No. _____

In The
Supreme Court of the United States

STATE OF OKLAHOMA, ex rel. E. Scott Pruitt, in his official capacity as Attorney General of Oklahoma,

Petitioner,

v.

SYLVIA M. BURWELL, in her official capacity as Secretary of the United States Department of Health and Human Services; and JACOB J. LEW, in his official capacity as Secretary of the United States Department of the Treasury,

Respondents.

On Petition For A Writ Of Certiorari Before Judgment To The United States District Court For The Eastern District Of Oklahoma

PETITION FOR A WRIT OF CERTIORARI BEFORE JUDGMENT

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QUESTION PRESENTED

Section 36B of the Internal Revenue Code, which was enacted as part of the Patient Protection and Affordable Care Act ("ACA"), authorizes federal tax-credit subsidies for health insurance coverage that is purchased through an "Exchange established by the State under section 1311" of the ACA.

The question presented is whether the Internal Revenue Service ("IRS") may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under Section 1321 of the ACA.

PARTIES TO THE PROCEEDINGS

Petitioner State of Oklahoma, ex rel. E. Scott Pruitt, in his official capacity as Attorney General of Oklahoma ("Oklahoma"), was plaintiff in the district court below, and is Appellee in the appeal pending before the Tenth Circuit.

Respondents are Sylvia M. Burwell, in her official capacity as Secretary of the United States Department of Health and Human Services, and Jacob J. Lew, in his official capacity as Secretary of the United States Department of the Treasury, were defendants in the district court below, and are Appellants in the appeal pending before the Tenth Circuit.

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OTHER AUTHORITIES

PETITION FOR A WRIT OF CERTIORARI BEFORE JUDGMENT

Petitioners respectfully pray for a writ of certiorari to review a decision of the United States District Court for the Eastern District of Oklahoma. An appeal of the decision of the District Court is presently pending in the United States Court of Appeals for the Tenth Circuit.

OPINIONS BELOW

The district court granted summary judgment in favor of Petitioner on September 30, 2014. App. 1. That decision is attached at App. 1.

JURISDICTION

The judgment of the district court was entered on September 30, 2014. Respondents' notice of appeal was timely filed with the Tenth Circuit on October 3, 2014. This petition for certiorari is filed within ninety days of the district court's entry of judgment, No. CIV-11-30-RAW (E.D. Okla. Sept. 30, 2014), and while judgment is still pending at the Tenth Circuit, No. 14-7080. The jurisdiction of this Court is proper under both 28 U.S.C. §§ 1254(1) and 2101(e).

STATUTES AND REGULATIONS INVOLVED

Relevant statutory provisions are reproduced in the Appendix. App. 26.

STATEMENT OF THE CASE

1. The question presented in this case is identical to that presented in *King v. Burwell*, No. 14-114. The Court has already decided that the question is worthy of review.[1] This petition presents the issue of whether the Court should also grant certiorari in this case and hear the cases together so that the common question can be resolved with the Court having before it all categories of parties with an interest in resolution of that question.[2]

Resolution of the question presented turns on the meaning and effect of the statutory phrase "an exchange established by a State under Section 1311." Sovereign States like Oklahoma, who are vested with the authority to make the critical exchange-establishing decision, have been thrust squarely into the center of this controversy.

[1] As such, this petition will focus solely on the benefits of having this case heard together with *King*.

[2] Petitioner does not propose to disrupt the briefing schedule in *King*. Thus, Petitioner requests that, to the extent the Court wishes for a response to this petition, the Court call for such a response on an expedited schedule. And then, should the Court grant the petition, Petitioner is amenable to simply being placed on the existing briefing schedule in *King*.

Indeed, the relevant ACA provisions turn on a decision the ACA leaves to the States and the States alone: whether to establish an ACA-compliant health insurance exchange. As the "architect of the ACA" has explained, the ACA "puts enormous power in the hands of states, to implement healthcare reform. * * * There is a huge role for states, to actually run these exchanges, and decide how people get health insurance in these states[.]" NoblisNetwork, *Jonathan Gruber at Noblis – January 18, 2012*, YouTube (Jan. 20, 2012), http://youtu.be/GtnEmPXEpr0.

The IRS, as a result of a policy disagreement over how most States were exercising that "enormous power," promulgated the challenged regulations to wrest that power away from the States and, in doing so, directly and palpably injured the States in their capacity as sovereigns.

Additionally, as explained in the *King* Petition, the challenged IRS regulations have triggered application of the so-called "large employer mandate" in States like Oklahoma. Petition for a Writ of Certiorari at 8, *King v. Burwell*, No. 14-114 (July 31, 2014), 2014 WL 3811246. Oklahoma knows this all too well because it, in its capacity as a large employer subject to that mandate, has begun to incur many thousands of dollars in compliance costs in order to avoid many millions of dollars more in penalties.

Oklahoma's unique status as both a sovereign and as a large employer also provides it with two bases for standing that are distinct from those relied

upon by the *King* petitioners. The government has – without conceding that the King petitioners have standing – represented to the Court that it will not challenge the standing of those petitioners before this Court. Brief for the Respondents in Opposition at 34 n.10, *King v. Burwell*, No. 14-114 (Oct. 3, 2014), 2014 WL 49785998. The effect of this representation, however, was not to eliminate the issue; rather, it serves to flag an issue that this Court has an obligation to consider *sua sponte*. Thus, to the extent that any member of this Court is concerned about the *King* petitioners' standing, having Oklahoma before the Court will help ensure that the merits of the important question presented can be reached.

2. This case began in early 2011 as a challenge to the ACA's individual mandate. Once this Court granted petitions for certiorari in suits raising similar challenges, the district court stayed Oklahoma's case pending the resolution of those cases.

After this Court upheld the individual mandate, Oklahoma filed a motion to lift the stay so that it could amend its complaint. On September 19, 2012, Oklahoma filed an amended complaint adding claims challenging the validity of the IRS regulations.

On December 3, 2012, the government filed a motion to dismiss the amended complaint on various jurisdictional grounds, including standing. *Oklahoma v. Burwell*, No. 6:11-cv-00030 (E.D. Okla. Aug. 12, 2013), ECF No. 71. Oklahoma argued that the IRS regulations injure it both in its capacity as a large

employer subject to the ACA's employer mandate and also in its capacity as a sovereign State vested with the statutory right under the ACA to decide whether to establish a health insurance exchange and subject itself to the various burdens and benefits associated with that decision. On August 12, 2013, the district court denied the government's motion as to the claims related to the IRS regulations, and the parties thereafter filed cross-motions for summary judgment.

On July 28, 2014, after briefing on the motions was complete, Oklahoma filed a motion for leave to supplement the summary judgment record to include evidence that had come to light relating to statements made by the "architect of the ACA," Jonathan Gruber, in early 2012. Motion for Leave to Supplement the Summary Judgment Record, *Oklahoma v. Burwell*, No. 6:11-cv-00030 (E.D. Okla. July 28, 2014), ECF No. 112. Gruber admitted that the ACA was designed to withhold tax credits in States that declined to establish exchanges as a means of pressuring the States into establishing state exchanges. Oklahoma argued that – because the government had relied on Gruber's work as evidence in support of its motion for summary judgment – supplementation of the record to dispute that evidence was appropriate. The district court granted Oklahoma's motion and allowed those statements into evidence as part of the summary judgment record.

On September 30, 2014, the district court granted summary judgment in Oklahoma's favor. App. 25. The district court found that costs arising from compliance

with the large employer mandate gave Oklahoma standing in its capacity as a large employer. App. 7-10. The court also found that Oklahoma suffered from no prudential bar to standing because Oklahoma did not seek to litigate the tax liability of a third party. App. 10-11. Additionally, the district court rejected the notion that the Anti-Injunction Act required Oklahoma to litigate its claim in a tax refund action. App. 11-12.

Turning to the merits, the district court relied heavily on the circuit court decisions in both *King* and *Halbig v. Burwell*, 758 F.3d 390 (D.C. Cir. 2014), *vacated*, 2014 WL 4627181 (D.C. Cir. 2014), finding the latter opinion more persuasive. Because the statutory text was unambiguous, the district court resolved the case under the first step of the familiar *Chevron* test. App. 12-17. The district court also emphasized that the plain text of 26 U.S.C. § 36B expressly qualifies the type of exchange covered as one "established by the State." App. 16. In considering the contrary Fourth Circuit result in *King*, the district court noted that even that opinion stated that the government's position was "only slightly" stronger and that the challenge to the IRS regulations had "common-sense appeal." App. 16-17. The plain meaning of the text thus indicated that Congress sought to limit subsidies to exchanges established by States and thereby "'directly spoke[ ] to the precise question at issue.'" App. 17-20 (alteration added). Therefore, the district court determined that the IRS regulations could not stand as a matter of law. App. 25.

