sharing payments. But what, exactly, do the Exchanges report with respect to "any health plan provided through the Exchange" when the taxpayer is not eligible for a tax credit because the taxpayer makes too much money? For those individuals, the Exchange must still report "not applicable" or "zero" for the third category of information—so there is nothing superfluous[10] or anomalous about applying these reporting requirements to federally-facilitated Exchanges even though not all categories of information apply to all taxpayers. Rather

[9] Paragraph (3) of 26 U.S.C. § 36B(f) was added a week late in the reconciliation bill, the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 § 1004(c), 124 Stat. 1029 (2010).

[10] The court in *Halbig* opined that limiting tax credits to state-established Exchanges renders "superfluous" the reference to federally-facilitated Exchanges in this section and used that as a basis to reject the plaintiffs' reading of the ACA. Halbig Slip Op. at 31. Yet, the court, just two pages earlier, had already dismissed the plaintiffs' concern that the IRS Rule rendered "established by the State" under section 1311 of the ACA superfluous. *Id.* at 29 n.11. There, the court reasoned that the canon against surplusage was "of no use here" because of this provision in 36B(f). *Id.* It should have held, then, that the canon against surplusage is equally of no use when comparing 36B(f) back against the "established by the State" language; instead, the court found that canon determinative.

than support the IRS Rule, this reporting provision simply imposes uniform reporting requirements in one section of the ACA on all Exchanges, regardless of the establishing entity. At the very least, this reporting requirement should not be sufficient to exponentially expand the Treasury's outlay for premium assistance credits by writing "established by the state" out of the ACA.

The court then turned to Section 1312 of the ACA, which is found at 42 U.S.C. § 18032. Halbig Slip Op. at 31-33. That section provides "that only 'qualified individuals' may purchase health plans in the individual markets offered through the Exchanges, and requires that a 'qualified individual' be a person who 'resides in the State that established the Exchange.'" Halbig Slip Op. at 31 (citing 42 U.S.C. § 18032(f)(1)(A)(ii)). After noting that there was "no separate provision defining 'qualified individual' for purposes of the federally-facilitated Exchanges," the court concluded that a literal reading of this language would mean that no one in the 34 states that opted not to establish an Exchange could buy coverage through the federally-facilitated Exchanges in those states, because none of them is in a "State that established [an] Exchange." Halbig Slip Op. at 31. To avoid this outcome, the court credited the government's argument that a federally-facilitated Exchange may "stand in the shoes of the state" for purposes of the residency requirement—and by extension, for purposes of the IRS Rule. Halbig Slip Op. at 31-32.

This conclusion is misguided. First, this residency requirement does not address the question posed in this case, namely, whether the IRS Rule's extra-statutory merger of Exchanges "established by the State" and Exchanges established by the Secretary is permissible under the first step of the *Chevron* analysis. In fact, this residency conundrum, if it is that, exists regardless of the IRS Rule. If eligibility to purchase coverage through an Exchange requires residence in the

"State that established the Exchange," then perhaps the court in *Halbig* is correct that no one in those 34 states with federally-facilitated Exchanges is eligible to purchase insurance. But that is absurd, a wholly unnecessary conclusion, and not of consequence to the validity of the IRS Rule.

Whether someone is a "qualified individual" must be considered in connection with an "Exchange." Section 1563 of the ACA defines an "Exchange" as "an American Health Benefit Exchange established under section 18031 [42 U.S.C. § 18031; ACA § 1311] of this title." 42 U.S.C. § 300gg-91(d)(21). In that context, then, the requirement that the "qualified individual" reside in the state that established the Exchange should be read to apply to state-established Exchanges, not federally-facilitated ones. In other words, the definition of a "qualified individual" relates to state-established Exchanges under section 1311 of the ACA, not those established by the federal government under section 1321 of the ACA. If Congress had meant for the definition to apply equally to both types of Exchanges, it would have said so plainly, as it did with the reporting requirements discussed immediately above. *See* 26 U.S.C. § 36B(f)(3) (applying reporting requirements to each Exchange "or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c)" of the ACA).

