

Anomalies in the Affordable Care Act that Arise from Reading the Phrase “Exchange Established by the State” Out of Context

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The Supreme Court is currently considering in *King v. Burwell* whether residents of all States can receive premium tax credits under the Patient Protection and Affordable Care Act (ACA).¹ The Plaintiffs-Petitioners brought this litigation as a challenge to the validity of a Treasury Department rule allowing all ACA health insurance Exchanges or marketplaces, including federally facilitated Exchanges (FFE), to support and grant the credits.² They invite the Court to focus solely on four words in two subsections of Section 36B of the Internal Revenue Code³ that they interpret as limiting tax credits to individuals who can use a State-operated Exchange to enroll in qualified health plans. If the Court follows existing precedent, however, it will look at the text of the statute as a whole, rather than at this single clause in isolation.⁴ If it does,

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¹ Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).

² Exchanges are often referred to as “marketplaces.” This article will use the statutory term, “Exchange.” The term “Exchange” is capitalized throughout this article as it is throughout the ACA. The capitalization is a reminder that the term is a defined term (see *infra* notes 22-24 and accompanying text), and includes FFEs as well as state-operated Exchanges.

³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1401(a), 124 Stat. 213 (2010) (codified as amended at 26 U.S.C. § 36B (2012)).

⁴ See Brief of William Eskridge, Jr. et al. as Amici Curiae in Support of Respondents at 6-12, *King v. Burwell*, 135 S. Ct. 475 (2014) (No. 14-114) [hereinafter Amicus Brief

the Court will see that reading “established by the State” as the limitation that Petitioners urge upon it makes it necessary for the Court to engage in endless rationalizations, evasions, and circumventions in reading the rest of the statute. Indeed, if the Court accepts their reading, at least fifty provisions of the ACA would be made anomalous, if not absurd.

The “Exchange established by the State,” language came out of the Senate Finance bill, S. 1796, which became a basis for the ACA in 2009.⁵ The Finance bill provided for state-operated Exchanges and federal fallback Exchanges, as does the final ACA, but considered all Exchanges, state-operated or federally facilitated, to be State Exchanges.⁶ According to the Finance bill—and the final ACA—all Exchanges are effectively “established by the State,” that is, they are exchanges that the State either elected to operate on its own or elected to permit the federal government to operate for it.

Interpreting the “Exchange established by the State” language of Section 36B to permit only Exchanges operated by states to issue premium tax credits creates four types of anomalies with respect to other provisions of the Affordable Care Act. First, it conflicts with the definitional sections of Title I, which define FFEs as Exchanges, possessing all the powers of state-operated Exchanges.⁷ Second, it renders a number of the provisions dealing with the functions and responsibilities of Exchanges nonsensical as applied to FFEs.⁸ Third, other instances where the ACA uses the phrase “Exchange established by the State” or “Exchange established under section 1311” cause difficulties if these phrases are interpreted as applying only to state-operated Exchanges.⁹ Finally, there are yet other sections of the ACA that would not operate as they were obviously intended if the “established by the State” language is read to exclude FFEs.¹⁰

of William Eskridge, Jr. et al. in Support of Respondents] (explaining why the Court must if it is to follow its own precedents consider the meaning of an entire statute and not focus on just a single phrase snipped out of context).

⁵ S. 1796, 111th Cong., § 1205 (2009) (proposing to add § 36B(b)(2)(A)(i) to the Internal Revenue Code); see Brief of Health Care Policy History Scholars in Support of Respondents at 6-12, *King v. Burwell*, 135 S. Ct. 475 (2014) (No. 14-114) (tracing the legislative history of the phrase “State exchanges” or “Exchanges established by the State”).

⁶ In the Finance Committee’s report filed simultaneously with S. 1796 on October 19, 2009, the term “state exchange” refers both to exchanges that result from exercise of the federal fallback power and to exchanges that support individuals’ right to the premium credits. S. REP. NO. 111-89, at 19, 37 (2009).

⁷ See *infra* Part I.

⁸ See *infra* Part II.

⁹ See *infra* Part III.

¹⁰ See *infra* Part IV.

Some of these anomalies are arguably minor if considered singly. Others, however, are quite difficult to explain away. Indeed, some are more properly characterized as “absurdities.” D.C. District Circuit Judge Thomas B. Griffith, for example, in his majority panel decision in *Halbig v. Burwell* (since vacated), was forced by his grim determination to find that only state-operated exchanges could grant premium tax credits, to conclude that FFEs could enroll individuals who were not “qualified,” leaving the term “qualified individuals” meaningless.¹¹ Petitioners also make this argument in their brief to the Supreme Court,¹² although they concede that the Department of Health and Human Services (HHS), pursuant to its “broad power [under 42 U.S.C. § 18041(c)] to ‘take such actions as are necessary to implement’ the ‘other requirements’” regarding the operation of Exchanges, could redefine “qualified individuals.”¹³ This, of course, begs the question of why HHS could not use the same “broad powers” to apply to FFEs the requirement that Exchanges make premium tax credits available.¹⁴

In any event, cumulatively, the incongruities that Petitioners’ reading of 36B creates make it difficult to see how the Supreme Court could rule for Petitioners without ignoring the “fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme,” which the justices have repeatedly acknowledged in their decisions.¹⁵

I. DEFINITIONS

Section 36B(a) provides that tax credits are available to any “applicable taxpayer,” a term explicitly defined to mean a taxpayer whose household income is between 100 and 400 percent of the federal poverty level without any qualification as to through what sort of Exchange the credit was issued.¹⁶ A separate subsection of 36B that establishes the formula for calculating the premium assistance amount ties it to the lesser of the cost of the second-lowest cost silver plan

¹¹ *Halbig v. Burwell*, 758 F.3d 390, 404-405 (D.C. Cir. 2014). *See infra* text accompanying notes 50-59 (discussion of the “qualified individual” issue).