The federal government appealed the district court's order, and Oklahoma now requests that a writ of certiorari issue to review the case, thereby complementing the Court's consideration of *King*.

REASONS FOR GRANTING THE WRIT

I. Hearing this case together with *King* will benefit the Court in its examination of the question presented by bringing before it all types of parties affected by the IRS regulations.

Resolution of the question presented affects the interest of four broad categories of parties. First, the interpretation of Section 36B affects individuals who meet the income criteria for a credit and subsidy by affecting their eligibility for a credit and subsidy, which in turn affects whether the individual is subject to individual mandate penalties. In particular, whether an exemption applies to individual mandate penalties based on affordability looks to a formula that calculates any credits or subsidies available. *See* 26 U.S.C. § 5000A(e)(B)(ii) (reducing "required contribution" based on availability of insurance subsidy).

Second, Section 36B's interpretation affects the federal government. Because it is tax credits against *federal* income tax that the section affects, the question presented clearly affects the federal government. The government also presumably has some interest in policy involving how invasively to regulate large

companies and how available to make its government-subsidized healthcare.

Third, the statute's construction has an impact on the States. It is the States that Congress commanded to create exchanges in the first place. 42 U.S.C. § 18031. It is also the States that Congress acknowledged have flexibility in whether to establish exchanges. 42 U.S.C. § 18041. Whether the consequences of those decisions include the availability of subsidies – and onerous large employer costs – means a great deal to the States. Oklahoma is the only litigant at hand that is a State who had to make the critical decision whether to establish an exchange pursuant to the statutory rights granted by Congress.

Fourth, interpretation of the tax credit provision affects large employers. Their insurance coverage obligations, penalty risks, and compliance costs depend on the availability of tax credits and subsidies. 26 U.S.C. § 4980H(b)(1)(B). Oklahoma is the only litigant at hand that is a large employer subject to these obligations.

King v. Burwell presents the Court with only two of the four perspectives described above. The individual Petitioners share the interests of other individuals who may be subject to individual mandate penalties because of lowered required contributions. Burwell can be assumed to have the objectives of the federal government in mind. But it is only by granting certiorari in Oklahoma's case and considering it together with *King* that the Court can ensure it also

hears from both a sovereign State that made the decision whether to establish an exchange *and* from a large employer who will face significant compliance costs and may face crushing penalties as a result of the challenged regulations.

The opportunity before the Court is particularly important when one of the parties not represented in *King* is the States. As explained above, the ACA places significant weight on the decision made by the States: whether tax credits and subsidies are available to its citizens, whether large employers in the States are subject to penalties for failure to comply with the employer mandate requirements, whether many individuals are subject to the individual mandate's penalty, and so on and so forth. Only Oklahoma – and not the individual petitioners in *King* – had to make the decision about whether to create an exchange. Given the unique role – the "enormous power" – that Congress vested in the States when it drafted the ACA, resolution of the question presented in *King* should not occur in the absence of a sovereign State, particularly a sovereign State that also happens to be a large employer made subject to the large employer mandate by the challenged regulations. Because of all this, Oklahoma is uniquely situated to offer the Court the perspective of two of the four categories of parties who will be directly affected by the outcome of *King*.

II. Adding Oklahoma as a party will provide additional bases for petitioners' standing to challenge the IRS regulations.

In its brief in opposition to the petition for certiorari in *King*, the government represented that, while it had vigorously contested the *King* petitioners' standing in the courts below, it would not do so before this Court. Brief for the Respondents in Opposition at 34 n.10, *King v. Burwell*, No. 14-114 (Oct. 3, 2014), 2014 WL 49785998. Oklahoma agrees that the *King* petitioners have standing. But – regardless of whether the government raises the issue – this Court has an obligation to confirm that Article III standing exists. To the extent any member of this Court might side with the government in its view of the *King* petitioners' standing, having Oklahoma as a petitioner would offer the Court a separate and independent route upon which to reach the merits.

Oklahoma, in fact, asserts two completely different bases for standing to challenge the IRS regulations than the individual petitioners in *King*: the State has a stake in this controversy both as a sovereign State making the decision whether to establish its own Exchange and as a large employer subject to ongoing compliance costs and penalty risks.

First, Oklahoma has standing as a large employer. The IRS regulations impose significant penalties on qualifying large employers if just one statutorily-defined full-time employee receives a federal subsidy toward purchasing health insurance. *See* 26 U.S.C.

§ 4980H(a), (c)(1). Because of the exceedingly low requirements for who qualifies as a "full-time employee," *id*. § 4980H(c)(4), Oklahoma could potentially find itself penalized if it does not offer coverage to employees currently not covered because of their part-time status outside of the ACA framework. Further, even if a large employer never actually must pay a penalty, that employer must expend substantial costs ensuring it complies with the Act. These costs and the real potentiality of penalties if Oklahoma does not expend additional fiscal resources providing insurance to more employees easily satisfy the constitutional requirements for a concrete injury both redressable by a Court and traceable to challenged conduct.

Second, Oklahoma has standing because its statutory power to choose whether to establish an Exchange and accept or reject the benefits associated with that decision has been critically undermined by the IRS regulations. Oklahoma is a State empowered with the decision whether to create a health insurance exchange. *See* 42 U.S.C. §§ 18031, 18041. The plain text of the statute contemplates that subsidies will only be available for state-established exchanges. 26 U.S.C. § 36B. And, of course, the scale of individual mandate penalties as well as the existence, at all, of the large employer mandate critically depend on the State's decision in this respect. The IRS regulations thus rob Oklahoma of a decision left to the State by Congress. Such a concrete affront to Oklahoma's

statutory rights is both redressable by the Court and traceable to the challenged conduct.

Oklahoma's role as a sovereign State has an important impact on standing. As this Court has recognized before, Oklahoma – unlike individuals – receives "special solicitude" when seeking to vindicate sovereign and quasi-sovereign interests. *Massachusetts v. EPA*, 549 U.S. 497, 520 (2007). Oklahoma's quest to vindicate statutory rights granted explicitly to the States to allow a decision with enormous policy consequences certainly deserves that kind of solicitude.

The Petitioners in *King v. Burwell* have standing that rests on an entirely different foundation. In light of Oklahoma's differing bases for standing, granting certiorari in Oklahoma's case would ensure that the Court can resolve the question presented without any standing problems arising down the road.

CONCLUSION

For these reasons, the petition for a writ of certiorari prior to judgment should be granted, this case should be placed on the briefing schedule already in place in *King v. Burwell* and heard together with *King* with no diminution in either petitioners'

argument time, and the judgment of the district court below should be affirmed.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF OKLAHOMA

STATE OF OKLAHOMA, ex rel. Scott Pruitt, in his official capacity as Attorney General of Oklahoma,	
Plaintiff,	
v.	
SYLVIA MATHEWS BURWELL[1], in her official capacity as Secretary of the United States Department of Health and Human Services; and JACOB J. LEW, in his official capacity as Secretary of the United States Department of the Treasury,	**Case No. CIV-11-30-RAW**
Defendants.	

ORDER

I. Introduction

Before the court are the cross-motions of the parties for summary judgment. This lawsuit is a challenge to a federal regulation. The Patient Protection and Affordable Care Act ("ACA" or "the Act")

[1] Pursuant to Rule 25(d) F.R.Cv.P., Sylvia Mathews Burwell is substituted in her official capacity for Kathleen Sebelius.

regulates the individual health insurance market primarily through "Exchanges" set up along state lines. An Exchange is a means of organizing the insurance marketplace to help individuals shop for coverage and compare available plans based on price, benefits, and services.

Specifically, Section 1311(b)(1) of the ACA requires that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange . . . for the State." *See* 42 U.S.C. §18031(b)(1). This directive, however, runs afoul of the principle that Congress cannot compel sovereign states to implement federal regulatory programs. *See Printz v. United States,* 521 U.S. 898, 925 (1997). The Act also provides, therefore, that states may choose not to establish such Exchanges. Oklahoma has so chosen. Under section 1321 of the Act, each state may "elect[ ] . . . to apply the requirements" for the state exchanges, or if "a State is not an electing State . . . or the [Health and Human Services] Secretary determines" that the State will fail to set up an Exchange before the statutory deadline, "the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate *such Exchange* within the State." *See* 42 U.S.C. §18041(b)-(c). (emphasis added).

