The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

SELECT COMMITTEE ON PATIENT PROTECTION AND AFFORDABLE CARE ACT
Senator Negron, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, January 22, 2013
TIME: 1:00 —3:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Negron, Chair; Senator Sobel, Vice Chair; Senators Bean, Brandes, Flores, Gibson, Grimsley, Legg, Simmons, Smith, and Soto

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Lessons from Massachusetts and Expected Impacts of PPACA in Florida		
	Jonathan Gruber, PhD, Massachusetts Institute of Technology		Presented
	Michael Cannon, Director of Health Policy Studies, Cato Institute		Presented
2	Presentation by the Office of Insurance Regulation		Not Considered
	Other Related Meeting Documents		

Jonathan Gruber

Dr. Jonathan Gruber is a Professor of Economics at the Massachusetts Institute of Technology, where he has taught since 1992. He is also the Director of the Health Care Program at the National Bureau of Economic Research, where he is a Research Associate. He is an Associate Editor of both the Journal of Public Economics and the Journal of Health Economics. In 2009 he was elected to the Executive Committee of the American Economic Association. He is also a member of the Institute of Medicine, the American Academy of Arts and Sciences, and the National Academy of Social Insurance.

Dr. Gruber received his B.S. in Economics from MIT, and his Ph.D. in Economics from Harvard University. Dr. Gruber's research focuses on the areas of public finance and health economics. He has published more than 140 research articles, has edited six research volumes, and is the author of *Public Finance and Public Policy*, a leading undergraduate text, and *Health Care Reform*, a graphic novel. In 2006 he received the American Society of Health Economists Inaugural Medal for the best health economist in the nation aged 40 and under.

During the 1997-1998 academic year, Dr. Gruber was on leave as Deputy Assistant Secretary for Economic Policy at the Treasury Department. From 2003-2006 he was a key architect of Massachusetts' ambitious health reform effort, and in 2006 became an inaugural member of the Health Connector Board, the main implementing body for that effort. In that year, he was named the 19th most powerful person in health care in the United States by Modern Healthcare Magazine. During the 2008 election he was a consultant to the Clinton, Edwards and Obama Presidential campaigns. During 2009-2010 he served as a technical consultant to the Obama Administration and worked with both the Administration and Congress to help craft the Patient Protection and Affordable Care Act. In 2011 he was named "One of the Top 25 Most Innovative and Practical Thinkers of Our Time" by Slate Magazine.

Testimony to Florida Senate

Jonathan Gruber

January 22, 2013

Genesis of the ACA: Massachusetts

- Romney's "three-legged stool"
- First leg: insurance market reform
- Second leg: individual mandate
- Third leg: extensive subsidies below 300% FPL
- Also set up "Connector" to facilitate non-subsidized purchase of insurance
  - www.mahealthconnector.org

Great Success!

- More than two-thirds of uninsured covered
  - Uninsurance rate only 2-3%
  - Private insurance rose dramatically
- Premiums in individual market down 50%
  - Fixing broken market through universal participation
- Premiums in employer market rose at national average
- Broad public support
  - Consistent two-thirds support

ACA is National Version of MA

- Rare case of running experiment first
- Same model in ACA
  - End insurance market discrimination
  - Mandate individual purchase (if affordable)
  - Affordability: Medicaid to 133% of FPL; tax credits to 400% of FPL
- Key: need *all three legs* for the stool to stand

Issues for Florida

1) Impacts of ACA on insurance market
2) Medicaid expansion
3) How active a role to play in exchange

ACA & Florida Insurance Market

- 50% of Floridians with private insurance get it from large employers
- There will be little effect on this group
- Large & self-insured firms largely unregulated
- Assessment if firms over 50 don’t offer insurance – but almost all do

ACA & Florida Insurance Market

- 22% of Floridians get insurance from small employers
- Modest rise in premiums – several percent
- Tax credits for smallest & lowest wage employers
- Benefits of choice through new health insurance exchange
- And get increased *pricing certainty* through end of health rating of premiums

ACA & Florida Insurance Market

- 6% of Floridians get insurance through individual market
- Premiums rise through two effects
  - Richer benefits
  - Higher prices since insurers can't reject the sick
- Offset by enormous tax credits
- And get true certainty of insurance
- Evidence: insurance key to good mental health as well as physical health

Prices in Individual Insurance Market

- Based on modeling in other states – fairly consistent story
- Large decrease in premiums in the individual market after accounting for tax credits
  - Most pay less to get better insurance
  - Young, higher income individuals likely to pay more, but will be getting better insurance

Don’t Buy the Rhetoric

- Remember that objective experts *and* evidence from Massachusetts say no meaningful effect on employer premiums
  - Pay attention to averages, not outliers
- Only real effect on the 6% of the market that buys insurance
- And most individuals in that market will see significant declines in premiums
- There will be some increases, but on average it will decline

Medicaid Expansion

- Federal government pays >90% of costs of expanding Medicaid to 133% of FPL
- If state doesn't do this, then those 100-133% of FPL can go into exchanges
  - Pay 2% of income
  - Get roughly $250 deductible plan
- But those below 100% FPL have no recourse

Implications of Rejecting Medicaid Expansion

1) Many more uninsured
   - 38 % of florida uninsured below poverty line – get nothing with no Medicaid expansion
   - worse health and more financial insecurity
2) Higher premiums in exchange
   - Based on analysis in other states, roughly 15% rise in premiums in the exchange
3) More uncompensated care
4) Reject enormous federal stimulus – despite paying the state's share of ACA costs!

What Role to Play in Exchange

- Two parts of administering an exchange
- The “hard part”: making the exchange function
  - Coordinating eligibility
  - Interoperability across platforms
  - Customer support
- The “fun part”: what should exchange look like?

Key Role of “Choice Architecture”

- Standard economics view: more choice is better
- Suggests a “yellow pages” approach to the exchange
- But much recent evidence suggests that this leads to confusion
  - Causes worse choices and “choice overload” with lower participation
  - Reduces competition since insurers exploit consumer confusion

Health Evidence: Medicare Part D

- We have experimented with choice in public insurance: Medicare Part D
- Typical senior has 50 PDPs to choose from
- Seniors do a terrible job choosing
  - 12% of seniors choose the lowest cost plan
  - Typical senior could save 30%
  - Choices *don't get better over time* – this isn't just about learning – fundamental problem

Massachusetts Experience

- First allowed broad choices within each "metallic tier"
  - Consumers were confused and displeased
- Moved to 7 sets of standardized benefits
  - Consumer satisfaction much higher
- But pressure from market to expand
  - Now introducing non-standardized options, but labeling them as such

No “Right Answer” Here

- But we know that yellow pages isn’t right
- Florida may want to play a role in guiding choices
- That said, getting late for 2014
- Feds appear to be allowing any qualified plan

Suggestion: Evaluation Process

- Florida could set up an evaluation process to assess the choice experience
  - Collect data on choices made – evaluate choice efficacy
  - Focus groups with consumers about choice experience
- Based on evidence may want to intervene in later years

Michael F. Cannon

Michael F. Cannon is the Cato Institute's director of health policy studies. Previously, he served as a domestic policy analyst for the U.S. Senate Republican Policy Committee under Chairman Larry E. Craig, where he advised the Senate leadership on health, education, labor, welfare, and the Second Amendment.

Cannon has appeared on ABC, CBS, CNN, CNBC, C-SPAN, Fox News Channel, and NPR. Cited by the Washington Post as "an influential health-care wonk at the libertarian Cato Institute," his articles have been featured in The Wall Street Journal, USA Today, the Los Angeles Times, the New York Post, the Chicago Tribune, the Chicago Sun-Times, the San Francisco Chronicle, Huffington Post, Forum for Health Economics & Policy, and the Yale Journal of Health Policy, Law, and Ethics.

Cannon is the co-editor of Replacing Obamacare: The Cato Institute on Health Care Reform and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It.

He holds a bachelor's degree in American government (B.A.) from the University of Virginia, and master's degrees in economics (M.A.) and law & economics (J.M.) from George Mason University.

The PPACA's Health Insurance Exchanges and Medicaid Expansion

Testimony of
Michael F. Cannon

before the

Select Committee on Patient Protection and Affordable Care Act
Florida Senate

January 22, 2013

Chairman Negron and members of the committee, my name is Michael F. Cannon. I am the director of health policy studies at the Cato Institute, a non-partisan, non-profit, educational foundation in Washington, D.C.. The mission of the Cato Institute is to promote the principles of individual liberty, limited government, free markets, and peace.

Introduction

The Patient Protection and Affordable Care Act and the Supreme Court's recent ruling in *NFIB v. Sebelius* give Florida officials considerable power to shape how that law operates in Florida—but only if the state declines to implement the health insurance Exchanges and the Medicaid expansion that law envisions. The moment Florida implements those programs, it cedes even greater control over its health care sector and the state's destiny to the federal government.

The PPACA

The Patient Protection and Affordable Care Act of 2010 depresses economic activity, eliminates jobs, increases health care costs, makes access to care less secure, increases the burden of government, and traps people in poverty. Repealing the PPACA is essential to making health care better, more affordable, and more secure.

In just its first six years, the PPACA will reduce economic output by as much as $750 billion[1] and eliminate an estimated 800,000 jobs.[2] Some of those job losses will be the result of the law's "employer mandate," which fines employers up to $2,000 per worker if they fail to offer "minimum value" and "affordable" health benefits.[3] The rest will result from the disincentives to work the Act creates, such as implicit marginal tax rates that exceed 100 percent for many low-income households.[4]

The "individual mandate" requires nearly all Americans to purchase a government-designed health plan or pay a penalty. That mandate has already increased the cost of health insurance for millions of Americans,[5] has forced many to choose between violating their religious principles and paying a fine,[6] and will increase premiums for millions more Americans when it takes full effect in 2014. Neutral observers and even supporters of the law project that in 2014, some consumers and employers will see their health insurance premiums rise by more than 100 percent.[7]

The PPACA's "community rating" price controls will destroy innovations that make health insurance better and more secure.[8] They have already caused the markets for child-only health insurance to collapse in 17 states and caused insurers to flee the child-only market in a further 18 states.[9] When implemented elsewhere, these price controls have forced health insurance companies to compete to avoid and mistreat the sick.[10] Millions of Americans will suffer those consequences if these price controls take full effect in 2014. When informed that these price controls will reduce the quality of care their families receive, consumers overwhelmingly oppose these supposedly popular provisions.[11]

The law's minimum "medical loss ratio" requirement has already forced at least one health insurance carrier, Principal Financial Group, to exit the market, forcing nearly one million Americans out of their existing coverage.[12]

The PPACA's Medicaid expansion will crowd out private health insurance and leave many Americans with less secure access to care. A recent study projected "high rates of crowd-out for Medicaid expansions aimed at working adults (82%), suggesting that the Medicaid expansion provisions of PPACA will shift workers and their families from private to public insurance without reducing the number of uninsured very much."[13] Nationwide, nearly one third of physicians refuse to accept new Medicaid patients.[14]

The Act will further reduce access to care by reducing incomes. From 2013 through 2022, it imposes $1.2 trillion in new taxes[15] and commits taxpayers to pay for an estimated $1.7 trillion in new federal spending.[16] Roughly half of that amount consists of subsidies to private health insurance companies that will flow through new government agencies called health insurance "exchanges." The balance comes from a 50 percent increase in the number of nonelderly Medicaid enrollees.[17]

Finally, the PPACA spends money the federal government simply does not have. The federal treasury is currently running a $1.1 trillion deficit and has accumulated an $11 trillion debt.[18] Exchanges would add roughly $700 billion to federal deficits over the next 10 years.[19] The Medicaid expansion would add another $931 billion.[20]

Congress and President Obama have already repealed one of the PPACA's three new entitlement programs: the Community Living Assistance Services and Supports Act, or CLASS Act.[21] They have also repealed federal funding for any new Consumer Operated and Oriented Plans,[22] which Congress enacted as an alternative to a "public option."[23]

Why Florida Should Not Create a Health Insurance "Exchange"

An astounding 32 states have refused to establish their own health insurance Exchange.[24] Many states that initially pursued an Exchange did a complete about-face. Oklahoma, Kansas, and Wisconsin each returned to the federal government tens of millions of dollars in Exchange-related grants.[25] After an Exchange bill died in the New Hampshire Senate, a bill to prohibit the state from establishing an Exchange cleared the legislature and was signed by Democratic Gov. John Lynch.[26]

Many factors are driving state officials to reject Exchanges.