¹² Brief for Petitioners at 49-50, *King v. Burwell*, 135 S. Ct. 475 (2014) (No. 14-114).

¹³ *Id.* at 48 n.6.

¹⁴ See 42 U.S.C. § 18052(a)(2)(D) (2012) (describing provision of tax credits under section 36B as a requirement in all States).

¹⁵ *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (quoting *Davis v. Michigan Dept. of Treasury*, 489 U.S. 803, 809 (1989)); *see also* Brief of William Eskridge, Jr. et al., *supra* note 4.

¹⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1401(a), 124 Stat. 215 (2010) (codified as amended at 26 U.S.C. § 36B(c)(1)(A) (2012)).

available to the taxpayer or to the actual premium paid by the taxpayer for a plan in which the taxpayer was enrolled “through an Exchange established by the State under 1311.”¹⁷ The same formula (but adding “section” before 1311) is used to define the “coverage month” for which an applicable taxpayer is eligible for premium tax credits in 26 U.S.C. § 36B(d)(2)(A)(i).¹⁸

Both subsections reference section 1311.¹⁹ Section 1311 provides that “[e]ach state shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an ‘Exchange’) for the state” that meets the requirements of section 1311.²⁰ Of course, Congress cannot literally order states to establish Exchanges, and thus section 1321 provides that if a state “elects” not to establish the “required” Exchange, the HHS “Secretary shall (directly or through

¹⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1401(a), 124 Stat. 213 (2010) (codified as amended at 26 U.S.C. § 36B(b)(2) (2012)).

¹⁸ Note that one of the two appearances of “enrolled in through an Exchange established by the State under [section] 1311” is redundant. Indeed it could be deleted from subsection (c)(2)(A)(i)—the “coverage month” definition—and subsection (b)(2)(A) would still do all the limiting work desired, whatever that may be, by testing the health plans one at a time. That subsection recognizes that members of a tax-filing unit might be enrolled in different plans. For any plan that does not meet all conditions, such as for not using an Exchange of any kind for enrollment, the premium paid for it does not count toward the sum.

In other words, Petitioners are incapable of producing a construction of section 36B, much less a construction of the whole ACA, that is free from redundancy, just as they claim respondents are incapable. In addition, as this article demonstrates repeatedly, the petitioners’ construction of section 36B would deprive many other sections of the ACA of meaning. But Petitioners’ case strictly depends on, among other things, rigid application of a no-surplusage principle. In sum, after various plain-meaning arguments are deployed against them, most notably the effect of the “Exchange” definition, discussed *infra* notes 22-24 and accompanying text, and of Congress’s directive in 42 U.S.C. § 18041(c)(1) that an FFE is “such Exchange,” touching off a string of references and incorporations, and the anomalies set out in this article, Petitioners are left having to establish overriding force for their four words. Some form of no-surplusage principle, applied to the four words, is the only way they can do this. For example, in their brief to the Fourth Circuit, invocations of such a principle appear at 19 and 22. Brief for Petitioners at 19 and 22, *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014). Yet the unavoidable redundancies in their own construction of section 36B make the principle unavailable to them. “[T]he canon against surplusage ‘assists only where a competing interpretation gives effect to every clause and word of a statute.’” *Microsoft Corp. v. i4i Ltd. Partnership*, 564 U.S. ___, ___, 131 S.Ct. 2238, 2248, 180 L.Ed.2d 131 (2011) cited at *Marx v. Gen. Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013).

¹⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311, 124 Stat. 173 (2010) (codified as amended at 42 U.S.C. § 18031 (2012)).

²⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(b)(1), 124 Stat. 173 (2010) (codified as amended at 42 U.S.C. § 18031(b)(1) (2012)).

agreement with a not-for-profit entity) establish and operate such Exchange within the State.”²¹

“Exchange” is defined by the ACA in section 1563 to mean “an American Health Benefit Exchange established under section 1311.”²² Because a section 1321 Exchange is an “Exchange” it is by definition a 1311 state Exchange. Section 1311(b)(1) similarly tells the reader what “Exchange” means: the entity that a State is there described as establishing, which must conform to the requirements of section 1311.²³ Finally, section 1311(d)(1) provides, as one of those requirements via subsection (b)(1)(C) and so confirmed as definitional: “[a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State.”²⁴ This defines any “Exchange” as “established by a State.”