Additionally, Congress authorized federal subsidies (in the form of tax credits) paid directly by the Federal Treasury to the taxpayer's insurer as an offset against his or her premiums. *See* 26 U.S.C. §36B; 42 U.S.C. §18082(c). The Act provides that a tax credit "shall be allowed" in a particular "amount,"

26 U.S.C. §36B(a), based on the number of "coverage months of the taxpayer occurring during the taxable year." 26 U.S.C. §36B(b)(1). A "coverage month" is a month during which "the taxpayer . . . is covered by a qualified heath plan . . . enrolled in through an Exchange *established by the State under section 1311* of the [ACA]." 26 U.S.C. §36B(c)(2)(A)(i) (emphasis added). The subsidy for any particular "coverage month" is based on premiums for coverage that was "enrolled in through an Exchange *established by the State under [section] 1311* of the ACA." 26 U.S.C. §36B(b)(2)(A) (emphasis added).

Further, the Act contains an "employer mandate." This provision may require an "assessable payment" by an "applicable large employer" if that employer fails to provide affordable health care coverage to its full-time employees and their dependents. *See* 26 U.S.C. §4980H(a)-(b). The availability of the subsidy also effectively triggers the assessable payments under the employer mandate, inasmuch as the payment is only triggered if at least one employee enrolls in a plan, offered through an Exchange, for which "an applicable premium tax credit . . . is allowed or paid." *Id.* Oklahoma contends it has standing in this case (among other reasons) because it constitutes an "applicable large employer" and the receipt of tax credits by any of its employees would trigger its liability for a penalty under that provision for failure to provide adequate coverage to those employees.

This contention arises because the Internal Revenue Service ("IRS") has promulgated a regulation (the

"IRS Rule") that extends premium assistance tax credits to anyone "enrolled in one or more qualified health plans through an Exchange." 26 C.F.R. §1.36B-2(a)(1). It then adopts by cross-reference an HHS definition of "Exchange" to include any Exchange, "regardless of whether the exchange is established or operated by a State . . . or by HHS." 26 C.F.R. §1.36B-1(k); 45 C.F.R. §155.20. In other words, the IRS Rule requires the Treasury to grant subsidies for coverage purchases through *all* Exchanges – not only those established by states under §1311 of the Act, but also those established by HHS under §1321 of the Act. The IRS Rule is under challenge in this case, with plaintiff arguing that the regulation is contrary to the statutory language.

II. Justiciability

As a threshold matter, the court must address defendants' assertion that plaintiff's challenge to the regulation is not justiciable.[2] It is the plaintiff's burden to establish the court's subject matter jurisdiction by a preponderance of the evidence. *Showalter v. Weinstein,* 233 Fed.Appx. 803, **4 (10th Cir. 2007). One branch of defendants' argument is that plaintiff lacks standing to sue.[3] "Article III standing is a

[2] Subject-matter jurisdiction is a condition precedent to reaching the merits of a legal dispute. *Haywood v. Drown,* 556 U.S. 729, 755 (2009).

[3] The court denied defendants' motion to dismiss on standing grounds, and defendants have renewed their assertion in the

(Continued on following page)

prerequisite to every lawsuit in federal court." *Bishop v. Smith,* 760 F.3d 1070, 1088 (10th Cir. 2014). "To establish Article III standing, a plaintiff must show: (1) that it has suffered a concrete and particular injury in fact that is either actual or imminent; (2) the injury is fairly traceable to the alleged actions of the defendant; and (3) the injury will likely be redressed by a favorable decision." *Kerr v. Hickenlooper,* 744 F.3d 1156, 1163 (10th Cir.2014).[4] Defendants move for judgment on the grounds that (1) Oklahoma does not suffer an injury in fact from the regulation and (2) even if Oklahoma suffered an injury in fact, that injury would not be redressable here.

The Act's "assessable payments" under the employer mandate are only triggered if at least one full-time employee obtains a subsidy by purchasing insurance on an Exchange. 26 U.S.C. §4980H(a)(2).

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present motion. "Each element of standing must be supported with the manner and degree of evidence required at the pertinent, successive stages of the litigation." *Tandy v. City of Wichita,* 380 F.3d 1277, 1284 (10th Cir.2004). At the summary judgment stage, the plaintiff cannot rest solely on the complaint's allegations, but must show injury in fact through affidavits or other evidence that tends to establish specific facts. *See Carolina Cas. Ins. Co. v. Pinnacol Assurance,* 425 F.3d 921, 927 (10th Cir.2005). In this regard, plaintiff places principal reliance upon an affidavit by Preston L. Doerflinger, both Secretary of Finance and Revenue of the State of Oklahoma and Director of the Oklahoma Office of Management and Enterprise Services. (#87-12).

[4] *See also Susan B. Anthony List v. Driehaus,* 134 S.Ct. 2334, 2341 (2014).

Oklahoma has not established its own Exchange, and therefore state employees would not be eligible for subsidies if not for the IRS Rule. Accordingly, the State of Oklahoma would, if not for the IRS Rule, face no risk of incurring penalties under the employer mandate.

As a result of the IRS Rule, however, the State of Oklahoma's employees now *are* eligible for the subsidies. Plaintiff contends that, as an employer,[5] it could face penalties if just one employee receives a federal subsidy. *See* 26 U.S.C. §4980H(a), (c)(1). Plaintiff also contends that the Act imposes compliance costs. "At the summary judgment stage, the injury-in-fact element requires that the plaintiff set forth by affidavit or other evidence specific facts which for purposes of the summary judgment will be taken to be true." *Clajon Prod. Corp. v. Petera,* 70 F.3d 1566, 1572 (10th Cir.1995).[6]

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[5] The court previously ruled that Oklahoma did not have "State *qua* State" standing. (#71). Plaintiff continues to press its theory that the IRS Rule harms the State of Oklahoma "by depriving it of a statutory right granted it by Congress, specifically the right to determine whether certain burdens tied to the State's decision to establish an Exchange will be imposed on the State and its Large Employers." (#87 at 16). This court does not see sufficient support in the case law for such a theory, but a higher court may differ.

[6] Such jurisdictional facts are not "taken to be true" at the final judgment stage. "'[W]hen a case has proceeded to final judgment after a trial . . . those facts (if controverted) must be adequately supported by the evidence adduced at trial to avoid dismissal on standing grounds.'" *Utah Ass'n of Counties v. Bush,*

(Continued on following page)

First, Oklahoma asserts that, as a result of the challenged regulations making credits and subsidies available in Oklahoma, the State will be forced to provide insurance to employees to whom it does not currently provide insurance, or be subject to enormous penalties. Defendants contend, and Oklahoma concedes, that Oklahoma already offers coverage to its state employees (and their dependents) pursuant to state law that meets the ACA's standards for "minimum value" and "affordability," thus facing no Section 4980H liability for those employees. Oklahoma contends, however, that state law (and federal law prior to the ACA) does not require that the State offer that insurance to every "full-time employee," as that term is defined in the ACA. Thus, according to Oklahoma's argument, it still faces a penalty for its failure to offer coverage to some employees whom it treats as part-time, but who (it contends) would be treated as full-time under Section 4980H. *See* 26 U.S.C. §4980H(c)(4) (employee is full-time if he or she is employed on average at least 30 hours per week).

Oklahoma describes two categories of employees with respect to whom (it contends) it faces potential

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455 F.3d 1094, 1100 (10th Cir.2006) (quoting *United States v. Hays,* 515 U.S. 737, 743 (1995)). Although the court in its discretion could hold an evidentiary hearing on the issue of standing, the court finds it unnecessary as matters of witness credibility are not at issue. The court finds the case may be resolved at the summary judgment stage without a trial. Therefore, this court reviews plaintiff's adduced evidence for sufficiency under the preponderance of the evidence standard.

liability for the Section 4980H large employer penalty. First, it asserts it may be penalized for a failure to offer coverage to variable-hour Tourism, Parks and Recreation Department (TPR) employees who work fewer than 1600 hours over a twelve-month period. Second, Oklahoma alleges that it may face a penalty for a failure to offer coverage to "999 employees," that is, employees for whom it does not know, at the time that they are hired, whether they will work for more than 1,000 hours over the first year of their service.

Defendants respond that Oklahoma is mistaken, principally because the regulations permit an employer to use a "look back" method of up to twelve months after the date of hire for newly-hired, variable hour employees, to determine whether those employees have averaged more than 30 hours a week over that period; only after that period (as well as an additional, optional 90-day administrative period) expires could those employees be treated as full-time for purposes of Section 4980H. Defendants cite 26 C.F.R. §54.4980H-3(d)(1) & (d)(3) for this point. Oklahoma responds (in indisputable fashion): "Complexities permeate the final Section 4980H regulations describing the look-back method." (#94 at 12). Oklahoma then provides a lengthy defense of its calculations.