First, the PPACA does not mandate that states create Exchanges.

Second, in many states, creating a PPACA-compliant Exchange would violate state law.

Third, Exchanges could require states to raise taxes. Based on estimates conducted in similar states (see attached), the cost of operating a Florida Exchange is likely to approach $100 million per year or more. Minnesota initially estimated its Exchange would cost $30 to $40 million per year to operate in 2015. The state subsequently increased that projection to $54 million in 2015 and $64 million in 2016. That's a 35-80 percent jump over initial projections and a growth rate of 19 percent per year.[27]

Fourth, there is no rush. The deadlines for establishing an Exchange are no more real than the "deadlines" for implementing REAL ID.

Fifth, states can always switch to a state-created Exchange if they decide they don't like a federal Exchange.

Sixth, state officials are increasingly coming to see the choice they face is not between a state-controlled Exchange and a federally controlled one, because even state-created Exchanges will be controlled by Washington.

Seventh, it is questionable whether the federal government will be able to create any Exchanges at all. The choice states actually face is therefore between a state-created, federally controlled Exchange and perhaps no Exchange at all.

Eighth, states are leery of committing to an Exchange when the federal government has yet to provide crucial information that states need to make an informed decision.

Ninth, creating an Exchange sets state officials up to take the blame when the PPACA increases insurance premiums and denies care to the sick.

Tenth, state officials would be assisting in the creation of something akin to a "public option" that could drive the state's domestic carriers out of business.

Eleventh, refusing to create an Exchange blocks federal subsidies for controversial abortifacients.

Twelfth, the PPACA is still unpopular, even after three years

Finally, rejecting an Exchange blocks major provisions of the PPACA. Those provisions include the tax penalties imposed by the employer and individual mandates and hundreds of billions of dollars in deficit spending. Rejecting an Exchange therefore improves a state's prospects for job creation, and protects the religious freedom and conscience rights of millions of employers and individuals whom the Obama administration would force to purchase items that violate their moral convictions.

Perhaps the most important reason not to establish an Exchange is the last. Under the PPACA, if Florida creates an Exchange, then all employers with 50 or more employees will be subject to a tax of up to $2,000 per worker under the Act's "employer mandate."[28] Employers with 50 workers could face a tax of $40,000, while those with 100 corkers would face a tax of $140,000. In addition, millions of Florida residents will be subject to the Act's "individual mandate." Families of four earning $24,000 per year who run afoul of this mandate would face a tax of $2,085.

If Florida opts not to establish an Exchange, however, it can exempt all its employers and 1.1 million Floridians from those taxes. Florida would be in a position to lure jobs away from other states where those crushing taxes would apply. My coauthor Jonathan Adler and I explain this feature of the PPACA in a forthcoming article in the law journal *Health Matrix*.[29]

Contrary to the statute and congressional intent, the IRS is attempting to tax employers and such individuals even in states that do not establish Exchanges. Oklahoma, which has opted not to establish an Exchange, has filed a complaint in federal court to block the IRS from taxing employers in the state. If Florida were to establish an Exchange and Oklahoma prevailed in court, then Florida will be at a competitive disadvantage with other states with respect to job creation. Even if one supports the creation of an Exchange, therefore, Florida should postpone that decision until *Pruitt v. Sebelius* and any similar cases are resolved.

Another alternative would be for Florida to protect the rights of its employers and residents by filing a similar suit to block the IRS's illegal taxes. In addition, a strengthened version of the Health Care Freedom Act could effectively block the IRS's illegal taxes, and even prevent the federal government from operating Exchanges.[30]

Why Florida Should Not Expand Medicaid

You are all too familiar with how little control Florida has over its Medicaid program. If Florida implements the PPACA's Medicaid expansion, it will cede further control over the state's budget and its health care sector to Washington.

As originally conceived, the PPACA's Medicaid expansion was mandatory. Congress made state implementation of the expansion a condition of receiving federal Medicaid funds. That mandate required states to expand their Medicaid rolls numerous ways, resulting in a 50 percent increase in nonelderly enrollees.[31] The penalty for non-compliance was states would lose all federal Medicaid funds, which comprise 12 percent of state revenues.[32] Twenty-six states, led by Florida, challenged that mandate as unconstitutional, and won. *NFIB v. Sebelius* frees states not to implement the law's Medicaid expansion—i.e., all mandatory Medicaid provisions of the law, not just the newly eligible adult population.[33]

States should exercise that freedom and refuse to expand their Medicaid programs, for several reasons.

First, Medicaid is rife with waste and fraud.[34]

Second, Medicaid increases the cost of private health care and insurance, crowds out private health insurance and long-term care insurance, and discourages enrollees from climbing the economic ladder.[35]

Third, there is scant reliable evidence that Medicaid improves health outcomes at all, and absolutely no evidence that it is a cost-effective way of doing so.[36]

Fourth, states still lack guidance from Washington about how the Medicaid expansion will operate. A recent survey of governors' statements on the Medicaid expansion found, "three quarters of [uncommitted] governors said they needed more information on federal requirements, cost and enrollment projections, and policy alternatives."[37]

Fifth, even if states were facing deadlines and armed with all the regulatory guidance they need (neither of which is the case), they cannot afford to expand Medicaid. My colleague Jagadeesh Gokhale estimates the expansion will cost the state of Florida roughly $20 billion over its first 10 years.[38] The National Conference of State Legislators reported that in 2012, states faced combined budget deficits of $32 billion.[39] States' finances have improved only modestly since.

Sixth, historical experience with government health programs shows that enrollment and spending often dramatically exceed projections. Yet such programs are never eliminated or pared back in any significant way.

Seventh, rejecting the Medicaid expansion would reduce federal deficits and would reduce total government spending even more. According to CBO estimates, the handful of states that have refused to expand Medicaid have reduced federal deficits by $84 billion.[40] The states that are refusing to expand Medicaid are doing more to reduce federal deficits than Congress and the president.

Finally, it would seem odd for Florida, which was a leader in the multi-state challenge to the PPACA that lead the Supreme Court to strike down the Medicaid mandate as unconstitutionally coercive, to respond to that victory by shrugging and implementing that costly

Medicaid expansion anyway. It would more befit Florida's role to join Maine in challenging the Obama administration's arbitrary attempt to limit the Supreme Court's Medicaid ruling in *NFIB v. Sebelius* to the newly eligible adult population.

Real Health Care Reforms

Americans' access to health care is less secure than it should be precisely because of government interventions like the PPACA. Blocking and repealing this Act are therefore positive steps that will make health care more secure. For example, the CBO reports that repealing the Act would reduce premiums for many consumers by freeing them to purchase more affordable health plans.[41] But state and federal officials should not stop there.

After rejecting both an Exchange and the Medicaid expansion, Florida should adopt reforms that make health care better and bring it within the reach of vulnerable Floridians.

First, Florida should enact a "Good Samaritan" law, like those enacted in Tennessee, Illinois, and Connecticut.[42] Volunteer groups like Remote Area Medical engage doctors and other clinicians from around the country to treat indigent patients in rural and inner-city areas. These clinicians are often turned away from providing free medical care to the poor because, while they are licensed to practice medicine in their own states, they are not licensed to practice medicine where Remote Area Medical is holding its clinics.

Remote Area Medical has had to turn away patients or scrap clinics in places California, Florida, and Georgia. "Before Georgia told us to stop," says founder Stan Brock, "we used to go down to southern Georgia and work with the Lions Club there treating patients." After a tornado devastated Joplin, Missouri, Remote Area Medical arrived with a mobile eyeglass lab, yet state officials prohibited the visiting optometrists from giving away free glasses.[43]

Tennessee, Illinois, and Connecticut have enacted laws that allow out-of-state-licensed clinicians to deliver free charitable care in their states without obtaining a new license. To protect patients, visiting clinicians should be subject to the licensing laws of the state in which they are practicing.

Second, Florida should apply for a waiver to determine whether Medicaid works. Most non-health care experts are surprised to learn how little reliable evidence there is that Medicaid has a positive impact on health, and how there is absolutely no evidence it is a cost-effective way to improve health.[44]

Rather than expand Medicaid, Florida should apply for a waiver to conduct an experiment like the Oregon Health Insurance Experiment (OHIE).[45] The OHIE randomly assigned patients to receive Medicaid or not, with the goal of producing reliable data to measure the impact of Medicaid on existing populations. Unfortunately, Oregon officials arbitrarily halted the experiment. Florida should apply for a waiver from the federal government to conduct a similar study with existing populations. There likely will be objections to randomly assigning

Medicaid slots to existing populations, yet the truly unethical position is to preserve or expand Medicaid without knowing whether it even helps the populations it is meant to help.

Third, Florida should let doctors and patients enact their own medical malpractice liability reforms. The cost of medical malpractice liability insurance increases the price of health care services, pricing many low-income patients out of the market. A given reform might reduce the price of medical services, but at the expense of preventing some injured patients from recovering the full cost of their injuries.[46] When these complicated tradeoffs exist, the best approach is to let patients choose the tradeoff that works best for them.

Florida should therefore allow patients and providers to adopt their own "med mal" reforms via contract.[47] Patients who want caps on non-economic damages, mandatory binding arbitration, medical courts, or a "loser pays" rule could have those measures, and any concomitant reduction in their medical bills. Patients who prefer to have an unlimited right to sue could write that into contracts with their medical providers, and pay whatever markup comes with that added protection.

The obstacle to such contracts is that courts do not enforce them. That unfortunate judicial trend denies access to care for low-income patients by denying them the opportunity to decide for themselves whether accessing medical care now is more important than having an unlimited right to sue in the unlikely event they suffer an injury due to a provider's negligence. In states that have already enacted caps on noneconomic damages or other med-mal reforms, freedom of contract would allow patients to obtain *greater* protections than those laws allow. Florida's legislature should direct courts to enforce such contracts.

Conclusion

Thank you for allowing me to address the committee today. I look forward to your comments.

(Attachments.)

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[1] Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Institute Policy Analysis No. 669, October 13, 2010, p. 8, http://www.cato.org/pubs/pas/PA669.pdf.

[2] Michael F. Cannon, "Yes, ObamaCare Will Eliminate Some 800,000 Jobs," Cato@Liberty, November 2, 2011, http://www.cato-at-liberty.org/yes-obamacare-will-eliminate-some-800000-jobs/.

[3] Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 2010, p. 49, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/117xx/doc11705/08-18-update.pdf. The employer mandate

applies to employers with more than 50 employees. The penalty for failing to provide "essential" and "affordable" health benefits is a fine of $2,000 per full-time employee, minus the first 30 full-time employees.

[4] Michael F. Cannon, "Obama's Prescription for Low-Wage Workers, High Implicit Taxes, Higher Premiums," Cato Institute Policy Analysis No. 656, January 13, 2010, http://www.cato.org/pubs/pas/pa656.pdf.

[5] Michael F. Cannon, "Should Everyone be Required to Have Health Insurance?" *Wall Street Journal*, January 23, 2012, http://www.cato.org/publications/commentary/should-everyone-be-required-have-health-insurance.

[6] Michael F. Cannon, "The Illiberality of ObamaCare," *Huffington Post*, February 14, 2012, http://www.huffingtonpost.com/michael-f-cannon/the-illiberality-of-obama_b_1276621.html.

[7] Jonathan Gruber et al., "The Impact Of The ACA On Wisconsin's Health Insurance Market," July 18, 2011 ("Prior to tax subsidies, 41% of the market will receive a premium increase that is higher than 50%...54% of the members receiving greater than a 50% premium increase are age 29 or under.); Dennis Smith, Wisconsin Secretary of Health Services, Email Correspondence with Author, January 13, 2012 (Citing supplemental findings from Gruber et al.: "Another way to look at the data is to just look at the 1% of single policies that see the highest increases after accounting for the tax subsidy. In this case these 'top' 1% see an average increase of 126%."); Jeremy D. Palmer, Jill S. Herbold, and Paul R. Houchens, "Milliman Client Report: Assist with the First Year of Planning for Design and Implementation of A Federally Mandated American Health Benefits Exchange in the Individual Market," 2011, p. 7, http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf ("In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%.").

[8] See Michael F. Cannon, "BCBSNC's Premium Refunds Show the Perils of ObamaCare," *Charlotte Observer*, October 6, 2010, http://www.cato.org/publications/commentary/bcbsncs-premium-refunds-show-perils-obamacare; and John H. Cochrane, "Health-Status Insurance: How Markets Can Provide Health Security," Cato Institute Policy Analysis No. 633, February 18, 2009, http://www.cato.org/pubs/pas/pa-633.pdf.