II. EXCHANGE FUNCTIONS AND RESPONSIBILITIES

The actual determination of eligibility for advance premium tax credits is governed by ACA sections 1411 through 1413.²⁵ These sections consistently refer to an “Exchange” without qualification. 42 U.S.C. § 18081(a), for example, provides:

The Secretary shall establish a program . . . for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 18032(f)(3), 18071(e), and 18082(d) of this title

²¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(c), 124 Stat. 173 (2010) (codified as amended at 42 U.S.C. § 18041(c) (2012)).

²² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1563, 124 Stat. 264 (2010) (codified as amended at 42 U.S.C. § 300gg-91(d)(21) (2012)); *see* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1551, 124 Stat. 258 (2010) (codified as amended at 42 U.S.C. § 18111 (2012)) (“Unless specifically provided for otherwise, the definitions contained in section 300gg-91 of this title shall apply with respect to this title”).

²³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(b)(1), 124 Stat. 173 (2010) (codified as amended at 42 U.S.C. § 18031(b)(1) (2012)).

²⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(d)(1), 124 Stat. 176 (2010) (codified as amended at 42 U.S.C. § 18031(d)(1) (2012)).

²⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, §§ 1411-1413, 124 Stat. 224-235 (2010) (codified as amended at 42 U.S.C. §§ 18081-18083 (2012)).

and section 36B(e) of title 26 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of title 26 or section 18071 of this title—(A) whether the individual meets the income and coverage requirements of such sections; and (B) the amount of the tax credit or reduced cost sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2)²⁶

42 U.S.C. § 18081(b)(3) sets out the information that must be provided by an applicant who wishes to enroll in a qualified health plan through an Exchange for whom a premium tax credit or cost-sharing reduction payment is being claimed.²⁷ 42 U.S.C. § 18081(c)(1) requires Exchanges to submit information submitted to them to HHS for verification, including information regarding tax credit and cost-sharing reduction eligibility information, which must be verified by the IRS.²⁸ 42 U.S.C. § 18081(c)(4)(B) gives HHS discretion in determining how Exchanges verify information in order to “reduce the administrative costs and burdens on the applicant.”²⁹ 42 U.S.C. § 18081(e) requires HHS to notify the Exchange of the results of the verification.³⁰ 42 U.S.C. § 18081(e)(2)(A)(i) provides that, if the information provided by the applicant is verified,

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

²⁶ 42 U.S.C. § 18081(a) (2012).

²⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(b)(3), 124 Stat. 225 (2010) (codified as amended at 42 U.S.C. § 18081(b)(3) (2012)).

²⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(c)(1), 124 Stat. 226 (2010) (codified as amended at 42 U.S.C. § 18081(c)(1) (2012)).

²⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(c)(4)(B), 124 Stat. 227 (2010) (codified as amended at 42 U.S.C. § 18081(c)(4)(B) (2012)).

³⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(e), 124 Stat. 227 (2010) (codified as amended at 42 U.S.C. § 18081(e) (2012)).

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 18082(c) of this title of the amount of any advance payment to be made.³¹

42 U.S.C. § 18081(e)(4)(A) provides the responsibilities of the Exchange to resolve certain inconsistencies in premium tax credit applications, while 42 U.S.C. §§ 18081(e)(4)(B)(i)–(ii) authorizes the Exchange to approve applications based on information provided by the applicant, or the Treasury Department, respectively, in certain circumstances.³² 42 U.S.C. § 18081(e)(4)(C) requires Exchanges to notify applicants of appeal rights regarding premium tax credit applications, while 42 U.S.C. § 18081(f)(2)(A) requires Exchanges to review at the request of an employer a determination by the Exchange that an employer did not provide minimum essential coverage or affordable coverage to an employee, thus making that employee eligible for advance premium tax credits.³³

42 U.S.C. § 18082(a)(1) requires HHS to establish a program under which:

[U]pon request of an Exchange, advance determinations are made under section 18081 of this title with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of title 26 and the cost-sharing reductions under section 18071 of this title.³⁴

Under 42 U.S.C. § 18082(c), HHS notifies Treasury and the Exchange of its determinations regarding premium tax credits and cost-sharing reduction payments and Treasury makes payments of the premium tax credits and cost-sharing reduction payments directly to qualified health plan issuers.³⁵ An issuer of a qualified health plan must

³¹ 42 U.S.C. § 18081(e)(2)(A) (2012).

³² 42 U.S.C. §§ 18081(e)(4)(A)–(B) (2012)).

³³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(e)(4)(C), 124 Stat. 229 (2010) (codified as amended at 42 U.S.C. § 18081(e)(4)(C) (2012)); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(f)(2)(A), 124 Stat. 229 (2010) (codified as amended at 42 U.S.C. § 18081(f)(2)(A) (2012)). For either the tax penalty under subsection (a) or subsection (b) of I.R.C. § 4980H, an element is that some employee received a premium tax credit, thus an employer has an interest in this determination See I.R.C. §§ 4980H(a)(2) and (b)(1)(B).

³⁴ 42 U.S.C. § 18082(a)(1) (2012).