The court would, of course, step into this quagmire if it were necessary to resolve the standing question. The intricacies are such that it would likely require an evidentiary hearing during which the court could ask questions of the witnesses and

counsel. In the court's view, such an inquiry is not necessary in this case, because standing has been established on another basis. For one thing, the look-back method is not self-executing. That is, compliance with the Act in general requires employee training and diversion of resources from other areas for implementation. *See* #87 at 14, ¶31; #87-12 at ¶¶34, 56-59.[7]

The Fourth Circuit held that Liberty University had standing to contest the employer mandate because "[e]ven if the coverage Liberty currently provides ultimately proves sufficient, it may well incur additional costs because of the administrative burden of assuring compliance with the employer mandate[.]" *Liberty Univ., Inc. v. Lew,* 733 F.3d 72, 89-90 (4th Cir.2013).[8] Compliance costs constitute an injury for purposes of standing. *See Virginia v. Am. Booksellers Ass'n. Inc.,* 484 U.S. 383, 392 (1988) (recognizing standing by business forced by threat of liability "to take significant and costly compliance measures."); *Ass'n of Private Sector Colleges v. Duncan,* 681 F.3d

[7] Specifically regarding plaintiff's ¶31, defendants state: "This paragraph is disputed for the same reason that paragraph 30 is disputed." (#91-1 at 14). The basis on which paragraph 30 is disputed, however, is that Oklahoma is incorrect about facing liability under §4980H, not the assertions regarding compliance costs.

[8] "Liberty need not show that it will be subject to an assessable payment to establish standing if it otherwise [proves] facts that establish standing." *Id.* at 89.

427, 458 (D.C. Cir.2012) (finding standing based on compliance costs).[9]

In addition to challenging plaintiff's Article III standing, defendants contend plaintiff has not demonstrated prudential standing either.[10] Defendants argue that plaintiff cannot challenge the IRS Rule's expansion of subsidies because of "the well-established position that, ordinarily, one may not litigate the tax liability of another." *Women's Equity Action League v. Cavazos,* 879 F.2d 880, 885 n.3 (D.C.Cir.1989) (citing *Allen v. Wright,* 468 U.S. 737, 748-49 (1984)). Because invalidating the Rule would

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[9] The defendants argue that one particular compliance cost cited by the plaintiff – namely, reporting under 26 U.S.C. §6056 – would apply to the State of Oklahoma even if it prevails in this action. This appears to be correct, and the court does not rely this provision to find standing.

[10] Generally, to meet prudential standing requirements, a plaintiff must (1) assert its own rights, not a third party's; (2) not bring a "generalized grievance" shared by a large class of citizens, and (3) protect an interest arguably within the zone of interests to be protected by the statute or constitutional guarantee. *See Sac & Fox Nation of Mo. v. Pierce,* 213 F.3d 566, 573 (10th Cir.2000). The court is satisfied these requirements are met in this case.

To the extent plaintiff proceeds under the Administrative Procedure Act ("APA"), plaintiff must also satisfy those standing requirements, specifically (1) there has been some "final agency action" and (2) plaintiff's claims "fall within the zone of interests protected by the statute forming the basis of its claims" *Catron County Board of Commissioners, New Mexico v. United States Fish & Wildlife Service,* 75 F.3d 1429, 1434 (10th Cir.1996). The court finds Oklahoma has standing under the APA.

deprive third parties of tax credits, the government argues, the plaintiff cannot bring this suit.

The issue before this court is whether plaintiff has Article III standing and has invoked an appropriate cause of action. As stated by a district court facing similar litigation: "Plaintiffs' claim is not a tax liability suit." *King v. Sebelius,* 997 F.Supp.2d 415, 424 (E.D.Va.), *aff'd, King v. Burwell,* 759 F.3d 358 (4th Cir.2014). "[H]ere Plaintiffs are challenging the IRS Rule and not the IRS's ability to collect taxes." *Id.* (footnote omitted).[11] Plaintiff prevailing in such a lawsuit might have an *incidental* effect on the granting of tax credits, but such a circumstance does not deprive the plaintiff of standing in the plaintiff's own right. Such incidental effects are the product of a reticulated statutory framework such as the ACA.[12]

Finally, defendants contend plaintiff must seek relief in a tax refund suit. Recently, two circuit courts rejected this position. *See Halbig v. Burwell,* 758 F.3d 390, 398 (D.C. Cir. 2014) ("We must therefore conclude that a tax refund suit is inadequate as an

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[11] In a supporting passage, *id.,* the district court in *King* cited *Hobby Lobby Stores, Inc. v. Sebelius,* in which the Tenth Circuit made a similar distinction. *See* 723 F.3d 1114, 1127 (10th Cir.2013).

[12] Defendants also contend that Oklahoma lacks an injury that could be redressed in this action because this court could not extinguish any absent employees' claim to a Section 36B tax credit. This court has found standing based on administrative burden and compliance costs. Such injury is redressable.

alternative remedy[.]"); *King v. Burwell,* 759 F.3d 358, 366 (4th Cir. 2014) ("The defendants' arguments are not persuasive."). This court agrees and does not find lack of standing on this basis.

III. The Merits

Finding this claim to be justiciable, the court turns to the merits. As just noted, the court has the benefit of two recent opinions by courts of appeals, which reach opposite conclusions. In *Halbig v. Burwell,* 758 F.3d 390 (D.C.Cir.2014), the majority struck down the IRS Rule. In *King v. Burwell,* 759 F.3d 358 (4th Cir.2014), the IRS Rule was upheld.[13] For the reasons described below, this court finds the *Halbig* decision more persuasive.[14] This court also independently relies on Tenth Circuit and Supreme Court authority.

"When faced with a challenge to the validity of a regulation, we apply the analytical framework provided by the United States Supreme Court in [*Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837 (1984)]." *Sundance*

[13] Both opinions were issued on the same day. Neither addresses the other.

[14] The panel decision in *Halbig* has been vacated pending *en banc* rehearing. *See* 2014 WL 4627181. Such status does not preclude this court from considering the decision's rationale, logic and analysis. *See, e.g., Iwata v. Intel Corp.,* 349 F.Supp.2d 135, 148 (D.Mass.2004); *Bruneau v. South Kortright Cent. School,* 962 F.Supp. 301, 305 n.3 (N.D.N.Y.1997).

Assocs., Inc., v. Reno, 139 F.3d 804, 807 (10th Cir.1998).

Chevron entails two steps. If the court determines "at the first stage of the inquiry that 'Congress has directly spoken to the precise question at issue,' the court 'must give effect to the unambiguously expressed intent of Congress.'" *See Ron Peterson Firearms, LLC v. Jones,* 760 F.3d 1147, 1155 (10th Cir.2014) (citation omitted).[15] If, however, "'the statute is silent or ambiguous with respect to the specific issue,'" the court "'will uphold the agency's interpretation if it is based on a permissible construction of the statute.'" *Id.*[16] "The first question, whether there

[15] Courts may use statutory language and legislative history at the first step of the *Chevron* analysis. *Id.* at 1157 n.10. When, however, the meaning of the statute is clear, it is both unnecessary and improper to resort to legislative history to divine congressional intent. *Id.* Neither the *Halbig* majority nor the *King* court found the legislative history terribly helpful, in any event. *See Halbig,* 758 F.3d at 407 ("Here, the scant legislative history sheds little light on the precise question of the availability of subsidies on federal Exchanges."); *King,* 759 F.3d at 372 ("We are thus of the opinion that nothing in the legislative history of the Act provides compelling support for either side's position.").

[16] Moreover, legislative history may not be used to *create* ambiguity in the statutory language. *See St. Charles Inv. Co. v. C.I.R.,* 232 F.3d 773, 776 (10th Cir.2000). "Our role in construing statutes was summarized by Justice Holmes: 'We do not inquire what the legislature meant; we ask only what the statute means.'" *Id.* (citations omitted).

Judge Easterbrook has expressed the outer limits of this skepticism: "Legislative intent is a fiction, a back-formation from other and often undisclosed sources. Every legislat*or* has

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is such an ambiguity, is for the court, and we 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).