[9] United States Senate, Committee on Health, Education, Labor and Pensions, *Ranking Member Report: Health Care Reform Law's Impact on Child-Only Health Insurance Policies*, 112th Congress, August 2, 2011, http://help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf.

[10] "Insurer Ends Health Program Rather Than Pay Out Big," *Washington Times*, October 14, 2009, http://www.washingtontimes.com/news/2009/oct/14/ny-insurance-company-tries-to-rid-itself-of-high-c/?page=all#pagebreak/; Editorial, "N.Y. Bill Would Protect High-Claims Patients," *Washington Times*, November 6, 2009, http://www.washingtontimes.com/news/2009/nov/6/ians-law-would-protect-high-claims-patients/?page=all#pagebreak, and *Between You and Your Doctor: The Bureaucracy of Private Health Insurance, Day 1, Before the House Committee on Oversight and Government Reform, Subcommittee on Domestic Policy*, 111th Cong. (September 16, 2009) (Testimony of Michael F. Cannon), http://www.cato.org/testimony/ct-mc-20090916.html.

[11] Reason-Rupe Public Opinion Surveys, "Reason-Rupe: March 2012 Topline Results (March 10-20)," March 26, 2012, http://reason.com/assets/db/13327241811317.pdf.

[12] Avery Johnson, "Principal Financial Quits Writing Health-Care Policies," *Wall Street Journal*, October 1, 2010, http://online.wsj.com/article/SB10001424052748704789404575524281126700388.html.

[13] Steven D. Pizer, Austin B. Frakt, and Lisa I. Iezzoni, "The Effect of Health Reform on Public and Private Insurance in the Long Run," March 9, 2011, http://ssrn.com/abstract=1782210. See also Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," *American Economic Review* 98, No. 3 (2008): 1083–1102; Geena Kim, "Medicaid Crowd-Out of Long-Term Care Insurance with Endogenous Medicaid Enrollment," 12th Annual Joint Conference of the Retirement Research Consortium, 2010.

[14] Sandra L. Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs* 31, No. 8 (2012), http://content.healthaffairs.org/content/31/8/1673.full.

[15] Douglas W. Elmendorf, "Letter to Rep. John Boehner on Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012," July 24, 2012, p. 6, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf.

[16] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 11, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[17] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 12, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[18] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012 to 2022*, January 2012, p. 10, http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012_Outlook.pdf.

[19] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 11, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf. This figure is reflects the net budgetary impact of $808 billion in refundable premium-assistance tax credits (foregone revenues and new outlays) and cost-sharing subsidies (new outlays), and $113 billion of penalties levied against employers (new revenues), which the tax credits and subsidies will trigger.

[20] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 11, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[21] American Taxpayer Relief Act of 2012, Pub. L. 112-240, Sec. 642, __ Stat. __ (2013).

[22] Sarah Kliff, "The Fiscal Cliff Cuts $1.9 Billion from Obamacare. Here's How.", *Washington Post*, January 2, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/02/the-fiscal-cliff-cuts-1-9-billion-from-obamacare-heres-how/. Elise Viebeck, "Health Plan Advocates Slam 'Cliff' Deal Cuts," *The Hill*, January 3, 2013, http://thehill.com/blogs/healthwatch/health-reform-implementation/275479-health-co-op-advocates-slams-cliff-deal-cuts. Sarah Kliff, "In 'Fiscal Cliff' Deal, a Blow to ObamaCare," *Washington Post*, January 15, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/15/co-ops-were-supposed-to-replace-the-public-option-now-they-are-dead/.

[23] Michael F. Cannon, "Fannie Med? Why a 'Public Option' Is Hazardous to Your Health," Cato Institute Policy Analysis No. 642, July 27, 2009, http://www.cato.org/sites/cato.org/files/pubs/pdf/pa642.pdf.

[24] Kaiser Family Foundation, "State Decisions For Creating Health Insurance Exchanges in 2014," State Health Facts, January 4, 2013, http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17.

[25] Kansas returned $31.5 million and Oklahoma returned $54.6 million, see "Kansas Returns Health Insurance Exchange Grant," *Reuters*, August 9, 2012, http://www.reuters.com/article/2011/08/09/usa-health-exchanges-idUSN1E7781U720110809. Wisconsin returned $37 million, See "Walker Turning Down $37 Million for Health Care," *Associated Press*, January 18, 2012, http://www.cbsnews.com/8301-505245_162-57361562/walker-turning-down-$37-million-for-health-care/.

[26] Matthew Spolar, "Lynch Signs Bill Prohibiting State Health Exchange," *Concord Monitor*, June 22, 2012, http://www.concordmonitor.com/article/337540/lynch-signs-bill-prohibiting-state-health-exchange?SESSefad2452e208c288985b42a449cd73d8=google.

[27] Elizabeth Stawicki, "Minnesota Facing Bigger Bill For State's Health Insurance Exchange," *Kaiser Health News*, November 25, 2012, http://www.kaiserhealthnews.org/stories/2012/november/26/minnesota-health-insurance-exchange.aspx.

[28] I.R.C. § 4980H(a).

[29] Jonathan H. Adler and Michael F. Cannon, "Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA," Case Legal Studies Research Paper No. 2012-27, December 14, 2012, pp. 42-44, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2106789; See also Michael F. Cannon and Jonathan H. Adler, "The IRS Has Gone Rogue," *National Review Online*, September 26, 2012, http://www.nationalreview.com/articles/328523/irs-has-gone-rogue-michael-f-cannon.

[30] I am indebted to Joe Coletti for alerting me to this joint-approval provision.

[31] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, March 2012, p. 12, http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[32] Cindy Mann, Joan C. Alker, and David Barish, "Medicaid and State Budgets: Looking At The Facts," May 2008, http://ccf.georgetown.edu/wp-content/uploads/2012/03/Medicaid_state-budgets-2008.pdf ("It is often reported that states spend, on average, almost 22 percent of their state budgets on Medicaid, but this figure can be misleading because it considers federal as well as state funds. On average, federal funds account for 56.2 percent of all Medicaid spending.").

[33] *NFIB v. Sebelius*, 567 U.S. __, __ (2012), http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. Emphasis added. Internal citations omitted.

[34] Michael F. Cannon, "Entitlement Bandits," *National Review*, July 4, 2011, http://www.cato.org/publications/commentary/entitlement-bandits-how-ryan-plan-would-curb-medicare-medicaid-fraud.

[35] Michael F. Cannon, "Medicaid's Unseen Costs," Cato Institute Policy Analysis No. 548, August 18, 2005, http://www.cato.org/publications/policy-analysis/medicaids-unseen-costs. See also Michael F. Cannon, "Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs," Cato Institute Briefing Paper No. 99, September 27, 2007, http://www.cato.org/publications/briefing-paper/sinking-schip-first-step-toward-stopping-growth-government-health-programs-0.

[36] Michael F. Cannon, "Oregon's Verdict on Medicaid," *National Review Online*, July 7, 2011, http://www.nationalreview.com/articles/271252/oregon-s-verdict-medicaid-michael-f-cannon.

[37] Benjamin D. Sommers and Arnold M. Epstein, "U.S. Governors and the Medicaid Expansion — No Quick Resolution in Sight," *New England Journal of Medicine*, January 16, 2013, http://www.nejm.org/doi/full/10.1056/NEJMp1215785.

[38] Jagadeesh Gokhale, "Estimating ObamaCare's Effect on State Medicaid Expenditure Growth," Cato Institute White Paper No. 4, January 11, 2011, http://www.cato.org/publications/working-paper/estimating-obamacares-effect-state-medicaid-expenditure-growth. See also Jagadeesh Gokhale and Angela C. Erickson, "The Effect of Federal Health Care 'Reform' on Kansas General Fund Medicaid Expenditures," Kansas Policy Institute, June 2011, http://www.kansaspolicy.org/researchcenters/healthcare/studiesanalysis/d79018.aspx; Jagadeesh Gokhale, Jagadeesh Gokhale, Angela C. Erickson, and Geoffrey Larence, "The Impact of ObamaCare on Nevada's Medicaid Spending," Nevada Policy Research Institute Analysis, May 5, 2011, http://npri.org/docLib/20110510_Impact_of_Obamacare_on_Nevadas_Medicaid_Spending.pdf; Jagadeesh Gokhale, "New Jersey's Medicaid Spending Escalation Under the PPACA" (Presentation, Common Sense Institute, New Jersey, December 20, 2011).

[39] National Council of State Legislatures, "State Budget Update," Spring 2012, http://www.ncsl.org/portals/1/documents/fiscal/sbu_spring2012_freeversion.pdf.

[40] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012, p. 2, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[41] Douglas W. Elmendorf, "Letter to Rep. John Boehner on Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012," July 24, 2012, p. 13, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf (Consumers in the individual market would be free to choose health plans that "cover a smaller share of enrollees' costs for health care and a slightly narrower range of benefits.").

[42] See CONN. GEN. STAT. § 52-557b; 745 ILL. COMP. STAT. ANN. 49/25; and TENN. CODE ANN. § 63-6-218.

[43] "Medical Volunteers Not Free to Cross State Lines," Associated Press, July 21, 2012, http://www.knoxnews.com/news/2012/jul/21/medical-volunteers-not-free-to-cross-state-lines/.

[44] Michael F. Cannon, "Oregon's Verdict on Medicaid," *National Review Online*, July 7, 2011, http://www.nationalreview.com/articles/271252/oregon-s-verdict-medicaid-michael-f-cannon#.

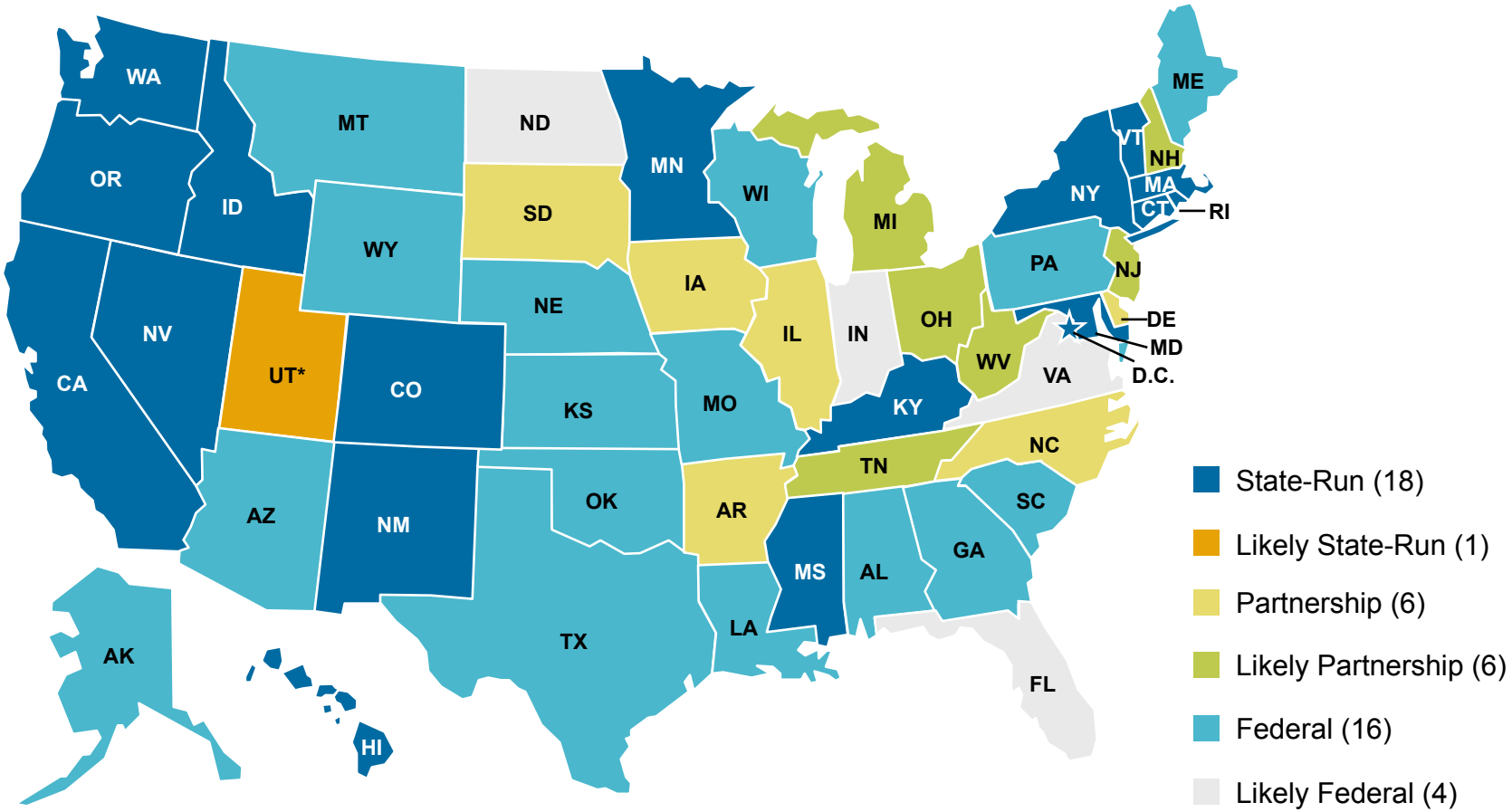
[45] Amy Finkelstein, et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *Quarterly Journal of Economics* 127, No. 3 (2012): 1243-1285.