³⁵ 42 U.S.C. § 18082(c)(1)–(2)(A) (2012).

notify the Exchange that it has reduced premiums charged in the amount of the advance tax credit.³⁶

42 U.S.C. § 18083(a) provides, “[t]he Secretary shall establish a system meeting the requirements of this section under which residents of **each** State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs.”³⁷ The term “applicable State health subsidy programs” explicitly includes premium tax credits.³⁸ 42 U.S.C. § 18083 also provides that “each state” shall be provided a single, streamlined application and that “each state” shall develop a secure electronic interface to handle premium tax credit applications.³⁹

It can be argued, of course, that these programs only determine eligibility based on section 36B, and that 36B only recognizes eligibility for individuals enrolled through a state-operated Exchange, but why would a FFE have to set up all these programs and make all these eligibility determinations only to tell individuals they are not eligible because no one in their state is eligible? And why would it be important to set up such a program in “each State,” no matter what kind of Exchange it had?

IRC § 6103(l)(21)(B) authorizes the release of information needed to establish eligibility for tax credits or cost-sharing reduction payments to “an Exchange established under the Patient Protection and Affordable Care Act.”⁴⁰ This is the information that applicants are supposed to provide under 42 U.S.C. § 18081(b)(3)(A) to an “Exchange” for their eligibility for premium tax credits to be determined.⁴¹

Other required Exchange functions also make no sense if FFEs cannot grant premium tax credits. As noted earlier,⁴² section 1563 of the ACA and other provisions define all Exchanges, including FFEs, as 1311 Exchanges, so federally-facilitated Exchanges must be able to carry out all 1311 (42 U.S.C. § 18031) Exchange functions.

42 U.S.C. § 18031(c)(5)(B) requires Exchanges to establish an internet portal to apply for premium tax credits and cost sharing reduction payments.⁴³ 42 U.S.C. § 18031(d)(4)(G) requires Exchanges to

³⁶ 42 U.S.C. § 18082(c)(2)(B)(i)-(ii) (2012).

³⁷ 42 U.S.C. § 18083(a) (2012) (emphasis added).

³⁸ 42 U.S.C. § 18083(e)(1) (2012).

³⁹ 42 U.S.C. §§ 18083(b)(1)(A), (c)(1) (2012).

⁴⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1414(a)(1), 124 Stat. 236 (2010) (codified as amended at 26 U.S.C. § 6103(l)(21) (2012)).

⁴¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1411(b)(3)(A), 124 Stat. 225 (2010) (codified as amended at 42 U.S.C. § 18081(b)(3)(A) (2012)).

⁴² See *supra* notes 22-24 and accompanying text.

⁴³ 42 U.S.C. § 18031(c)(5)(B) (2012).

“establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title.”⁴⁴ Exchanges must certify individuals for exemptions under the individual responsibility requirement under 42 U.S.C. § 18031(d)(4)(H), some of which involve determinations of tax credit eligibility.⁴⁵

Under 42 U.S.C. § 18031(d)(4)(I), Exchanges must notify the IRS of “the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of title 26” because the employer failed to offer minimum essential coverage or because the employer failed to offer adequate and affordable coverage.⁴⁶ Then, under 42 U.S.C. § 18031(d)(4)(J), Exchanges must notify employers when individuals cease to be covered under a qualified health plan, which is relevant to employers because an employee’s enrollment in a plan, if joined with advance premium tax credits, may result in the employers’ I.R.C. § 4980H liability.⁴⁷ Exchanges must establish navigator programs under 42 U.S.C. §§ 18031(d)(4)(K) and 18031(i).⁴⁸ One of the duties of a navigator is to “distribute fair and impartial information concerning . . . the availability of premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title.”⁴⁹ Again, petitioners cannot explain why Congress would have hidden two phrases in the formula for calculating tax credits that would have required an FFE to perform all of these functions for no purpose.

A basic function of an Exchange is to “make available qualified health plans to qualified individuals and qualified employers.”⁵⁰ 42 U.S.C. § 18032(a)(1) provides “[a] qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.”⁵¹ The term “qualified individual” is used

⁴⁴ 42 U.S.C. § 18031(d)(4)(G) (2012).

⁴⁵ 42 U.S.C. § 18031(d)(4)(H) (2012).

⁴⁶ 42 U.S.C. § 18031(d)(4)(I) (2012).

⁴⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(d)(4)(J), 124 Stat. 177 (2010) (codified as amended at 42 U.S.C. § 18031(d)(4)(J) (2012)).

⁴⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(d)(4)(K), 124 Stat. 177 (2010) (codified as amended at 42 U.S.C. § 18031(d)(4)(K) (2012)); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(i)(1), 124 Stat. 180 (2010) (codified as amended at 42 U.S.C. § 18031(i) (2012)).

⁴⁹ 42 U.S.C. § 18031(i)(3)(B) (2012).

⁵⁰ 42 U.S.C. § 18031(d)(2)(A) (2012).