In *Sundance Associates,* the Tenth Circuit reviewed regulations seeking to implement a federal statute requiring producers of sexually explicit matter to maintain certain records. The statute defined those persons who would qualify as producers. The regulation defined "producer" to apply to both primary and secondary producers. The Tenth Circuit found that the regulation clashed impermissibly with the statutory definition, which expressly excluded "mere distribution" and other activities such as might be engaged in by what the regulation called a "secondary producer."[17] The Tenth Circuit found the regulation invalid at stage one of *Chevron. See* 139 F.3d at 808. The court went on to note that, assuming *arguendo* that the statutory language was unclear, the

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an intent, which usually cannot be discovered, since most say nothing before voting on most bills; and the legislat*ure* is a collective body that does not have a mind; it 'intends' only that the text be adopted, and statutory texts usually are compromises that match no one's first preference." Frank H. Easterbrook, foreword to *Reading Law: The Interpretation of Legal Texts,* by Antonin Scalia & Bryan A. Garner, xxii (1st ed.2012) (emphasis in original).

[17] In the case at bar, a statutory definition also exists. In section 1304(d) of the Act, "State" is defined to mean "each of the 50 States and the District of Columbia." 42 U.S.C. §18024(d).

regulation was an impermissible construction of the statute. *Id.* at 810.

The court found that the government's interpretation (that the evident exception in the statute was actually intended to broaden the statute's scope) "leads us down a path toward Alice's Wonderland, where up is down and down is up, and words mean anything." *Id.* at 808.[18] In words pertinent to the present case, the Tenth Circuit stated "neither the court nor the Attorney General has the authority to rewrite a poor piece of legislation (if, indeed, that is what it is). That responsibility lies solely with Congress." *Id.* at 810

Similarly, the majority in *Halbig* resolved the issue at the first stage of *Chevron,* finding that inasmuch as "the ACA unambiguously restricts the section 36B subsidy to insurance purchased on Exchanges 'established by the State,' we reverse the district court and vacate the IRS's regulation." *Halbig,* 758 F.3d at 394. *See also id.* at 412 ("Accordingly, applying the statute's plain meaning, we find that section 36B unambiguously forecloses the interpretation embodied in the IRS Rule and instead limits the availability of premium tax credits to state-established Exchanges.").

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[18] Cf. *King,* 759 F.3d at 377 (Davis, J., concurring) (" '[E]stablished by the State' indeed means established by the state – except when it does not[.]").

The majority in *Halbig* acknowledged that sections 1311 and 1321 do establish "some degree of equivalence between state and federal exchanges[.]" *Id.* at 402. This equivalence is such, the court went on, that "if section 36B had authorized credits for insurance purchased on an 'Exchange established under 1311,' the IRS Rule would stand." *Id.* That is not, however, the language chosen by Congress. Instead, credits are authorized only for coverage purchased on an "Exchange established by the State under section 1311." Faced with that statutory language, "the government offers no textual basis – in sections 1311 and 1321 or elsewhere – for concluding that a federally-established Exchange is, in fact or legal fiction, established by a state." *Id.*

In contrast, the court in *King* adopted the "legal fiction" interpretation. It resolved the case at step two of *Chevron,* finding the statutory language ambiguous, giving deference to the IRS's determination, and upholding the IRS Rule as a permissible exercise of the agency's discretion. *King,* 759 F.3d at 363.

The court in *King* acknowledged that "[t]here can be no question that there is a certain sense to the plaintiffs' position." *Id.* at 368. Ultimately, however, "the court is of the opinion that the defendants have the stronger position, although only slightly." *Id.* at 369. On one hand, "the court cannot ignore the common-sense appeal of the plaintiffs' argument; a literal reading of the statute undoubtedly accords more closely with their position." *Id.* On the other hand, "it makes sense to read §1321(c)'s directive that HHS

establish "such Exchange" to mean that the federal government acts on behalf of the state when it establishes its own Exchange." *Id.* Thus, the court concluded the statute was ambiguous and moved to stage two of the *Chevron* analysis. The court then upheld the regulation, being "primarily persuaded by the IRS Rule's advancement of the broad policy goals of the Act." *Id.* at 373.

This court concludes that what even the *King* court called the "common-sense appeal" of the plaintiff's position should prevail. Dissenting in *Halbig,* Judge Edwards describes his reading of the Act, wherein "'established by the State' is [a] term of art that includes any Exchange within a State." *Halbig,* 758 F.3d at 417 (Edwards, J., dissenting). If this view is correct, it is an unusual term of art, in that one word is statutorily defined in a way that precludes the alternative reading. Under 42 U.S.C. §18024(d), "State" cannot mean the federal government. This definition is dispositive when combined with the interpretive hurdle presented by the phrase "established by."

In other words, the "legal fiction" reading does not appear to comport with normal English usage, as Professor Richard Epstein describes:

> These long and learned opinions should not obscure the fact that at the root of the case is a simple question: Do the words an "exchange established by a State" cover an exchange that is established by the federal government "on behalf of a state"? To the

> unpracticed eye, the two propositions are not synonyms, but opposites. When I do something on behalf of myself, it is quite a different thing from someone else doing it on my behalf. The first case involves self-control. The second involves a change of actors. It is not, moreover, that the federal government establishes the exchange on behalf of a state that has *authorized* the action, under which case normal principles of agency law would apply. Quite the opposite: the federal government decides to act because the state has refused to put the program into place. It is hard to see, as a textual matter, why the two situations should be regarded as identical when the political forces at work in them are so different.
>
> http://ricochet.com/understanding-obamacare-subsidy-rulings/ (July 22, 2014) (emphasis in original)

Professor Nicholas Bagley takes the opposing view, asserting that "the best way to understand the phrase [i.e., 'established by the State'] is that it was a shorthand for exchange, whoever happened to establish it." http://theincidentaleconomist.com/wordpress/what-did-congress-mean-by-established-by-the-state/ (July 25, 2014). He points to various perceived anomalies which would result from the "literal" reading. Neither court of appeals adopted the "anomalies" argument. The court in *King* said it was "unpersuaded" on this point. 759 F.3d 358, 371 (4th Cir.2014).

The majority in *Halbig* (viewing the argument under the absurdity doctrine)[19] found that the purported anomalies did not cross the "'high threshold' of unreasonableness before we conclude that a statute does not mean what it says." 758 F.3d at 402. Thus, "[n]othing about the imperative to read section 36B in harmony with the rest of the ACA requires interpreting 'established by the State' to mean anything other than what it plainly says." *Id.* at 406. In any event, the Supreme Court "does not revise legislation . . . just because the text as written creates an apparent anomaly as to some subject it does not address." *Michigan v. Bay Mills Indian Cmty.,* 134 S. Ct. 2024, 2033 (2014).

At the first step of the *Chevron* analysis, the court asks "whether Congress has directly spoken to the precise question at issue." *In re FCC 11-161,* 753 F.3d 1015, 1040 (10th Cir.2014) (citation omitted). On this particular "precise question," however, case law does not provide "wiggle room" for finding ambiguity. This is because tax credits must be expressed in "clear and unambiguous language." *Yazoo & Miss.*

[19] "The absurdity doctrine is an exception to the rule that the plain and ordinary meaning of a statute controls. . . . [W]here a plain language interpretation of a statute would lead to an absurd outcome which Congress clearly could not have intended, the court employs the absurdity exception to avoid the absurd result." *In re McGough,* 737 F.3d 1268, 1276 (10th Cir.2013).

Valley R.R. Co. v. Thomas, 132 U.S. 174, 186 (1889).[20] *See also Shami v. C.I.R.,* 741 F.3d 560, 567 (5th Cir.2014) (Tax credits are a matter of *legislative* grace, are only allowed as clearly provided for by statute, and are narrowly construed).[21]

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[20] Both the court in *King* and the dissent in *Halbig* brushed this contention aside by citing *Mayo Foundation for Medical Education and Research v. United States,* 131 S.Ct. 704 (2011) and its statement that "[t]he principles underlying [the] decision in *Chevron* apply with full force in the tax context." *Id.* at 713. The quoted statement in *Mayo Foundation,* however, appears in a discussion of stage *two* of *Chevron.* Rather, in this court's view, the *Yazoo* requirement of "clear and unambiguous language" goes to stage one and the preliminary issue of ambiguity. "When the statute is unambiguous, there has been no delegation to the agency to interpret the statute and therefore the agency's interpretation deserves no consideration at all, much less deference." *Terrell v. United States,* 564 F.3d 442, 450 (6th Cir.2009). "Under *Chevron,* the statute's plain meaning controls, whatever the Board might have to say." *Scialabba v. Cuellar de Osorio,* 134 S.Ct. 2191, 2203 (2014). Again, the only "clear and unambiguous language" on this "precise question" is that only those covered "through an Exchange established by the State under section 1311 of the [ACA]" may receive "premium assistance amounts." There is no "clear and unambiguous language" that one who purchases on a federal Exchange is so entitled, as required by the *Yazoo* decision.

[21] "We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" *Util. Air Regulatory Group v. EPA,* 134 S.Ct. 2424, 2444 (citation omitted). Tax credits of the scope involved here would appear to fit within this category.