[46] Shirley Svorny, "Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?" Cato Institute Policy Analysis No. 685, October 20, 2011, http://www.cato.org/publications/policy-analysis/could-mandatory-caps-medical-malpractice-damages-harm-consumers.

[47] Michael F. Cannon, "Reforming Medical Malpractice Liability through Contract," Cato Institute Working Paper, November 12, 2010, http://www.cato.org/publications/working-paper/reforming-medical-malpractice-liability-through-contract.

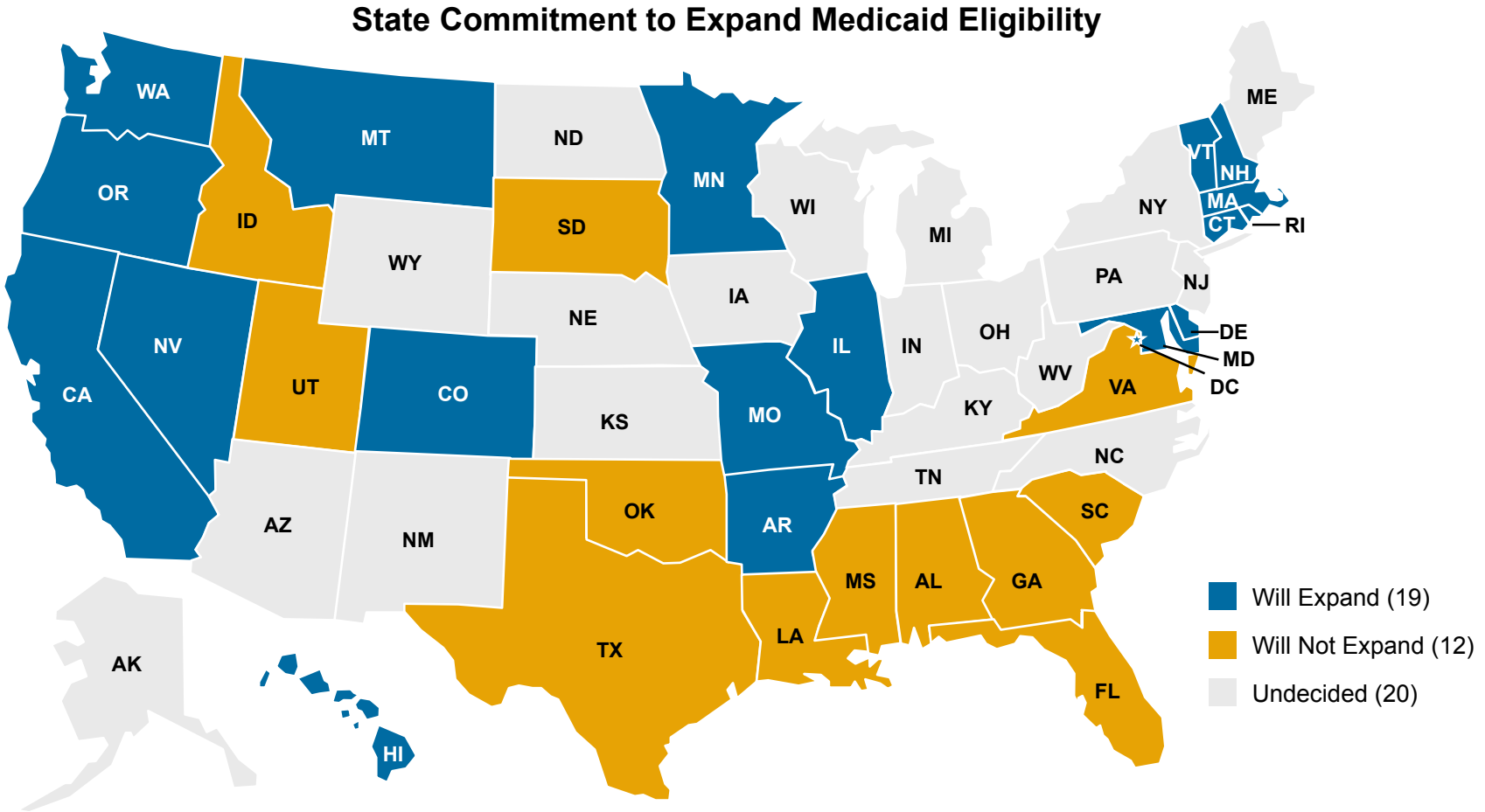
Avalere Exchange Progress Map

Insurance Exchange Operational Model



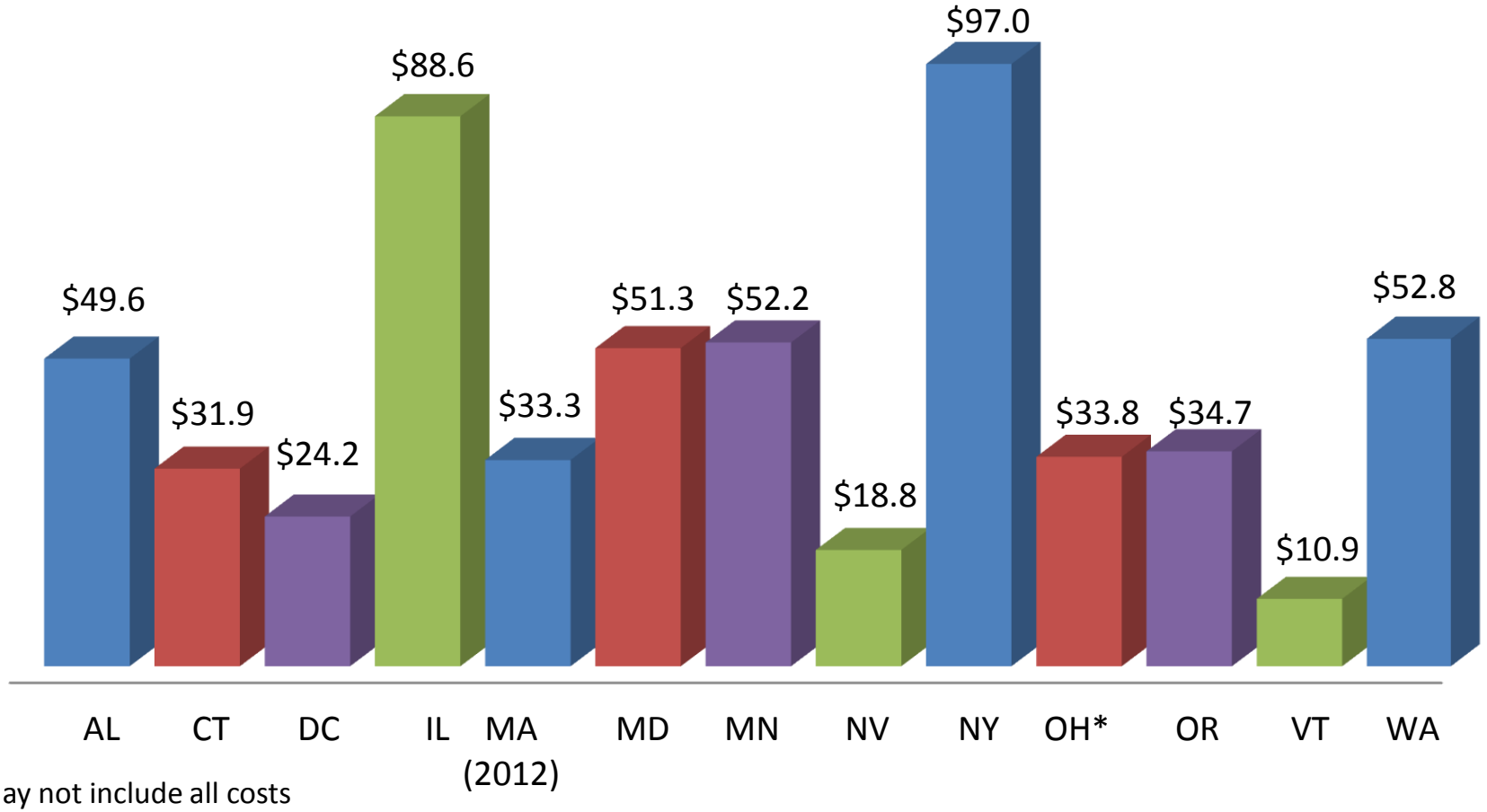
*Utah asked HHS to certify its existing small group exchange, Avenue H, as fully compliant with HHS requirements for a state-run exchange.

To Date, 19 States Plan to Expand Medicaid Eligibility, 12 Will Not Expand, and the Remainder Are Undecided



Source: Avalere *State Reform Insights*, Updated January 7, 2013

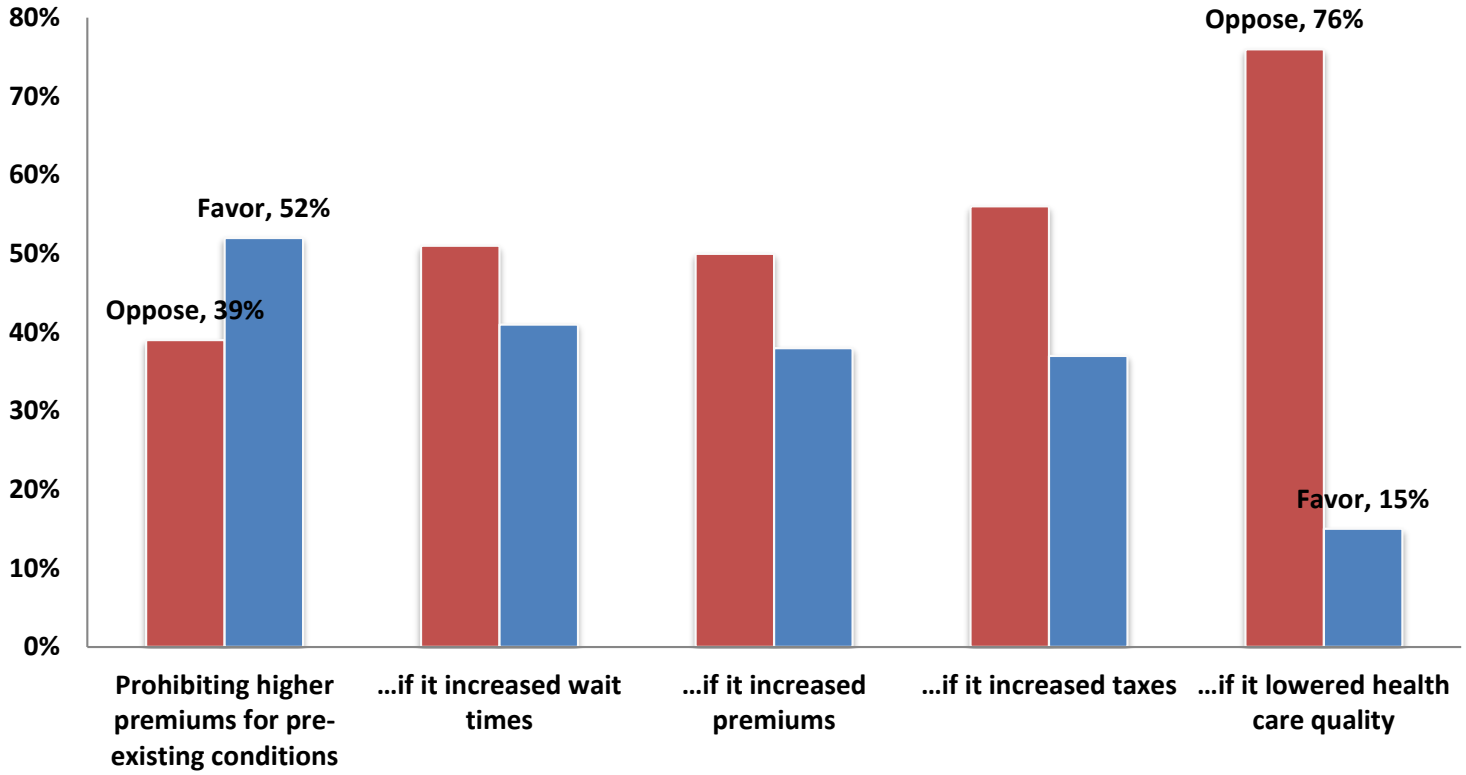
Estimated Exchange Operating Costs in Select States 2015 ($Millions)