⁵¹ 42 U.S.C. § 18032(a)(1) (2012).

repeatedly in the ACA to refer to individuals served by an Exchange, or to distinguish “qualified individuals” from individuals not qualified to enroll in coverage through an Exchange.⁵² Only “qualified individuals” may enroll in catastrophic health plans, thus catastrophic plans would not be available in FFE states.⁵³ States without “qualified individuals” will also be barred from the basic health plan provision of the statute.⁵⁴

A qualified individual is defined by the ACA, with respect to an Exchange (the term is used elsewhere in the statute for other purposes), as “an individual who—(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange.”⁵⁵ Obviously, if only state-operated Exchanges can be considered to be State-established Exchanges, then FFEs cannot enroll qualified individuals in qualified health plans, leaving open the question of why FFEs exist at all. Conversely, if there are no “qualified individuals” who can enroll in FFEs, there is no need for the language in 36B restricting premium tax credits to state-established Exchanges.⁵⁶ Petitioners, in attempting to deal with the “qualified individual” issue, basically argue that individuals who are not “qualified individuals” can enroll through the federal Exchanges,⁵⁷ a silly argument given how the term is used in the ACA.⁵⁸

⁵² See 42 U.S.C. §§ 18031(b)(2), (c)(1)(F), (c)(5)(B), (e)(1)(B), and (i)(4)(A)(ii) (2012); 42 U.S.C. §§ 18032(d)(3)(A) and (d)(3)(C) (2012); see also 42 U.S.C. §§ 18032(f)(1)(B) (excluding incarcerated individuals from definition of “qualified individuals”) and (f)(3) (2012) (limiting “qualified individuals” to those who are “lawful residents” of the United States).

⁵³ 42 U.S.C. § 18032(d)(3)(C) (2012).

⁵⁴ 42 U.S.C. § 18051(e)(1) (2012).

⁵⁵ 42 U.S.C. § 18032(f)(1)(A) (2012).

⁵⁶ 26 U.S.C. § 36B(b)(2) (2012) (“The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of— (A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer’s spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or (B) the excess (if any) of—(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over (ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer’s household income for the taxable year.”).

⁵⁷ Petitioners’ Brief, *supra* note 12, at 48.

⁵⁸ See *supra* note 52. Also, there would be no residency requirement at all, for use of the Exchange. Even foreign residents could use any FFE, so far as Federal law would be concerned. Once this attempt to escape the anomaly with non-qualified-individuals is rejected, it would also follow, from the text of the ACA if taken with a hyper-literalism comparable to the Petitioners’, that their merits position defeats their own standing. Since no plan could be bought on an FFE consistently with the ACA, it reasonably follows that there would be no “plan available” on any FFE. But, per the text of I.R.C. § 5000A(e)(1)(B)(ii), the amount of the premium for the lowest cost bronze “plan

They also argue that HHS can use its authority to make rules under 42 U.S.C. § 18041 to get around this problem,⁵⁹ but, as noted earlier, why could not HHS under the same authority work around the 36B “established by the State” language?

Finally, there are the reporting requirements of 26 U.S.C. § 36B(f).⁶⁰ Section 36B(f) is a subsection of the same section that contains the “established by the State” language on which these cases are based. Section 36B(f) is entitled “Reconciliation of credit and advance credit” and requires the reconciliation of advance premium tax credits provided to enrollees with the actual credits they are due at the end of the tax year.⁶¹ Section 36B(f) provides that:

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

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

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

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

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

available” is a critical factor for attaining the affordability exemption of subsection (e)(1). With no such plan extant, that premium amount is either non-existent or zero. Either way it cannot “exceed[]” any number, which is the condition of the exemption and which Petitioners and all residents of FFE States could not satisfy. Petitioners rely on this affordability exemption to claim standing in this action. Petitioners’ Brief, *supra* note 12, at 8-9.

⁵⁹ Petitioners’ Brief, *supra* note 12, at 48.

⁶⁰ 26 U.S.C. § 36B(f) (2012).

⁶¹ *Id.*

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

(F) Information necessary to determine whether a taxpayer has received excess advance payments.⁶²

This provision explicitly applies to persons carrying out the responsibilities of FFEs (1321 Exchanges), and thus to States with FFEs, and requires them to report information to the IRS and to taxpayers regarding receipt of premium tax credits. This information may be of use to the IRS for determining compliance with the individual mandate, but its primary purpose, as noted in its title, is for reconciliation of advance premium tax credits with actual tax credits due. This provision was added by the Health Care and Education Reconciliation Act,⁶³ which was adopted subsequent to the amended ACA, and thus under the canons of statutory construction its language should prevail over contrary language, if any, found in the earlier adopted ACA.⁶⁴

III. OTHER “ESTABLISHED BY THE STATE” PROVISIONS

The term “established by the State” appears in several other places in the ACA. One of these uses is arguably compatible with limiting the phrase to state-operated Exchanges.⁶⁵ In each of the other places at which the phrase appears, however, it does not make sense to read the term “Exchanges” as applying exclusively to state-operated Exchanges.

42 U.S.C. § 1396w-3 requires states, as a condition of receiving any federal financial assistance after January 1, 2014, to enroll individuals identified by an “Exchange established by the State” in their Medicaid

⁶² 26 U.S.C. § 36B(f)(3) (2012).

⁶³ Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

⁶⁴ The later-adopted language should prevail under the principle of “leges posteriores priores contrarias abrogant—the rule that the more recent of two conflicting statutes shall prevail.” *See* *United States v. Under Seal*, 709 F.3d 257, n.2 (4th Cir 2013).