The court in *King* noted the importance of the tax credits, but reached the opposite conclusion, i.e., "given the importance of the tax credits to the overall statutory scheme, it is reasonable to assume that Congress created the ambiguity in this case

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IV. Conclusion

The court is aware that the stakes are higher in the case at bar than they might be in another case. The issue of consequences has been touched upon in the previous decisions discussed. Speaking of its decision to vacate the IRS Rule, the majority in *Halbig* stated "[w]e reach this conclusion, frankly, with reluctance." 758 F.3d at 412.

Other judges in similar litigation have cast the plaintiffs' argument in apocalyptic language. The first sentence of Judge Edwards' dissent in *Halbig* is as follows: "This case is about Appellants' not-so-veiled attempt to gut the Patient Protection and Affordable Care Act ('ACA')." 758 F.3d at 412-13. Concurring in *King,* Judge Davis states that "[a]ppellants' approach would effectively destroy the statute. . . ." 759 F.3d 358, 379 (Davis, J., concurring). Further, "[w]hat [appellants] may not do is rely on our help to deny to millions of Americans desperately-needed health insurance. . . . ." *Id.*

Of course, a proper legal decision is not a matter of the court "helping" one side or the other. A lawsuit challenging a federal regulation is a commonplace occurrence in this country, not an affront to judicial dignity. A higher-profile case results in greater scrutiny of the decision, which is understandable and appropriate. "[H]igh as those stakes are, the principle

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with at least some degree of intentionality." 759 F.3d at 373 n.4. This court disagrees, for the reasons stated.

of legislative supremacy that guides us is higher still . . . This limited role serves democratic interests by ensuring that policy is made by elected, politically accountable representatives, not by appointed life-tenured judges." *Halbig,* 758 F.3d at 412.

This is a case of statutory interpretation. "The text is what it is, no matter which side benefits." *Bormes v. United States,* 759 F.3d 793, 798 (7th Cir.2014). Such a case (even if affirmed on the inevitable appeal) does not "gut" or "destroy" anything. On the contrary, the court is *upholding* the Act as written. Congress is free to amend the ACA to provide for tax credits in both state and federal exchanges, if that is the legislative will.[22] As the Act presently stands, "vague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Assocs.,* 508 U.S. 248, 261 (1993) (emphasis in original). It is a "core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regulatory Group v. EPA,* 134 S.Ct. 2427, 2446 (2014). "But in the last analysis, these always-fascinating policy discussions are beside the point. The role of this Court is to apply the statute as it is written – even if we think some other approach might 'accor[d] with good policy.'"

[22] "If Congress enacted into law something different from what it intended, then it should amend the statute to conform to its intent." *Lamie v. U.S. Trustee,* 540 U.S. 526, 542 (2004).

Burrage v. United States, 134 S.Ct. 881, 892 (2014) (quoting *Commissioner v. Lundy,* 516 U.S. 235, 252 (1996) (other citation omitted)). *See also Michigan v. Bay Mills Indian Community,* 134 S.Ct. 2024, 2034 (2014) ("This Court has no roving license, in even ordinary cases of statutory interpretation, to disregard clear language simply on the view that . . . Congress 'must have intended' something broader."); *Util. Air Regulatory Group v. EPA,* 134 S.Ct. 2427, 2446 (2014) ("The power of executing the laws necessarily includes both authority and responsibility to resolve some questions left open by Congress that arise during the law's administration. But it does not include a power to revise clear statutory terms that turn out not to work in practice.").[23]

The animating principles of this court's decision have been articulated by the Tenth Circuit: "[C]ourts, out of respect for their limited role in tripartite government, should not try to rewrite legislative compromises to create a more coherent, more rational statute. A statute is not 'absurd' if it could reflect the

[23] In his dissent in *Halbig,* Judge Edwards states "§36B(b) interpreted as Appellants urge would function as a poison pill to the insurance markets in the States that did not elect to create their own Exchanges. This surely is not what Congress intended." 758 F.3d at 415-16 (Edwards, J., dissenting). This comes close to simply postulating a congressional intent that the statute "work," which effectively negates *Chevron* analysis. "The question . . . is not what Congress 'would have wanted' but what Congress enacted[.]" *Republic of Argentina v. Weltover, Inc.,* 504 U.S. 607, 618 (1992).

sort of compromise that attends legislative endeavor." *Robbins v. Chronister,* 435 F.3d 1238, 1243 (10th Cir.2006).[24] "An agency's rule-making power is not 'the power to make law,' it is only the 'power to adopt regulations to carry into effect the will of Congress as

[24] The court permitted plaintiff to supplement the record with statements made by Professor Jonathan Gruber, who was involved in the ACA's drafting. (#115). It is evidently undisputed that in January, 2012, Prof. Gruber made the statement "if you're a state and you don't set up an Exchange, that means your citizens don't get their tax credits." What is disputed is whether Prof. Gruber's statement was "off the cuff." The statement evidently has now been disavowed on his part. In any event, the court does not consider this statement as reflecting "legislative intent" (a concept in which the court has little faith anyway) because Prof. Gruber is not a member of Congress and his statement was made after the Act had passed. The court takes the statement for the limited relevance of words of *interpretation,* not intent. That is to say, the statement cuts against any argument that the plaintiff's interpretation is absurd on its face, or that plaintiff's argument that the statutory language might support a reading of "incentivizing" states to set up exchanges is "nonsense, made up out of whole cloth." *Halbig,* 758 F.3d at 414 (Edwards, J., dissenting).

Also in his *Halbig* dissent, Judge Edwards states "Appellants have not explained why Congress would want to encourage States to operate Exchanges rather than the federal government doing so, nor is there any indication that Congress had this goal." *Id.* at 426 (Edwards, J., dissenting). This court finds such an indication in Section 1311 of the Act itself, which purports to *direct* States to establish Exchanges. Professor James Blumstein argues that, after drafting this provision, the drafters recognized the "anti-commandeering principle" and added Section 1321 as what he calls an " 'oops' provision." http://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/03/19/professor-james-blumstein-on-halbig-v-sebelius/ (March 19, 2014). This likewise is not an absurd interpretation.

expressed by the statute.'" *Sundance Associates,* 139 F.3d at 808 (citation omitted) "In reviewing statutes, courts do not assume the language is imprecise . . . Rather, we assume that in drafting legislation, Congress says what it means." *Id* at 809.

The court holds that the IRS Rule is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law, pursuant to 5 U.S.C. §706(2)(A), in excess of statutory jurisdiction, authority, or limitations, or short of statutory right, pursuant to 5 U.S.C. §706(2)(C), or otherwise is an invalid implementation of the ACA, and is hereby vacated. The court's order of vacatur is stayed, however, pending resolution of any appeal from this order.

It is the order of the court that the motion of the defendants for summary judgment (#91) is hereby denied. The motion of the plaintiff for summary judgment (#87) is hereby granted.

ORDERED THIS 30th DAY OF SEPTEMBER, 2014.

/s/ Ronald A. White
HONORABLE RONALD A. WHITE
UNITED STATES DISTRICT JUDGE
EASTERN DISTRICT OF OKLAHOMA

Title 26, § 36B. Refundable credit for coverage under a qualified health plan

(a) In general

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

(b) Premium assistance credit amount

For purposes of this section –

(1) In general

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

(2) Premium assistance amount

The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of –

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

by the State under 1311[1] of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of –

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

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

(3) Other terms and rules relating to premium assistance amounts

For purposes of paragraph (2) –

(A) Applicable percentage

(i) In general

Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

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

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

(ii) Indexing

(I) In general

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

(II) Additional adjustment

Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under

subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) Failsafe

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

(B) Applicable second lowest cost silver plan

The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which –

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

(ii) provides –

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

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

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

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

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

(C) Adjusted monthly premium

The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if

each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) Additional benefits

If –

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

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

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

monthly premium or the adjusted monthly premium under paragraph (2).