*May not include all costs

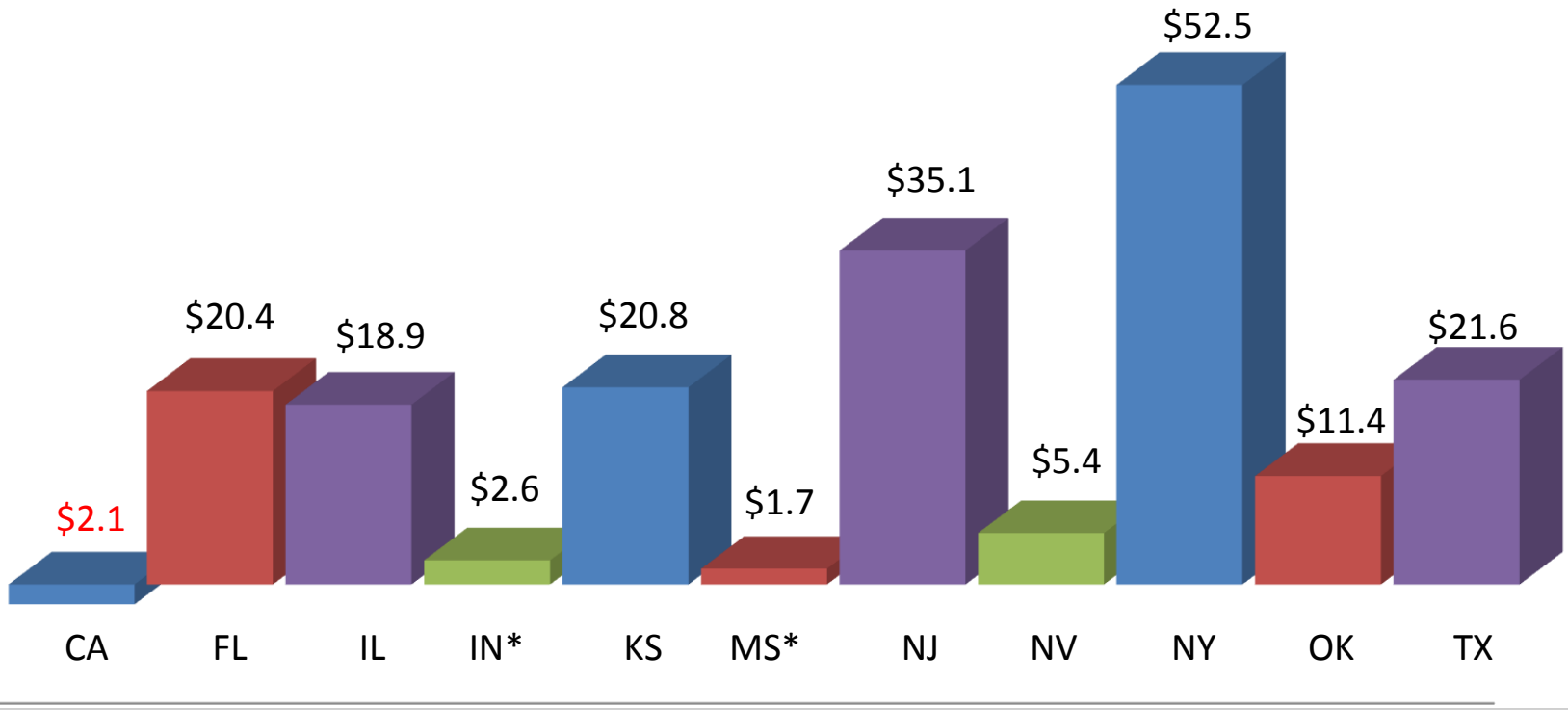
Sources: Robert L. Carey, "Financial Sustainability of the Alabama Exchange," November 2011; Mercer, "Health Insurance Exchange Planning Report: State of Connecticut," January 19, 2012; District of Columbia, "Health Benefit Exchange Design Review Narrative," 2012;Wakely, "Illinois Exchange Strategic and Operational Needs Assessment," September 2011; Wakely, "Maryland Health Benefit Exchange: Financing the Exchange Vendor Report," November 7, 2011; Commonwealth Health Insurance Connector Authority, "FY 2011 & FY 2012 Administrative Operating Budget," June 9, 2011; Minnesota Department of Commerce, "8.1 Finance Preliminary Budget Estimates," November 27, 2012; New York Health Benefit Exchange, "New York State Health Benefit Exchange Five Year Budget – DRAFT," October 26, 2012Milliman, "Financing Options to Sustain Ohio's Exchange," August 2011; Oregon Health Insurance Exchange Corporation, "Oregon Health Insurance Exchange Corporation Business Plan," February 2012; Silver State Health Insurance Exchange, "Design Review Section 8.0 Finance and Accounting," September 28, 2012; Burns and Associates, "Vermont Health Insurance Exchange Planning: Task 6.0: Analysis of Exchange Financial Functions," August 30, 2011; Washington State Health Care Authority, "8.1: Model budget and revenue generation plan," October 10, 2012.

When Asked about Likely Costs, Americans Oppose 'Popular' Provisions by 5-1



Source: Reason-Rupe, March 2012.

Ten-Year Cost of PPACA's Medicaid Expansion in Select States (Billions)



*Only first seven years available (SFY 2014-2020).

Sources: Jagadeesh Gokhale and Angela C. Erickson, "The Effect of Federal Health Care 'Reform' on Kansas General Fund Medicaid Expenditures," Kansas Policy Institute, June 2011; Jagadeesh Gokhale, Angela C. Erickson, and Jason Sutton, "Projecting Oklahoma's Medicaid Expenditure Growth under the PPACA," Oklahoma Council of Public Affairs, May 18, 2011; Jagadeesh Gokhale, Angela C. Erickson, and Geoffrey Lawrence, "The Impact of ObamaCare on Nevada's Medicaid Spending," Nevada Policy Research Institute Analysis, May 5, 2011; Jagadeesh Gokhale, "New Jersey's Medicaid Spending Escalation Under the PPACA" (Presentation, Common Sense Institute, New Jersey, December 20, 2011); Michael Gargano, Affordable Care Act (ACA) – Medicaid Financial Impact Analysis (Indiana), September 18, 2012; John D. Meerschaert, "Financial Impact of the Patient Protection and Affordable Care Act, As Amended by H.R. 4782, The Reconciliation Act of 2010, On the Mississippi Medicaid Budget," October 1, 2010.

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TAXATION WITHOUT REPRESENTATION:
The Illegal IRS Rule to Expand Tax Credits under the PPACA

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Forthcoming in HEALTH MATRIX: JOURNAL OF LAW-MEDICINE

Available at SSRN: http://ssrn.com/abstract=2106789

Abstract

The Patient Protection and Affordable Care Act (PPACA) provides tax credits and subsidies for the purchase of qualifying health insurance plans on state-run insurance exchanges. Contrary to expectations, many states are refusing or otherwise failing to create such exchanges. An Internal Revenue Service (IRS) rule purports to extend these tax credits and subsidies to the purchase of health insurance in federal exchanges created in states without exchanges of their own. This rule lacks statutory authority. The text, structure, and history of the Act show that tax credits and subsidies are not available in federally run exchanges. The IRS rule is contrary to congressional intent and cannot be justified on other legal grounds. Because tax credit eligibility can trigger penalties on employers and individuals, affected parties are likely to have standing to challenge the IRS rule in court.

TAXATION WITHOUT REPRESENTATION:
The Illegal IRS Rule to Expand Tax Credits under the PPACA

Jonathan H. Adler[*] and Michael F. Cannon[**]

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I. Introduction

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA, or "the Act") into law.[1] The PPACA creates a complex scheme of new government regulations, mandates, subsidies, and agencies in an effort to achieve near-universal health insurance coverage. Immediately after passage, a majority of state attorneys general and numerous business and public interest groups filed suit challenging various portions of the new law, most notably the so-called "individual mandate" and Medicaid expansion. This litigation wound its way to the U.S. Supreme Court, which produced a divided ruling upholding the constitutionality of the mandate but limiting the Medicaid expansion.[2] This decision did not end the controversy surrounding the PPACA, however.[3] Additional litigation has already ensued and is likely to continue in the years to come.[4]

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[1] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 244 (2010).

[2] *See* Nat'l Fed'n Indep. Bus. v. Sebelius, 567 U.S. __ (2012) (divided Supreme Court upholds constitutionality of individual mandate as a tax but invalidates conditioning of federal Medicaid funds on state acceptance of Medicaid expansion).

[3] News reports suggesting Chief John Roberts may have switched his vote after oral argument have only fueled the controversy. *See* Jan Crawford, *Roberts Switched Views to Uphold Health Care Law*, CBS NEWS, July 1, 2012, http://www.cbsnews.com/8301-3460_162-57464549/roberts-switched-views-to-uphold-health-care-law/?pageNum=2&tag=contentMain;contentBody.

[4] *See* Rob Field, *Legal Challenges to Obamacare Live On*, THE FIELD CLINIC, Dec. 7, 2012, http://www.philly.com/philly/blogs/fieldclinic/Legal-Challenges-to-Obamacare-Live-On.html; Jonathan H. Adler, *The ObamaCare Cases Keep Coming*, NATIONAL REVIEW ONLINE, Oct. 15, 2012, http://www.nationalreview.com/articles/330400/obamacare-cases-keep-coming-jonathan-h-adler; Jack M. Balkin, *The Right Strikes Back: A New Legal Challenge for Obamacare*, THE ATLANTIC ONLINE, Sept. 17, 2012, http://www.theatlantic.com/national/archive/2012/09/the-right-strikes-back-a-new-legal-challenge-for-obamacare/262443/; Jennifer Haberkorn, *More Legal Challenges to ACA on Way*, POLITICO, July 3, 2012, http://www.politico.com/news/stories/0712/78104.html; Michael Doyle, *It ain't over – more legal challenges to health care law coming*, MCCLATCHY NEWSPAPERS, June 29, 2012, http://www.mcclatchydc.com/2012/06/29/v-print/154456/it-aint-over-more-legal-challenges.html; Reuters, Supreme *Court Health Care Ruling Just The*

The PPACA's congressional sponsors created incentives for states to implement much of the law, and reasonably expected that states would do so.[5] States help implement many complex federal programs, from Medicaid to the Clean Air Act. Among other things, the PPACA encourages states to create new agencies called health insurance "Exchanges" to execute many of the law's key features. If a state fails to create an Exchange that meets federal standards, the Act authorizes the federal government to create a "fallback" Exchange for that state. As an inducement to state officials, the Act authorizes tax credits and subsidies for certain households that purchase health insurance through an Exchange, but restricts those entitlements to Exchanges created by states. Apparently this was not inducement enough.