⁶⁵ 42 U.S.C. § 18031(f)(3)(A) (2012) permits a State to authorize an “Exchange established by the State” to contract out responsibilities to an “eligible entity,” incorporated under the law of one or more States. Note that this is the one place in the portion of the ACA that created freestanding sections, codified in 42 U.S.C. chapter 157, where the “established by the State” phrase is used to describe an Exchange. Other places where this phrase is used are in amendments to pre-existing statutes such as the Internal Revenue Code, thus codified well away from those freestanding sections. In these locations, the phrase serves a descriptive purpose, pointing the reader back to the core ACA sections that describe Exchanges. *E.g.*, 26 U.S.C. §§ 36B(b)(2)(A), (c)(2)(A)(i) (2012).

and CHIP programs and to ensure that individuals who are ineligible for Medicaid and CHIP are enrolled through “such an Exchange” in a qualified health plan with premium tax credits.⁶⁶ A state without an “Exchange established by the State” could not, therefore, have an approved Medicaid program after January 1, 2014. Exchanges “established by the State” can also under this section enter into agreements for the State Medicaid agency to determine eligibility for premium tax credits and must link the Exchange “established by the State” website to the state’s CHIP website.⁶⁷ Again, why would FFEs not be permitted to coordinate with Medicaid and CHIP programs?

Moreover, 42 U.S.C. § 1396w-3(b)(1)(D) requires a secure electronic interface between the state Medicaid program and the “Exchange established by the State.”⁶⁸ Assuming a state could have a Medicaid program in a FFE state, is security not an equal concern? It also makes no sense that a Medicaid program would need to coordinate with respect to enrollees enrolled in Medicaid or CHIP and a qualified health plan for state-operated Exchanges but not the FFE.⁶⁹ Finally, it is, at least, arguable that all Exchanges, and not just state-established Exchanges, should have to coordinate their websites with Medicaid and CHIP program websites in the state in which the Exchange is located.

42 U.S.C. § 1397ee(d)(3)(B) requires states that exceed their CHIP funding allotment to enroll children not eligible for Medicaid in a qualified health plan through an “Exchange established by the State.”⁷⁰ 42 U.S.C. § 1397ee(3)(C) provides that, “[w]ith respect to each State,” HHS shall review the benefits and cost-sharing available through qualified health plans offered through “an Exchange established by the State under section 1311” to determine their equivalence to CHIP plans.⁷¹ Again, it makes no sense that states in FFE states would not be able to do the same. The text of the statute says that these are conditions that must be met for a state to have an approved CHIP program,⁷² and thus a state with an FFE could not have an approved CHIP program.

⁶⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. II, § 2201, 124 Stat. 289 (2010) (codified as amended at 42 U.S.C. § 1396w-3(b)(1)(B)-(C) (2012)).

⁶⁷ *Id.*

⁶⁸ 42 U.S.C. § 1396w-3(b)(1)(D) (2012).

⁶⁹ 42 U.S.C. § 1396w-3(b)(1)(E) (2012).

⁷⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. II, § 2101(b)(1), 124 Stat. 286 and tit. X, § 10203(c)(2)(B), 124 Stat. 928 (2010) amended Section 2105(d) of the Social Security Act (codified as amended at 42 U.S.C. § 1397ee(d)(3)(B) (2012)).

⁷¹ 42 U.S.C. § 1397ee(d)(3)(C) (2012).

⁷² 42 U.S.C. § 1397ee(a)(3)(A) (2012) (“In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E),

42 U.S.C. § 1396a(gg) requires that, subject to certain exceptions, states must maintain their Medicaid eligibility standards that were in effect on the date of enactment of the ACA until HHS determines that an “Exchange established by the State under section 1311” is fully operational.⁷³ The maintenance of effort provision was obviously put in place to keep states from reducing Medicaid coverage until the ACA Medicaid expansions and premium tax credit programs were in place, but there is no reason this requirement should be limited to states with state Exchanges. Petitioners argue that the maintenance of effort provision remains in place in states with FFEs.⁷⁴ But this is inconsistent with the exception for states with budget deficits in 1396a(bb)(3), which ends on December 31, 2013.⁷⁵ It is also not the way that the states have understood the provision, including states that filed an amicus brief for Petitioners but have changed their Medicaid programs since 2013.⁷⁶

Finally, 42 U.S.C. § 1320b-23(a)(2) requires pharmacy benefit managers to report certain pricing information to HHS if they manage pharmacy benefits for a qualified health plan offered “through an Exchange established by a State under section 1311.”⁷⁷ Why limit this requirement to state-operated Exchanges?

Several provisions of the ACA refer to “an Exchange established under 1311.” 26 U.S.C. § 6055, for example, requires entities that provide minimum essential coverage to report the coverage to the IRS and to covered taxpayers, and requires the return to specify whether the coverage was through a qualified health plan through an “Exchange established under section 1311.”⁷⁸ 26 U.S.C. § 125(f)(3) provides that the exclusion from an employee’s gross income of health benefits offered through a cafeteria plan does not apply to plans offered through an “Exchange established under section 1311.”⁷⁹ Section 1331 of the ACA,

to each State that meets the condition under paragraph (4) [Enrollment and retention provisions for children] for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year.”).

⁷³ 42 U.S.C. § 1396a(gg)(1) (2012). A corresponding addition to the main list of State plan requirements, § 1396a(74), refers to subsection (gg). The two provisions were added by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. II, § 2001(b), 124 Stat. 275 (2010)).