(E) Special rule for pediatric dental coverage

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

(c) Definition and rules relating to applicable taxpayers, coverage months, and qualified health plan

For purposes of this section –

(1) Applicable taxpayer

(A) In general

The term "applicable taxpayer" means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not

[2] See References in Text note below.

exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

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

If –

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

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) Married couples must file joint return

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

(D) Denial of credit to dependents

No credit shall be allowed under this section to any individual with respect to

whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) Coverage month

For purposes of this subsection –

(A) In general

The term "coverage month" means, with respect to an applicable taxpayer, any month if –

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

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

(B) Exception for minimum essential coverage

(i) In general

The term "coverage month" shall not include any month with respect to an individual if for such month the individual

is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) Minimum essential coverage

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

(C) Special rule for employer-sponsored minimum essential coverage

For purposes of subparagraph (B) –

(i) Coverage must be affordable

Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage

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

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

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

(ii) Coverage must provide minimum value

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

(iii) Employee or family must not be covered under employer plan

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

(iv) Indexing

In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) Definitions and other rules

(A) Qualified health plan

The term "qualified health plan" has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care

Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) Grandfathered health plan

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

(d) Terms relating to income and families

For purposes of this section –

(1) Family size

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

(2) Household income

(A) Household income

The term "household income" means, with respect to any taxpayer, an amount equal to the sum of –

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

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

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

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

(B) Modified adjusted gross income

The term "modified adjusted gross income" means adjusted gross income increased by –

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

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

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

(3) Poverty line

(A) In general

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

(B) Poverty line used

In the case of any qualified health plan offered through an Exchange for coverage

during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) Rules for individuals not lawfully present

(1) In general

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

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

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

(i) A method under which –

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

(II) the taxpayer's household income is equal to the product of the

taxpayer's household income (determined without regard to this subsection) and a fraction –

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

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

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

(2) Lawfully present

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

(3) Secretarial authority

The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the

least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Reconciliation of credit and advance credit

(1) In general

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

(2) Excess advance payments

(A) In general

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

(B) Limitation on increase

(i) In general

In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in

accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

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

(ii) Indexing of amount

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

(I) such dollar amount, multiplied by

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

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

(3) Information requirement

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

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

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

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

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

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

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

(g) Regulations

The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for –

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

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

Title 26, § 4980H. Shared responsibility for employers regarding health coverage

(a) Large employers not offering health coverage

If –

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled 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 the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(b) Large employers offering coverage with employees who qualify for premium tax credits or cost-sharing reductions

(1) In general

If –

(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled 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 the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to 1/12 of $3,000.

(2) Overall limitation

The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(c) Definitions and special rules

For purposes of this section –

(1) Applicable payment amount

The term "applicable payment amount" means, with respect to any month, 1/12 of $2,000.

(2) Applicable large employer

(A) In general

The term "applicable large employer" means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

(B) Exemption for certain employers

(i) In general

An employer shall not be considered to employ more than 50 full-time employees if –

(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

(ii) Definition of seasonal workers

The term "seasonal worker" means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and

retail workers employed exclusively during holiday seasons.

(C) Rules for determining employer size

For purposes of this paragraph –

(i) Application of aggregation rule for employers

All persons treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) Application of employer size to assessable penalties

(i) In general

The number of individuals employed by an applicable large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating –

(I) the assessable payment under subsection (a), or

(II) the overall limitation under subsection (b)(2).

(ii) Aggregation

In the case of persons treated as 1 employer under subparagraph (C)(i), only 1 reduction under subclause (I) or (II)[1] shall be allowed with respect to such persons and such reduction shall be allocated among such persons ratably on the basis of the number of full-time employees employed by each such person.

(E) Full-time equivalents treated as full-time employees

Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time

[1] So in original. Probably means subclause (I) or (II) of clause (i).

employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

(3) Applicable premium tax credit and cost-sharing reduction

The term "applicable premium tax credit and cost-sharing reduction" means –

(A) any premium tax credit allowed under section 36B,

(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

(C) any advance payment of such credit or reduction under section 1412 of such Act.

(4) Full-time employee

(A) In general

The term "full-time employee" means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

(B) Hours of service

The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application

of this paragraph to employees who are not compensated on an hourly basis.

(5) Inflation adjustment

(A) In general

In the case of any calendar year after 2014, each of the dollar amounts in subsection (b) and paragraph (1) shall be increased by an amount equal to the product of –

(i) such dollar amount, and

(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

(B) Rounding

If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

(6) Other definitions

Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

(7) Tax nondeductible

For denial of deduction for the tax imposed by this section, see section 275(a)(6).

(d) Administration and procedure

(1) In general

Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Time for payment

The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

(3) Coordination with credits, etc.

The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.

Title 26, § 5000A. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment

(1) In general

If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return

Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty

If an individual with respect to whom a penalty is imposed by this section for any month –

(A) is a dependent (as defined in section 152) of another taxpayer for the other

taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty

(1) In general

The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of –

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts

For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount

An amount equal to the lesser of –

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income

An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount

For purposes of paragraph (1) –

(A) In general

Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in

The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount

In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to –

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

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

(4) Terms relating to income and families

For purposes of this section –

(A) Family size

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

(B) Household income

The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of –

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

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

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

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

(C) Modified adjusted gross income

The term "modified adjusted gross income" means adjusted gross income increased by –

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

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

(d) Applicable individual

For purposes of this section –

(1) In general

The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions

(A) Religious conscience exemption

Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is –

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry

(i) In general

Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry

The term "health care sharing ministry" means an organization –

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present

Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals

Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions

No penalty shall be imposed under subsection (a) with respect to –

(1) Individuals who cannot afford coverage

(A) In general

Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph,

the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution

For purposes of this paragraph, the term "required contribution" means –

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees

For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) Indexing

In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for "8 percent" the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold

Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

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[1] So in original. Probably should be followed by "the".

(3) Members of Indian tribes

Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps

(A) In general

Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules

For purposes of applying this paragraph –

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships

Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage

For purposes of this section –

(1) In general

The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs

Coverage under –

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code,

including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers);[2] or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan

Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market

Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan

Coverage under a grandfathered health plan.

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[2] So in original. The semicolon probably should be a comma.

(E) Other coverage

Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan

The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is –

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage

The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits –

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories

Any applicable individual shall be treated as having minimum essential coverage for any month –

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms

Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure

(1) In general

The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules

Notwithstanding any other provision of law –

(A) Waiver of criminal penalties

In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies

The Secretary shall not –

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

Title 26, § 18031. Affordable choices of health benefit plans

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

(1) Planning and establishment grants

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

(2) Amount specified

For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) Use of funds

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

(4) Renewability of grant

(A) In general

Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant –

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

(I) establishing an Exchange; and

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

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

(B) Limitation

No grant shall be awarded under this subsection after January 1, 2015.

(5) Technical assistance to facilitate participation in SHOP Exchanges

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

(b) American Health Benefit Exchanges

(1) In general

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

[1] See References in Text note below.

(A) facilitates the purchase of qualified health plans;

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

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

(2) Merger of individual and SHOP Exchanges

A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary

(1) In general

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum –

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

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

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r-8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

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

of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

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

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

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

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

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

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under

section 1139A of the Social Security Act [42 U.S.C. 1320b-9a].

(2) Rule of construction

Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) Rating system

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

(4) Enrollee satisfaction system

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

(5) Internet portals

The Secretary shall –

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

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

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

(6) Enrollment periods

The Secretary shall require an Exchange to provide for –

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

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

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

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

(d) Requirements

(1) In general

An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) Offering of coverage

(A) In general

An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) Limitation

(i) In general

An Exchange may not make available any health plan that is not a qualified health plan.

(ii) Offering of stand-alone dental benefits

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

(3) Rules relating to additional required benefits

(A) In general

Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

(B) States may require additional benefits

(i) In general

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

(ii) State must assume cost

A State shall make payments –

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

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

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

(4) Functions

An Exchange shall, at a minimum –

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

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

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

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

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

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.], or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application

of any premium tax credit under section 36B of title 26 and any cost-sharing reduction under section 18071 of this title;

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

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

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

(I) transfer to the Secretary of the Treasury –

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

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

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

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

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 18081(b)(4) of this title that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

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

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

(5) Funding limitations

(A) No Federal funds for continued operations

In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January

1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds

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

(6) Consultation

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

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

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

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

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs

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

(e) Certification

(1) In general

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

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

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

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

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

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the

Exchange determines are inappropriate or too costly.

(2) Premium considerations

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

(3) Transparency in coverage

(A) In general

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

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

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

(vi) Data on rating practices.

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

(viii) Information on enrollee and participant rights under this title[1]

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

(B) Use of plain language

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

(C) Cost sharing transparency

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

(D) Group health plans

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

(f) Flexibility

(1) Regional or other interstate exchanges

An Exchange may operate in more than one State if –

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

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

(2) Subsidiary Exchanges

A State may establish one or more subsidiary Exchanges if –

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

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

(3) Authority to contract

(A) In general

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

(B) Eligible entity

In this paragraph, the term "eligible entity" means –

(i) a person –

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

(II) that has demonstrated experience on a State or regional basis in the individual and small group

health insurance markets and in benefits coverage; and

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

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

(g) Rewarding quality through market-based incentives

(1) Strategy described

A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for –

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

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and

post discharge reinforcement by an appropriate health care professional;

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

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

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

(2) Guidelines

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

(3) Requirements

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

(h) Quality improvement

(1) Enhancing patient safety

Beginning on January 1, 2015, a qualified health plan may contract with –

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

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

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

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

(2) Exceptions

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

(3) Adjustment

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

(i) Navigators

(1) In general

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

(2) Eligibility

(A) In general

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

(B) Types

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

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

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

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

(3) Duties

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

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

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

(C) facilitate enrollment in qualified health plans;

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

(E) provide information in a manner that is culturally and linguistically appropriate to

the needs of the population being served by the Exchange or Exchanges.