As of August 2012, only fifteen states and the District of Columbia had taken affirmative steps to create a PPACA-compliant Exchange.[6] Dozens of states are either dragging their heels or flatly refusing to cooperate with implementation.[7] Contrary to initial expectations, a large

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Beginning Of Obamacare Legal Challenges, MSNBC.COM, June 18, 2012, *available at:* http://leanforward.msnbc.msn.com/_news/2012/06/18/12284836-foes-plan-next-wave-of-healthcare-lawsuits.

http://www.nationalreview.com/articles/330400/obamacare-cases-keep-coming-jonathan-h-adler

[5] *Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2011: Hearing Before the H. Comm. on Appropriations*, 111th Cong. 170-171 (March 10, 2010) (Statement by Kathleen Sebelius, Secretary, Department of Health and Human Services), *available at*: http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg58233/pdf/CHRG-111hhrg58233.pdf ("We have already had lots of positive discussions, and States are very eager to do this. And I think it will very much be a State-based program."); Max Baucus, Chairman of Senate Finance Committee, Statement at Health Care Reform Newsmaker Series: Sen. Max Baucus, Kaiser Family Foundation, Families USA and the National Federation of Independent Business (May 21, 2009), at 23, *available at:* http://www.kff.org/healthreform/upload/052109_Baucus_newsmakers_transcript.pdf ("States will still be able to make a lot of decisions, perhaps, but there will be significant measures left to states, but still in a way where Americans will know, that in whatever state they live, that they're going to get quality, they're getting affordable, and access to affordable, quality healthcare.").

[6] Kaiser Family Foundation, State Health Facts, *State Action Toward Creating Health Insurance Exchanges* (Aug. 1, 2012), http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17 (Thirteen states have enacted legislation (including DC, MA and UT). Three others, Kentucky, New York and Rhode Island, have established exchanges through executive action). PRICEWATERHOUSECOOPER, IMPLICATIONS OF THE US SUPREME COURT RULING ON HEALTH CARE 8 (2012), *available at:* http://pwchealth.com/cgi-local/hregister.cgi/reg/implications-of-the-US-Supreme-Court-ruling-on-healthcare.pdf.

[7] *See* J. Lester Feder and Jason Millman, *Exchanges Hit Roadblocks in Red States*, POLITICO, Apr. 18, 2012, http://www.politico.com/news/stories/0412/75331.html; Elise Viebeck, *Fifteen Governors Reject or Leaning Against Expanded Medicaid Program*, THE HILL'S HEALTHWATCH, July 3, 2012,

number of states will not create Exchanges before the PPACA's key provisions take effect in 2014. As Health and Human Services (HHS) Secretary Kathleen Sebelius commented in February 2012, the federal government could be responsible for running Exchanges in fifteen to thirty states.[8] Subsequent reports suggest the final number may be even higher.[9]

This apparent miscalculation creates a number of problems for implementation of the PPACA. The tax credits and subsidies for the purchase of qualifying health insurance plans in state-run Exchanges serve as more than just an inducement to states. These entitlements also operate as the trigger for enforcement of the Act's "employer mandate." As a consequence, that mandate is effectively unenforceable in states that decline to create an Exchange. The tax credits further play a role in the enforcement of the Act's "individual mandate," such that a state's decision not to create an Exchange would exempt more than half of its currently uninsured residents from that mandate.[10] Because such a large number of states may decline to create Exchanges of their own, it may be difficult to implement the law as supporters had hoped.

A final Internal Revenue Service (IRS) rule issued on May 18, 2012, attempts to fix this problem by extending eligibility for tax credits and cost-sharing subsidies to those who purchase qualifying insurance plans in *federally* run Exchanges.[11] The PPACA, however, precludes the

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http://thehill.com/blogs/healthwatch/health-reform-implementation/236033-fifteen-governors-reject-or-leaning-against-expanded-medicaid-program.

[8] *See* J. Lester Feder, *Sebelius: Exchange funding request was anticipated*, POLITICO PRO, Feb. 14, 2012, https://www.politicopro.com/go/?id=9220 [subscription only] ("We don't know if we're going to be running an exchange for 15 states, or 30 states.").

[9] *See* J. Lester Feder and Jason Millman, *Few States Set for Health Exchanges*, POLITICO, May 21, 2012, http://www.politico.com/news/stories/0512/76596.html ("Many insurance experts and health policy consultants predict only a dozen or so states will be ready to run exchanges on their own — and a few say that projection may be too sunny").

[10] We are indebted to Richard Urich for alerting us to the relationship between state-established Exchanges and the individual mandate's affordability exemption.

[11] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 76 FEDERAL REGISTER 50935 (August 17, 2011), *available at:* http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf.

IRS from issuing tax credits in federal Exchanges. The plain text of the Act only authorizes premium-assistance tax credits and cost-sharing subsidies for those who purchase plans on state-run Exchanges, and the IRS rule's attempt to offer them to other individuals cannot be legally justified on other grounds. In other words, the IRS is attempting to create two entitlements not authorized by Congress and, in the process, to tax employers and individuals whom Congress did not authorize the agency to tax.

It may be somewhat surprising that the PPACA contains such a gaping hole in its regulatory scheme. We were both surprised to discover this feature of the law, and initially characterized it as a "glitch."[12] Yet our further research demonstrates that this feature was intentional and purposeful, and that the IRS's rule has no basis in law. This supposed fix is actually an effort to rewrite the law and provide for something Congress never enacted, and indeed that the PPACA's authors intentionally chose not to include in the law.

This Article explains the importance of the law's limitation on the availability of tax credits for health insurance for implementation of the PPACA and details the case for and against the IRS rule. Part II provides a brief overview of the PPACA's legislative history and explains the regulatory structure that the Act creates to govern private health insurance markets—paying particular attention to the instability the law introduces into those markets, the role of tax credits and subsidies in mitigating that instability, and the central role of health insurance "Exchanges." Part III describes the IRS rule and the agency's justification for it. Part IV shows how the IRS rule is contrary to the text, structure, purpose, and history of the PPACA. Part V identifies and evaluates other potential legal rationales for the IRS rule and finds them

[12] *See, e.g.*, Jonathan H. Adler and Michael F. Cannon, *Another ObamaCare Glitch*, WALL ST. J., Nov. 16, 2011. The authors were first made aware of this aspect of the PPACA by a presentation by attorney Thomas Christina at the American Enterprise Institute in December 2010. *See* Thomas Christina, *What to Look for Beyond the Individual Mandate (And How to Look for It)* (Dec. 6, 2010), *available at*: http://www.aei.org/files/2010/12/06/Christina20101206.pdf.

wanting. Part VI explains that while an IRS rulemaking expanding the eligibility of tax credits or subsidies beyond that authorized by Congress would normally escape judicial review, the interactions of the tax credit provisions with the law's employer and individual mandates provides a basis for Article III standing to challenge the IRS rule. States may have standing to sue as well.[13] In other words, this question is likely to be resolved in federal court.

II. The PPACA

What we now call the PPACA is the product of three different bills, two of which originated in the Senate and a third that made limited amendments to the final Senate bill at the behest of the House of Representatives. In 2009, two Senate committees reported major health care legislation. On September 17, the Health, Education, Labor, and Pensions (HELP) Committee approved the "Affordable Health Choices Act" (S. 1679).[14] On October 19, the Senate Finance Committee approved the "America's Healthy Future Act of 2009" (S. 1796).[15] The two Senate bills shared many features. Before either bill reached the Senate floor, Senate Majority Leader Harry Reid (D-NV) assembled the chairmen of those committees and

[13] At the time of this writing, one state (Oklahoma) has filed suit against the IRS rule. *See* Wayne Greene, *AG Pruitt revises health-care suit, aims to block Affordable Care Act taxes, subsidies*, TULSA WORLD, Sept. 20, 2012, http://www.tulsaworld.com/news/article.aspx?subjectid=711&articleid=20120920_16_A11_CUTLIN601704.

[14] U.S Library of Congress: Thomas, *Bill Summary & Status, 111th Congress, S. 1697, All Information*, 2009, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:SN01679:@@@L&summ2=m&; Affordable Health Choices Act, S. 1697, 111th Cong. (2009), http://www.gpo.gov/fdsys/pkg/BILLS-111s1679pcs/pdf/BILLS-111s1679pcs.pdf.

[15] U.S Library of Congress: Thomas, *Bill Summary & Status, 111th Congress, S. 1796, All Information*, 2009, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:SN01796:@@@L&summ2=m&; America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009), http://www.gpo.gov/fdsys/pkg/BILLS-111s1796pcs/pdf/BILLS-111s1796pcs.pdf.

congressional and White House staff in his office in the U.S. Capitol, where they merged the two committee-reported bills into the Patient Protection and Affordable Care Act.[16]

Though Senate Democrats held a sixty-seat majority—the minimum necessary to break a Republican filibuster—Senator Reid had difficulty collecting yea votes from every member of his caucus.[17] Once he had corralled all sixty votes, Senate Democrats broke the Republican filibuster. The new Patient Protection and Affordable Care Act cleared the U.S. Senate before sunrise on December 24, 2009, without a vote to spare.[18]

Congressional Democrats had intended to have a conference committee merge the PPACA with the "Affordable Health Care for America Act" (H.R. 3962) that had passed the House of Representatives in November.[19] Had this occurred, the PPACA might look quite different than it does today. But in January 2010, Republican Scott Brown won a special election to fill the seat vacated by the death of Sen. Edward Kennedy (D-MA). Brown's victory shifted the political terrain. It gave Senate Republicans the forty-first vote necessary to filibuster a conference report on the House and Senate bills.

As a result, House and Senate Democrats abandoned a conference committee in favor of a novel strategy. House Democrats agreed to pass the PPACA exactly as it had passed in the Senate, but only upon receiving assurances that after the House amended the PPACA through the

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[16] David M. Herszenhorn and Robert Pear, *White House Team Joins Talks on Health Care Bill*, N.Y. TIMES, Oct. 14, 2009, http://www.nytimes.com/2009/10/15/health/policy/15health.html (quoting Senate Majority Leader Harry Reid (D-NV): "This is legislating at its best.").

[17] Brian Montopoli, *Tallying the Health Care Bill's Giveaways*, CBS NEWS, Dec. 21, 2009, http://www.cbsnews.com/8301-503544_162-6006838-503544.html.

[18] United States Senate, *Vote Summary: On Passage of the Bill (H.R. 3590 as Amended)*, (Dec. 24, 2009) http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396.

[19] U.S Library of Congress: *Thomas, Bill Summary & Status, 111th Congress, H.R. 3962, CRS Summary*, (Nov. 7, 2009), http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03962:@@@D&summ2=1&; Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009), http://www.gpo.gov/fdsys/pkg/BILLS-111hr3962pcs/pdf/BILLS-111hr3962pcs.pdf.

"budget reconciliation" process, the Senate would immediately approve those amendments. Since Senate rules protect reconciliation bills from a filibuster, the PPACA's supporters needed only fifty-one votes to pass the House's "reconciliation" amendments. The downside of this strategy was that the rules governing budget reconciliation limited the amendments House Democrats could make.[20] Supporters opted for an imperfect bill—that is, a bill that did not accomplish all they may have set out to do, but for which they had the votes—over no bill at all.

The Act signed into law by President Obama and the law that the IRS rule purports to implement—the PPACA—is thus a hybrid of the two Senate-committee-reported bills, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA).[21] This history, and the need to resort to the reconciliation process to pass the final law, helps explain why the final legislation looks as it does, and why the Act does not conform with the hopes or expectations of some of its supporters.[22]

III. The PPACA's Regulatory Structure

The PPACA attempts to achieve near-universal health insurance coverage through an interdependent system of government price controls, mandates, and subsidies. In order to understand the significance of the IRS rule, it is important to understand the role of health insurance Exchanges and how they were intended to complement the other reforms enacted by the PPACA.

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[20] John Carney, *How Does Reconciliation Work in Congress?*, BUSINESS INSIDER, Jan. 17, 2010 http://articles.businessinsider.com/2010-01-17/news/29990286_1_41st-vote-filibuster-vote-republican-filibuster; Alan Greenblatt, *Senate Faces Slog Over Health Bill Amendments*, NPR, Mar. 21, 2010, http://www.npr.org/templates/story/story.php?storyId=124993274.

[21] Congress has further amended PPACA through subsequent legislation. Those amendments do not affect the matter at hand.

[22] For example, in January 2010 eleven House Democrats raised objections to relying upon state-based health insurance exchanges as opposed to a single federal exchange. *See U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans*, MY HARLINGEN NEWS, Jan. 11, 2010, http://www.myharlingennews.com/?p=6426. Despite these concerns, all eleven voted in favor of the PPACA.