The omission by Congress of a similar provision for defining a qualified individual relative to section 1321 Exchanges does not undermine the conclusion that when Congress said "Exchange established by the state," whether in this section or with respect to the premium assistance credits—and therefore the employer mandate penalties—it meant an "Exchange established by the state." In other words, there simply is not a residency requirement for the federal Exchanges.[11] This conclusion, which avoids the absurd result that no one in the 34 states

[11] There is a practical limitation that makes this a non-issue. Exchanges offer products regulated and approved by state insurance commissioners. The policies available have a decidedly local flavor—medical practice groups and hospitals still contract with insurance companies and their

with federally-facilitated Exchanges can buy insurance through those Exchanges, preserves the meaning and intent of the language Congress chose in crafting the eligibility requirements for the tax credits and does not superimpose language into the ACA that Congress did not choose to use.

Further, even if this provision is read to assume that a state-established Exchange exists for residency purposes, and therefore the federal Exchange "stands in the shoes" of the state Exchange for this purpose, there is no similar assumption when one considers the premium assistance credits. To see the difference, one must go back to the language that creates the premium assistance credits. Those credits are available only for applicable "coverage months," which are those months in which the taxpayer was enrolled in a plan offered in the individual market (which can be offered through a federal Exchange) through an "Exchange established by the State under 1311 of" the ACA (which excludes plans in the individual market offered through a federal Exchange). ACA § 1401, 26 U.S.C. § 36B(b)(2)(A). The specific inclusion of a section 1311 Exchange in the premium assistance credit eligibility formula necessarily excludes a section 1321 Exchange from that formula. That is, this provision does not *presume* that every state established its own Exchange for tax credit purposes the way in which the "qualified individual" definition was read in *Halbig* for eligibility purposes (Halbig Slip Op. at 32); instead, Section 368 limits the premium assistance credits to taxpayers in those states that did establish their own Exchanges. Thus, one can still have the limiting provision on the tax credits and still recognize that a citizen of Indiana is eligible to purchase coverage through HealthCare.gov. *See Carr*, 965 F.2nd at 178 ("Because Congress placed the limiting clause only in certain portions of the statute, we presume that the clause restricts the reach only of those provisions.) To give effect to every provision of the ACA, to avoid unnecessary Constitutional implications, and to adhere

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insureds still work within that network. There is no reasonable risk of an Indiana resident enrolling in a plan offered through HealthCare.gov in North Dakota, for example.

to the principle that tax credits must be granted with clarity, one must in fact read the "qualified individual" criteria in this manner; otherwise, one twists the language of the ACA beyond its breaking point.

The *Halbig* decision also considered the purpose and legislative history of the ACA in further support of its decisions to validate the IRS Rule. Slip. Op. at 33-37. Those arguments are addressed above in Sections II.C and II.D.

CONCLUSION

"Where Congress has established a clear line, the agency cannot go beyond it." *City of Arlington*, 133 S. Ct. at 1874. In the ACA, Congress established a "clear line" when it limited the premium assistance tax credits and cost-sharing reductions to those who purchased coverage through Exchanges established by the States under section 1311 of the ACA, and thereby limited the scope of the employer mandate penalties only to those states that established their own Exchanges. The Executive Branch, and in particular the IRS, leapt over and well beyond this clear line by extending, through the IRS Rule, the availability of these premium assistance tax credits and cost-sharing reductions to coverage purchased through federal Exchanges. As a consequence, the IRS Rule extended the employer mandate penalties to employers in all 50 states, regardless of whether or not the states established their own Exchanges. This usurpation of constitutional authority and utter disregard of the Congressional intent set forth in the ACA with unencumbered, unadorned language cannot stand. The IRS Rule must be invalidated. For the foregoing reasons, the plaintiffs respectfully request that this Court enter summary judgment in their favor.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 6, 2014, a copy of the foregoing "Amended Brief in Support of Plaintiff School Corporations' Motion for Summary Judgment" was filed electronically. Notice of this filing will be sent to the following parties by operation of the Court's Electronic filing system. Parties may access this filing through the Court's system.

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