(4) Standards

(A) In general

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

(i) be a health insurance issuer; or

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

(5) Fair and impartial information and services

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

(6) Funding

Grants under this subsection shall be made from the operational funds of the Exchange and

not Federal funds received by the State to establish the Exchange.

(j) Applicability of mental health parity

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

(k) Conflict

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

Title 26, § 18041. State flexibility in operation and enforcement of Exchanges and related requirements

(a) Establishment of standards

(1) In general

The Secretary shall, as soon as practicable after March 23, 2010, issue regulations setting standards for meeting the requirements under this title,[1] and the amendments made by this title,[1] with respect to –

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

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

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

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

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

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[1] See References in Text note below.

(2) Consultation

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

(b) State action

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

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

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

(c) Failure to establish Exchange or implement requirements

(1) In general

If –

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

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

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

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

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

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

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

(2) Enforcement authority

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

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

(d) No interference with State regulatory authority

Nothing in this title[1] shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[1]

(e) Presumption for certain State-operated Exchanges

(1) In general

In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) Process

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

26 C.F.R. § 1.36B-1 Premium tax credit definitions.

(a) *In general*. Section 36B allows a refundable premium tax credit for taxable years ending after December 31, 2013. The definitions in this section apply to this section and §§1.36B-2 through 1.36B-5.

(b) *Affordable Care Act*. The term *Affordable Care Act* refers to the Patient Protection and Affordable Care Act, Public Law 111-448 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), as amended by the Medicare and Medicaid Extenders Act of 2010, Public Law 111-309 (124 Stat. 3285 (2010)), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Public Law 112-9 (125 Stat. 36 (2011)), the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10 (125 Stat. 38 (2011)), and the 3% Withholding Repeal and Job Creation Act, Public Law 112-56 (125 Stat. 711 (2011)).

(c) *Qualified health plan*. The term *qualified health plan* has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)) but does not include a catastrophic plan described in section 1302(e) of the Affordable Care Act (42 U.S.C. 18022(e)).

(d) *Family and family size*. A taxpayer's family means the individuals for whom a taxpayer properly claims a deduction for a personal exemption under section 151 for the taxable year. Family size means

the number of individuals in the family. Family and family size may include individuals who are not subject to or are exempt from the penalty under section 5000A for failing to maintain minimum essential coverage.

(e) *Household income* – (1) *In general*. Household income means the sum of –

(i) A taxpayer's modified adjusted gross income; plus

(ii) The aggregate modified adjusted gross income of all other individuals who –

(A) Are included in the taxpayer's family under paragraph (d) of this section; and

(B) Are required to file a return of tax imposed by section 1 for the taxable year (determined without regard to the exception under section (1)(g)(7) to the requirement to file a return).

(2) *Modified adjusted gross income*. Modified adjusted gross income means adjusted gross income (within the meaning of section 62) increased by –

(i) Amounts excluded from gross income under section 911;

(ii) Tax-exempt interest the taxpayer receives or accrues during the taxable year; and

(iii) Social security benefits (within the meaning of section 86(d)) not included in gross income under section 86.

(f) *Dependent*. Dependent has the same meaning as in section 152.

(g) *Lawfully present*. Lawfully present has the same meaning as in 45 CFR 155.20.

(h) *Federal poverty line*. The Federal poverty line means the most recently published poverty guidelines (updated periodically in the FEDERAL REGISTER by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2)) as of the first day of the regular enrollment period for coverage by a qualified health plan offered through an Exchange for a calendar year. Thus, the Federal poverty line for computing the premium tax credit for a taxable year is the Federal poverty line in effect on the first day of the initial or annual open enrollment period preceding that taxable year. See 45 CFR 155.410. If a taxpayer's primary residence changes during a taxable year from one state to a state with different Federal poverty guidelines or married taxpayers reside in separate states with different Federal poverty guidelines (for example, Alaska or Hawaii and another state), the Federal poverty line that applies for purposes of section 36B and the associated regulations is the higher Federal poverty guideline (resulting in a lower percentage of the Federal poverty line for the taxpayers' household income and family size).

(i) [Reserved]

(j) *Advance credit payment*. Advance credit payment means an advance payment of the premium tax

credit as provided in section 1412 of the Affordable Care Act (42 U.S.C. 18082).

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

(l) *Self-only coverage*. Self-only coverage means health insurance that covers one individual.

(m) *Family coverage*. Family coverage means health insurance that covers more than one individual.

(n) *Rating area*. [Reserved]

(o) *Effective/applicability date*. This section and §§1.36B-2 through 1.36B-5 apply for taxable years ending after December 31, 2013.

45 C.F.R. § 155.20 Definitions.

The following definitions apply to this part:

Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Agent or broker means a person or entity licensed by the State as an agent, broker or insurance producer.

Annual open enrollment period means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange.

Applicant means:

(1) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part, or transmitted to the Exchange by an

agency administering an insurance affordability program for at least one of the following:

(i) Enrollment in a QHP through the Exchange; or

(ii) Medicaid, CHIP, and the BHP, if applicable.

(2) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

Application filer means an applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in 26 CFR 1.36B-1(d), an authorized representative of an applicant, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part.

Benefit year means a calendar year for which a health plan provides coverage for health benefits.

Catastrophic plan means a health plan described in section 1302(e) of the Affordable Care Act.

Code means the Internal Revenue Code of 1986.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for

non-network providers, and spending for non-covered services.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Educated health care consumer has the meaning given the term in section 1304(e) of the Affordable Care Act.

Eligible employer-sponsored plan has the meaning given the term in section 5000A(f)(2) of the Code.

Employee has the meaning given to the term in section 2791 of the PHS Act.

Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Code are treated as one employer.

Employer contributions means any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enrollee means a qualified individual or qualified employee enrolled in a QHP.

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

Exchange Blueprint means information submitted by a State, an Exchange, or a regional Exchange that sets forth how an Exchange established by a State or a regional Exchange meets the Exchange approval standards established in § 155.105(b) and demonstrates operational readiness of an Exchange as described in §155.105(c)(2).

Exchange service area means the area in which the Exchange is certified to operate, in accordance with the standards specified in subpart B of this part.

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

Federally-facilitated SHOP means a Small Business Health Options Program established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Full-time employee has the meaning given in section 498011 (c)(4) of the Code effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which it is effective for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

Grandfathered health plan has the meaning given the term in § 147.140. *Group health plan* has the meaning given to the term in § 144.103.

Health insurance issuer or *issuer* has the meaning given to the term in §144.103.

Health insurance coverage has the meaning given to the term in § 144.103.

Health plan has the meaning given to the term in section 1301(b)(1) of the Affordable Care Act.

Individual market has the meaning given the term in section 1304(a)(2) of the Affordable Care Act.

Initial open enrollment period means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

Issuer application assister means an employee, contractor, or agent of a QHP issuer who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or

redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define large employer by substituting "51 employees" for "101 employees." The number of employees shall be determined using the method set forth in section 498011(c)(2) of the Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which the method shall be used for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

Lawfully present has the meaning given the term in § 152.2.

Minimum essential coverage has the meaning given in section 5000A(f) of the Code.

Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the standards described in § 155.210.

Plan year means a consecutive 12 month period during which a health plan provides coverage for

health benefits. A plan year may be a calendar year or otherwise.

Plain language has the meaning given to the term in section 1311(e)(3)(B) of the Affordable Care Act.

Qualified employee means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP. Beginning in 2017, if a State allows large employers to purchase coverage through the SHOP, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for one or more QHPs in the large group market offered through the SHOP.

Qualified health plan or *QHP* means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified health plan issuer or *QHP issuer* means a health insurance issuer that offers a QHP in accordance with a certification from an Exchange.

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

SHOP means a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting "50 employees" for "100 employees." The number of employees shall be determined using the method set forth in section 4980H(c)(2) of the Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which the method shall be used for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

Small group market has the meaning given to the term in section 1304(a)(3) of the Affordable Care Act.

Special enrollment period means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or

change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

State means each of the 50 States and the District of Columbia.