A. A Three-Legged Stool

Among the central features of the PPACA are new regulatory controls limiting medical underwriting by health insurance companies.[23] Specifically, the Act requires carriers to charge individuals of a given age the same premium, regardless of their health status.[24] This type of government price control, known as "community rating," reduces premiums for those with pre-existing conditions but increases premiums for low-risk consumers, and thereby encourages healthy people to wait until they fall ill to purchase health insurance.[25] Such price controls can produce a vicious cycle of adverse selection: the influx of high-risk consumers and exodus of low-risk consumers cause premiums to rise, which leads additional low-risk customers to drop coverage, leading to further price increases, and so on.[26] In other contexts, community-rating price controls have caused comprehensive health insurance plans and even entire carriers to exit certain health insurance markets,[27] often to the point of market collapse.[28]

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[23] Mark A. Hall, *The Factual Bases for Constitutional Challenges to the Constitutionality of Federal Health Insurance Reform*, 38 N. KY. L. REV. 457, 464 (2011) ("prohibiting medical underwriting" is among the PPACA's "core provisions").

[24] The Act prohibits carriers from adjusting premiums for any reason other than age (allowable variation: a 3 to 1 ratio for adults only); family size (two categories: individual or family); smoking status (carriers may charge smokers up to 50 percent more than nonsmokers); or by geographic "rating areas." Carriers may not adjust premiums according to an applicant's health status or sex. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Section 1201, 124 Stat. 155 (2010).

[25] The Act's "guaranteed issue" provisions also require carriers to offer health insurance to all applicants, regardless of health status.

[26] Thomas C. Buchmueller, *Consumer Demand for Health Insurance*, NBER REPORTER (2006), *available at:* http://www.nber.org/reporter/summer06/buchmueller.html. (Discussing health insurance exchanges at Harvard University and the University of California system: "One factor contributing to adverse selection in the UC and Harvard cases is that, in each system, premium contributions faced by employees and premium payments to plans were 'community rated' – that is, they did not vary with the risk characteristics of those being insured. As discussed earlier, one result is thus that the most generous plan faced an adverse selection death spiral.")

[27] Thomas C. Buchmueller, *Consumer Demand for Health Insurance*, NBER REPORTER (Summer 2006), *available at:* http://www.nber.org/reporter/summer06/buchmueller.html.

[28] Brief for Texas Public Policy Foundation, et al. as Amici Curiae Supporting Petitioners, Nat'l Fed. of Indep. Business v. Sebelius, 567 U.S ___ (2012) Nos. 11-393 & 11-400, ("Before Congress took up health care reform in 2009, a handful of states had experimented with major health insurance reforms including guaranteed issue and some form of community rating compression, focused on the individual insurance market. These reform efforts generally had disastrous effects: States experienced adverse selection spirals, with increased numbers of uninsured,

To combat the instability introduced by its community-rating price controls, the Act imposes an "individual mandate" that requires nearly all Americans to purchase a health insurance policy covering a minimum package of "essential" coverage.[29] Failure to comply may result in a penalty paid to the IRS.[30] In addition, the Act imposes an "employer mandate" that requires employers to offer "affordable" health benefits of "minimum value" to all full-time employees and their dependents.[31] Failure may result in penalties against the employer.[32] The combined effect of the PPACA's price controls and individual mandate is that health-insurance premiums could increase by as much as 100 percent or more for some young and healthy households.[33]

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large premium increases, and insurers exiting the individual market." (internal citations omtitted)). U.S. SENATE, COMM. ON HEALTH, EDUCATION, LABOR AND PENSIONS, RANKING MEMBER REPORT: HEALTH CARE REFORM LAW'S IMPACT ON CHILD-ONLY HEALTH INSURANCE POLICIES (Aug. 2, 2011), http://help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf; CENTERS FOR MEDICARE AND MEDICAID SERVICES, OFFICE OF THE ACTUARY, ESTIMATED FINANCIAL EFFECTS OF THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT," AS AMENDED 14 (Apr. 22, 2010), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf ("Although Title VIII includes modest work requirements in lieu of underwriting and specifies that the program is to be 'actuarially sound' and based on 'an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period,' there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.").

[29] *See* Hall, *supra* note __.

[30] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Section 1501, 124 Stat. 244 (2010). Although styled as a penalty for failure to comply with a regulatory mandate, the Supreme Court ultimately upheld thepenalty as an exercise of the federal government's taxing power. *See* Nat'l Fed'n Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2594-2600 (2012).

[31] *Id.* § 1513 revised by the Health Care and Education Reconciliation Act of 2010 (Defining an "applicable large employer" as one "who employed an average of at least 50 full-time employees on business days during the preceding calendar year.").

[32] *Id.*

[33] JONATHAN GRUBER ET AL., THE IMPACT OF THE ACA ON WISCONSIN'S HEALTH INSURANCE MARKET (July 18, 2011). ("Prior to tax subsidies, 41% of the market will receive a premium increase that is higher than 50%...54% of the members receiving greater than a 50% premium increase are age 29 or under.); Email Correspondence from Dennis Smith, Wisconsin Secretary of Health Services, (Jan. 13, 2012) (Citing supplemental findings from Gruber et al.: "Another way to look at the data is to just look at the 1% of single policies that see the highest increases after accounting for the tax subsidy. In this case these 'top' 1% see an average increase of 126%."); JEREMY D. PALMER, JILL S. HERBOLD, AND PAUL R. HOUCHENS, MILLIMAN CLIENT REPORT: ASSIST WITH THE FIRST YEAR OF PLANNING FOR DESIGN AND IMPLEMENTATION OF A FEDERALLY MANDATED AMERICAN HEALTH BENEFITS EXCHANGE IN THE INDIVIDUAL MARKET 7 (2011), *available at*: http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf, ("In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%.").

Given the burden those higher premiums will impose on low-income households, the Act offers refundable "premium assistance" tax credits to households with incomes between 100 and 400 percent of the federal poverty level (FPL).[34] The Act further offers "cost-sharing subsidies" that enable households between 100 and 250 percent of FPL to obtain, at no additional cost to themselves, more than the mandatory minimum level of coverage.[35] This premium assistance, however, is only available for the purchase of insurance in health care exchanges.[36]

These features of the PPACA's regulatory scheme are interdependent. An apt metaphor is that of a three-legged stool: removing any of the three above-mentioned "legs"—the price controls, the individual mandate, or the tax credits and subsidies—could cause the structure to collapse. Remove the price controls, and premiums for high-risk households would increase dramatically; those households would have a more difficult time complying with the individual mandate. Remove either the individual mandate or the tax credits, and the Act's price controls would further threaten the viability of health insurance markets by pushing low-income/low-risk households to exit the market.

B. Exchanges, Tax Credits & the Employer Mandate

Health insurance exchanges ("Exchanges") play an essential role in PPACA's regulatory scheme. As the Department of Health and Human Services (HHS) explains, "Exchanges are integral to the Affordable Care Act's goals of prohibiting discrimination against people with pre-

[34] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1401, 124 Stat. 119, 213-214 (2010) Revised by Sec. 1001(a)(1)(A) of the Health Care and Education Reconciliation Act (HCERA).

[35] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1402, 124 Stat. 119, 221-222 (2010) Revised by Sec. 1001(a)(2) of HCERA.

[36] *See infra*

existing conditions and insuring all Americans."[37] Specifically, Exchanges are government agencies that oversee the buying and selling of health insurance within a state; monitor carriers' compliance with the Act's health-insurance price controls, implement measures to mitigate the perverse incentives created by the Act's price controls;[38] report to the IRS on whether individuals and employers are complying with the individual and employer mandates;[39] and distribute hundreds of billions of dollars in government subsidies to private health insurance companies.[40]

Like the individual and employer mandates, Exchanges help to limit how much of the cost of the Act's insurance expansion appears in the federal budget. By requiring households to give money directly to insurance companies, the individual mandate keeps those transactions off the government's books.[41] Likewise, the employer mandate requires employers to purchase

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[37] CENTERS FOR MEDICARE & MEDICAID SERVICES, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES 3 (May 16, 2012), http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

[38] Timothy S. Jost, *Implementing Health Reform: A Final Rule On Health Insurance Exchanges*, HEALTH AFFAIRS BLOG, Mar. 13, 2012, http://healthaffairs.org/blog/2012/03/13/implementing-health-reform-a-final-rule-on-health-insurance-exchanges/. In this essay, Jost explains that state-run Exchanges

> must ensure that [qualified health plan] service areas cover at least a county except under exceptional circumstances to discourage redlining. The final rule QHP standards require QHPs to meet network adequacy standards. Specifically, plans must maintain 'a network that is sufficient in number and types of provides, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay' and include essential community providers. QHPs…cannot employ marketing practices or benefit designs that will discourage enrollment of individuals with significant health needs.

Id.

[39] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 177 (2010).

[40] *Executive Business Meeting to Consider an Original Bill Providing for Health Care Reform: Hearing before the S. Comm. on Finance*, 111th Cong. (2009) (Testimony of Tom Barthold, Chief of Staff of the Joint Committee on Taxation) ("in terms of the direct payment, the mark would direct the payments go directly to the insurance provider"); *see also id.* (Testimony of Douglas W. Elmendorf, Director, Congressional Budget Office).

[41] *See* Michael F. Cannon, *The $1.5 Trillion Fraud*, NATIONAL REVIEW (ONLINE), Nov. 6, 2009, http://www.cato.org/publications/commentary/$15-trillion-fraud. ("President Clinton's ill-fated health plan had an individual mandate, too. Back in 1994, the CBO decided that since 'the mandatory premiums . . . would constitute an exercise of sovereign power,' the agency would treat all premiums as federal revenues, including them in the federal budget. That revealed to the public the full cost of Clinton's health plan. Clinton's secretary of health and human services, Donna Shalala, called the CBO's decision 'devastating.' Journalist Ezra Klein writes that it 'helped kill the bill.'"). *See also* Michael F. Cannon, *Bland CBO Memo, or Smoking Gun?* CATO@LIBERTY, Dec. 16, 2009, http://www.cato-at-liberty.org/bland-cbo-memo-or-smoking-gun/ (explaining how the PPACA's authors carefully avoided having the CBO include the mandatory premiums in federal budgets).

coverage for their workers, thereby removing those transactions from the federal budget and even household budgets.[42] In this way, the PPACA achieves its redistributionist goals off-budget.

Similarly, Exchanges reduce the Act's impact on the federal budget by limiting eligibility for tax credits and subsidies. Allowing all households within the relevant income ranges to claim these entitlements would dramatically increase the federal deficit and significantly disrupt existing employer-sponsored insurance arrangements. The PPACA's authors therefore offered these entitlements only to certain households that purchase a qualified health plan through an Exchange. In addition to household-income criteria, individuals are eligible for tax credits only if they are not Medicaid-eligible and do not receive an offer of "minimum value" and "affordable" self-only health coverage from an employer.[43]

Offering tax credits and subsidies within Exchanges, however, creates an incentive for employers to drop their health benefits so that their workers can gain access to them. If employers did so in large numbers, the PPACA's budgetary footprint would grow.[44] The

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[42] The money employers use to purchase employee health benefits comes out of employees' cash compensation rather than profits. *See* JONATHAN GRUBER, *Health Insurance and the Labor Market*, JOSEPH NEWHOUSE AND ANTHONY CULYER, EDS., THE HANDBOOK OF HEALTH ECONOMICS. AMSTERDAM: NORTH HOLLAND, P. 645-706.

[43] The PPACA defines "minimum value" as coverage with an actuarial value of at least 60 percent, and defines "affordable" as when the explicit (i.e., employee-paid) portion of the premium for self-only coverage is less than 9.5 percent of household income. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1401, 124 Stat.119, 216-217 (2010) Revised by Sec. 1001(a)(2)(A) of HCERA. According to the IRS:

> Consistent with these statutory provisions, the proposed regulations provide that an employer-sponsored plan also is affordable for a related individual for purposes of section 36B if the employee's required contribution for self-only coverage under the plan does not exceed 9.5 percent of the applicable taxpayer's household income for the taxable year, even if the employee's required contribution for the family coverage does exceed 9.5 percent of the applicable taxpayer's household income for the year.

Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 76 FEDERAL REGISTER 50935 (Aug. 17, 2011), *available at:* http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf. Functionally, employer plans must also satisfy certain benefit mandates imposed by Section 1001 of the PPACA, though these mandates technically operate independently of the employer mandate. *See* http://www.americanbenefitscouncil.org/documents/hcr_ehb_summary-cm020112.pdf.