⁷⁴ Brief for Petitioners, *supra* note 12 at 50.

⁷⁵ 42 U.S.C. § 1396a(gg)(3) (2012).

⁷⁶ See Brief of the Commonwealth of Virginia et al. as Amici Curiae in Support of Affirmance at 35-36, *King v. Burwell*, 135 S. Ct. 475 (2014) (No. 14-114).

⁷⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. VI, § 6005, 124 Stat. 698 (2010) (codified at 42 U.S.C. § 1320b-23(a)(2) (2012)).

⁷⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1502(a), 124 Stat. 250 (2010) (codified at 26 U.S.C. § 6055 (2012)).

⁷⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1515(a), 124 Stat. 258 (2010) (to be codified at 26 U.S.C. § 125(f)(3)).

which establishes the basic health plan program, provides that an individual eligible for basic health plan coverage may not enroll in a qualified health plan through an “Exchange established under section 1311.”⁸⁰ Finally, the ACA amends 42 U.S.C. § 405(c)(2)(C), section 205(c)(2)(C) of the Social Security Act, to give an “Exchange established under section 1311” the ability to collect and use Social Security numbers.⁸¹ We can think of no reason why these provisions should apply to state-operated Exchanges but not FFEs. Judge Griffith at least conceded that FFEs were 1311 Exchanges, but that means all other 1311 requirements apply to FFEs.⁸²

IV. OTHER ANOMALIES

Obviously the biggest anomaly is that the three-legged stool on which the entire Title I is built collapses if the premium tax credit leg is removed. The premium tax credits are necessary, along with the individual mandate, to make the market reforms work. All three elements are necessary for the ACA to expand coverage as it was intended to do. Removing the premium tax credits would lead to a dramatic reduction in the number of Americans covered by health insurance, as recent studies by Rand and the Urban Institute demonstrate.⁸³

Judge Griffith explained this anomaly away in *Halbig* by arguing that the same situation exists with respect to the territories and the

⁸⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1311(d)(1), 124 Stat. 176 (2010) (codified at 42 U.S.C. § 18031(d)(1) (2012)).

⁸¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1414(a)(2), 124 Stat. 237 (2010) (codified as amended at 42 U.S.C. § 405(c)(2)(C)(first x) (2012)).

⁸² See *Halbig v. Burwell*, 758 F.3d 390, 404 n.6 (D.C. Cir. 2014), *vacated*, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014). See *supra* text accompanying notes 22–24.

⁸³ See EVAN SALTZMAN AND CHRISTINA EIBNER, THE RAND CORPORATION, THE EFFECT OF ELIMINATING THE AFFORDABLE CARE ACT’S TAX CREDITS IN FEDERALLY FACILITATED MARKETPLACES 1 (2015), *available at* http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf (“Enrollment in the ACA-compliant individual market . . . would decline by 9.6 million, or 70 percent, in federally facilitated marketplace (FFM) states”); LINDA J. BLUMBERG, ET AL., URBAN INSTITUTE, CHARACTERISTICS OF THOSE AFFECTED BY A SUPREME COURT FINDING FOR THE PLAINTIFF IN KING V. BURWELL 1 (2015), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf417633 (“Of the 9.3 million people estimated to lose tax credits under a finding for King, two-thirds would become uninsured”); LINDA J. BLUMBERG, ET AL., URBAN INSTITUTE, THE IMPLICATIONS OF A SUPREME COURT FINDING FOR THE PLAINTIFF IN KING V. BURWELL: 8.2 MILLION MORE UNINSURED AND 35% HIGHER PREMIUMS 1 (2015), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf417289 (“We estimate that a victory for the plaintiff would increase the number of uninsured in 34 states by 8.2 million people”).

CLASS Act.⁸⁴ In fact, however, the Centers for Medicare and Medicaid Services had already changed its interpretation of the statute regarding the territories (and Judge Griffith's clerk missed it) so that none of the three legs apply in the territories.⁸⁵ And, Congress explicitly required HHS to determine whether an actuarially sound CLASS Act program could be created and repealed the Act when HHS determined that it was not possible.

In another anomaly, 42 U.S.C. § 18052 creates a procedure through which states can, beginning in 2017, obtain waivers from HHS from certain requirements of the ACA, including the individual and employer mandates and the Exchange requirements, if they come up with a proposal that would afford coverage that was at least as comprehensive and affordable and cover at least a comparable number of residents as does the ACA.⁸⁶ The amount of foregone tax credits would be given the state to administer its plan.⁸⁷ If a state can nullify the employer mandate and the Exchange provisions of the ACA, and greatly weaken the individual mandate, by simply not operating a state Exchange, it would not have to wait until 2017, meet the requirements of the section, or get a waiver. The rigorous procedural and substantive requirements under this provision become meaningless. Moreover, how would HHS determine the amount of tax credits the state should get if it was getting none before 2017 because it did not set up a state Exchange?

Another option provided by the ACA is for states to establish Basic Health Program. 42 U.S.C. § 18051(d)(3)(A)(i) provides that a state participating in the BHP is paid 95 percent of premium tax credits and cost-sharing reduction payments due its residents under 36B and 1402.⁸⁸ In an FFE states, this would be \$0, so such a state could not have a BHP. Yet another option is for states to establish a demonstration project for wellness programs in the individual market.⁸⁹ This provision imposes a

⁸⁴ *Halbig v. Burwell*, 758 F.3d 390 (D.C. Cir. 2014), *vacated*, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014). In his decision, D.C. Circuit Judge Thomas B. Griffith discussed the lack of an individual mandate or premium subsidies in the Community Living Assistance Services and Supports (CLASS) Act, Pub. L. No. 111-148, tit. VIII, 124 Stat. 828 (2010) (codified at 42 U.S.C. §§ 30011-30011-9), *repealed by* American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, tit. VI, § 642, 126 Stat. 2358 (2013).

⁸⁵ Letter from Marilyn Tavenner, Dep't of Health & Human Servs., to Comm'r Gregory R. Francis, Office of Lieutenant Governor (July 16, 2014), *available at* <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf>.

⁸⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1332, 124 Stat. 203 (2010) (codified at 42 U.S.C. § 18052 (2012)).

⁸⁷ 42 U.S.C. § 18052(a)(3) (2012).

⁸⁸ 42 U.S.C. § 18051(d)(3)(A)(i) (2012).

⁸⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1201(4), 124 Stat. 154 (2010) (codified at 42 U.S.C. § 300gg-4(l)(3)(A)(ii) (2012)).

requirement that the program “not increase the cost to the Federal Government in providing credits under section 36B of title 26”⁹⁰; this provision is meaningless if premium tax credits are not available in a state with an FFE.

42 U.S.C. § 18031(f) provides for regional Exchanges.⁹¹ Regional Exchanges would not, however, under Petitioners’ blinkered definition, be “established by the State.”⁹² 42 U.S.C. § 300gg-93(c)(5) provides for consumer assistance programs for which all states or Exchanges can apply, which include among their duties assisting consumers in obtaining premium tax credits.⁹³ 29 U.S.C. §§ 218b(a)(1)–(2) require employers in all states to inform their employees of the availability of tax credits.⁹⁴ Moreover, pre-2010 Exchanges, recognized under 42 U.S.C § 18031(e), are not “established by the State under section 1311” and thus also could not grant premium tax credits.⁹⁵

Under 42 U.S.C. § 18054(a)(1), multistate plans must be available in all states.⁹⁶ Under 42 U.S.C. § 18054(c)(3)(A), “[a]n individual enrolled in a multi-State qualified health plan under this section shall be eligible for credits under section 36B of title 26 and cost sharing assistance under section 18071 of this title in the same manner as an individual who is enrolled in a qualified health plan.”⁹⁷

42 U.S.C. § 18031(d)(4) requires states to assume the cost of benefits that the state requires qualified health plans to cover, in addition to the cost of the essential health benefits required under the ACA.⁹⁸ This makes sense if the premium tax credits and cost-sharing reduction payments assist in making the essential health benefits affordable. It makes little sense if the consumer must pay the full cost of the essential health benefits in FFE states, but the state must cover the cost of non-essential benefits only.

Finally, Section 1401(c) of the ACA requires the GAO to, not later than five years after enactment, conduct a study of the availability of

⁹⁰ *Id.*

⁹¹ 42 U.S.C. § 18031(f) (2012).

⁹² *Id.*

⁹³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1002, 124 Stat. 138 (2010) (codified as amended at 42 U.S.C. § 300gg-93(c)(5) (2012)).

⁹⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1512, 124 Stat. 252 (2010) (codified as amended at 29 U.S.C. § 218B(a)(1)–(2) (2012)).

⁹⁵ 42 U.S.C. § 18031(e) (2012).

⁹⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1334(a)(1), tit. X, § 10104(q), 124 Stat. 902 (2010) (codified as amended at 42 U.S.C. § 18054(a)(1) (2012)).

⁹⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. X, § 10104(q), 124 Stat. 904 (2010) (codified as amended at 42 U.S.C. § 18054(c)(3)(A) (2012)).

⁹⁸ 42 U.S.C. § 18031(d)(4) (2012).

affordable coverage, including the impact of the tax credits on affordability.⁹⁹ Section 1313 requires a similar study of Exchange operations.¹⁰⁰ If Congress only intended tax credits to be available through state-operated Exchanges, it seems like it would have directed a major focus on these studies to be on the difference in affordability in state-operated versus FFE states. Of course, this is not mentioned.

V. CONCLUSION

Under well-established precedent, the Supreme Court must consider the entire text of the Affordable Care Act in determining whether the IRS rule permitting FFEs to grant premium tax credits is valid. If it finds for the rule's validity, the Court must conclude, as have six of the nine lower court judges that have considered the issue, that the statute, as a whole, either conclusively requires that the FFEs grant tax credits, or, at least, that the IRS rule permitting them to do so is a permissible interpretation of the ACA. A conclusion to the contrary simply cannot be reconciled with numerous provisions of the statute.

⁹⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1401(c), 124 Stat. 220 (2010).

¹⁰⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1313(b), tit. X, § 10104(k), 124 Stat. 184, 902 (2010) (codified as amended at 42 U.S.C. § 18033(b) (2012)).