[44] This would also further undermine the claim made by the PPACA's proponents that it would not cause people to lose their existing health insurance. *See e.g., Barack Obama promises you can keep your health insurance, but there's no guarantee,* POLITIFACT, Aug. 11, 2009, http://www.politifact.com/truth-o-

employer mandate attempts to prevent such employer "dumping." It penalizes employers with more than fifty workers if they fail to offer "minimum value" and "affordable" health benefits to all employees. By compelling employers to offer health benefits, and thereby restricting access to the Exchanges, the employer mandate reduces the federal budgetary impact of the Act's insurance expansion and reduces disruption to existing insurance arrangements.[45]

Exchanges, in turn, play an essential role in enforcing the employer mandate. Before the IRS may levy a penalty against an employer, (1) the employer must fail to offer "minimum value" or "affordable" coverage to all full-time employees and their dependents, and (2) one of the employer's full-time employees must enroll in a qualified health plan through an Exchange "to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee."[46] If an employer fails to offer "minimum value" coverage, the Act fines the employer $2,000 for every full-time employee who is eligible for a tax credit through an Exchange (after exempting the first thirty employees). If an employer offers coverage that is "minimum value" but not "affordable," the Act fines the employer either $3,000 for each employee who receives or is eligible for a tax credit through an Exchange, or the penalty for not

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meter/statements/2009/aug/11/barack-obama/barack-obama-promises-you-can-keep-your-health-ins/ (Quoting President Barack Obama: "If you like your health care plan, you can keep your health care plan.")

[45] Some analysts predict worker exodus and employer dumping will occur despite the PPACA's attempts to prevent it. DOUGLAS HOLTZ-EAKIN & CAMERON SMITH, LABOR MARKETS AND HEALTH CARE REFORM: NEW RESULTS (May 2010), *available at:* http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf. *But see* LINDA BLUMBERG ET AL., "WHY EMPLOYERS WILL CONTINUE TO PROVIDE HEALTH INSURANCE: THE IMPACT OF THE AFFORDABLE CARE ACT (2011), *available at:* http://www.urban.org/UploadedPDF/412428-The-Impact-of-the-Affordable-Care-Act.pdf; *see also* CONGRESSIONAL BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT (2012), *available at:* http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf; CONGRESSIONAL BUDGET OFFICE, CBO AND JCT'S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE (2012), *available at:* http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf.

[46] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1513, 124 Stat. 119, 253 (2010).

offering "minimum value" coverage, whichever is less.[47] Employer groups have expressed concern about both the size and the unpredictability of these penalties.[48]

C. Tax Credits & the Individual Mandate

Exchanges also play a key role in the enforcement of the individual mandate. Subject to certain exemptions, the PPACA requires all U.S. residents to obtain a minimum level of health insurance coverage or pay a tax penalty.[49] When fully phased-in by 2016, penalties will be the greater of a flat fee of $695 (singles) to $2,085 (families of four or more) or 2.5 percent of income in excess of the income-tax filing threshold, up to a limit of the nationwide average premium of all "bronze" level health plans available to the taxpayer's age and household size.[50] One estimate posits the maximum penalty will reach $7,779 for a single fifty-five year old, and $18,085 for a family of four with a fifty-five year-old head of household, by 2016.[51]

The Act exempts taxpayers from that penalty if coverage is deemed not "affordable"—defined as when the "required contribution" to the cost of health insurance exceeds roughly 8

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[47] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1513, 124 Stat. 119, 253-256 amended by HCERA (adds Sec. 4980H to the Internal Revenue Code).

[48] *February Outlook: Business and Health Reform*, COBANK, http://www.cobank.com/Newsroom-Financials/CoBank-News-Feed/February-Outlook.aspx. (Last visited July 10, 2012) (Quoting Robert Graboyes, Senior Fellow for Health and Economics at the National Federation of Independent Business Research Foundation):

> What makes it very difficult for businesses is that the penalties involve so much that is outside of their control or even outside of their view. Let's say you're married with two children and you and your wife together earn $100,000. Now your wife's income drops a bit, and you're below $89,000. Your employer and your wife's employer will both be slammed with a fine. I have jokingly referred to this as the 'employee's spouse's uncle tax,' because it is literally true that an employer could be fined because one of its employees has a spouse who has an elderly uncle who moves into their spare bedroom, thereby increasing family size.

[49] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1501, 124 Stat. 119, 242-250 amended by HCERA (adds Sec. 5000A to the Internal Revenue Code).

[50] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, I.R.C § 5000A(b) and (c), 124 Stat. 119, 244-246 (amended by PPACA Sec. 10106 (b), 124 Stat. 119, 909-910).

[51] Milliman, p. 11, *available at:* http://publications.milliman.com/publications/health-published/pdfs/measuring-strength-individual-mandate.pdf.

percent of household income.[52] In the case of a household that does not have an offer of "minimum value" and "affordable" coverage from an employer, the "required contribution" is the difference between the premium for the lowest-cost plan available to the household through an Exchange, and any premium-assistance tax credit for which the household is eligible.[53]

Importantly, the mere fact that a taxpayer is eligible for premium-assistance tax credits will deprive many taxpayers of this "affordability" exemption. Their eligibility for tax credits will bring their "required contribution" below 8 percent of household income, thereby subjecting them to penalties.

D. Tax Credits & State-Run Exchanges

The PPACA's authors envisioned that each state would have its own Exchange, operated by state officials. As President Obama explained shortly after signing the PPACA, "by 2014, each state will set up what we're calling a health insurance exchange."[54] The PPACA does not force states to create Exchanges, however. Though the Act declares that each state "shall" create an Exchange and lays out rules for state-run Exchanges,[55] it does not and could not mandate that states establish one.[56] A direct command that state governments assist in the implementation of a

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[52] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, I.R.C § 5000A(e)(1)(A), 124 Stat. 119, 246-247 (2010).

[53] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, I.R.C § 5000A(e)(1)(B)(ii), 124 Stat. 119, 247 (2010).

[54] Barack Obama, U.S President, Remarks on Health Insurance Reform in Portland, Maine (April 1, 2010), *available at*: http://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-portland-maine. *See also*, Nat'l Fed'n Indep. Bus. v. Sebelius, 567 U.S. at __ (2012) (Scalia, Kennedy, Thomas, and Alito, JJ. dissenting) ("The ACA requires each State to establish a health insurance 'exchange.'").

[55] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 173 (2010).

[56] *See* Jonathan H. Adler, *Cooperation, Commandeering or Crowding Out? Federal Intervention and State Choices in Health Care Policy*, 20 KAN. J.L. & PUB. POL'Y 199 (2011); *see also* Michael F. Cannon, *Will States Lose Medicaid Funds If They Fail to Create an ObamaCare 'Exchange'?*" CATO@LIBERTY, Feb. 6, 2012, http://www.cato-at-liberty.org/will-states-lose-medicaid-funds-if-they-fail-to-create-an-obamacare-%E2%80%98exchange%E2%80%99/.

federal regulatory scheme would constitute unconstitutional commandeering.[57] If Congress believes state cooperation is necessary to facilitate the implementation of a federal program, it must create incentives for state action. The Supreme Court has explained there are "a variety of methods, short of outright coercion, by which Congress may urge a State to adopt a legislative program consistent with federal interests."[58] Among other things, the federal government may offer states financial assistance or threaten to implement the program directly if the state refuses to go along.[59] The use of such incentives to induce state cooperation is often referred to as "cooperative federalism"[60] and is quite common. In the PPACA, Congress used such "cooperative" measures to encourage state creation of Exchanges.

Though the Act provides that states "shall" create their own exchanges, it actually gives states a choice. Section 1311 declares, "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')" and lays out rules for state-run Exchanges.[61]

If a state fails to create an Exchange under Section 1311, the Act directs the federal Department of Health and Human Services to create an Exchange for that state.[62] Specifically,

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[57] *See* Printz v. United States, 521 U.S. 898, 925 (1997) ("the Federal Government may not compel the states to implement, by legislation or executive action, federal regulatory programs."); New York v. United States, 505 U.S. 144, 162 (1992) ("the Constitution has never been understood to confer upon Congress the ability to require States to govern according to Congress's instructions").

[58] *New York*, 505 U.S. at 167.

[59] *See NFIB*, 132 S.Ct. at 2602 ("Congress may use its spending power to create incentives for States to act in accordance with federal polices. But when 'pressure turns into compulsion,' the legislation runs contrary to our system of federalism." (citation omitted)).

[60] *New York*, 505 U.S. at 167 ("where Congress has the authority to regulate private activity under the Commerce Clause, we have recognized Congress' power to offer States the choice of regulating that activity according to federal standards or having state law pre-empted by federal regulation . . . This arrangement . . . has been termed "a program of cooperative federalism.").

[61] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 173 (2010). Among the "requirements" for purposes of Section 1311, an Exchange must be "a governmental agency or nonprofit entity that is established by a State." *Id.* § 1311(d)(1).

[62] *Id.*, § 1321.

Section 1321 requires the HHS Secretary to "establish and operate" an Exchange within any state that either fails to create an exchange or fails to implement the PPACA's health insurance regulations to the Secretary's satisfaction. Section 1321 thus requires a federal "fallback" for states that do not create Exchanges of their own.

As noted above, the PPACA provides tax credits for the purchase of qualifying health insurance plans on such Exchanges. Specifically, Section 1401 adds a new Section 36B to the Internal Revenue Code that authorizes refundable "premium assistance tax credits" for the purchase of qualifying health insurance plans in exchanges established by states under Section 1311.[63] These are "refundable" tax credits, meaning that in many cases the credit does not just reduce tax liability but also results in government outlays—initially to taxpayers, but ultimately to private insurance companies.[64] Section 1402 also authorizes "cost-sharing" subsidies for the purchase of health insurance plans on Exchanges. Congress designed these subsidies to help lower-income households obtain more comprehensive coverage .[65] Section 1402 makes these direct outlays to private health insurance companies available only where tax credits are available—i.e., through state-run exchanges.[66]

III. The IRS Rule

On August 17, 2011, the IRS proposed a regulation to implement Section 36B that would offer premium-assistance tax credits through federal Exchanges. As proposed by the IRS, the rule provided that:

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[63] *Id.*, §1401.

[64] Nonrefundable credits only reduce a taxpayer's tax liability. For example, if a taxpayer has a $5,000 tax liability and is eligible for a $6,000 non-refundable credit, it will wipe out her tax liability but she will receive only $5,000 of benefit rather than the full $6,000. If the credit is refundable, however, she receives the full $6,000 benefit: the credit wipes out her $5,000 tax liability and the IRS issues her a $1,000 payment.

[65] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1402, 124 Stat. 119, 221 (2010).

[66] *Id.*

> a taxpayer is eligible for the credit for a taxable year if . . . the taxpayer or a member of the taxpayer's family (1) is enrolled in one or more qualified health plans through an Exchange established under [S]ection 1311 *or 1321* of the Affordable Care Act . . . .[67]

If the tax credits authorized by Section 1401 are to be available without regard to whether an insurance plan is purchased through a state-run (Section 1311) or federal Exchange (Section 1321), the same will be true for cost-sharing subsidies, which Section 1402 makes available wherever tax credits are available. Since the receipt of tax credits or cost-sharing subsidies by workers triggers tax penalties against employers, another result of the rule is that it taxes employers who otherwise would be exempt from PPACA's employer mandate—i.e., employers in states that decline to create an Exchange. Because the availability of tax credits will reduce the "required contributions" of many taxpayers from above 8 percent of household income to below that threshold, another result is that the rule taxes many individuals who would otherwise be exempt from the individual mandate—again, individuals in states that decline to create an Exchange.

The proposed rule did not identify any specific statutory authority for the extension of tax credits and cost-sharing subsidies, or the imposition of the individual and employer mandates on exempt persons, through federal Exchanges. And indeed the plain text of the PPACA does not authorize these actions in federal Exchanges. The rule thus amends the tax code by offering tax credits not authorized by the statute, and by taxing individuals and employers whom the statute does not authorize the IRS to tax. The IRS's decision to offer tax credits in federal Exchanges,

[67] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 76 FEDERAL REGISTER 50934 (August 17, 2011) (emphasis added), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf.

and its rationale for that decision, are departures from the agency's strict adherence to the plain meaning of the statute concerning far less consequential matters.[68]

Ironically, tax reduction is only a minor part of the tax-credit rule's impact. On balance, the rule is a large tax increase. Since the tax credits are "refundable" (i.e., individuals with no tax liability receive a cash payout from the IRS) and the cost-sharing subsidies are federal payments that flow directly to private health insurance companies, the rule also appropriates federal dollars

[68] *See, e.g.*, Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30378 (May 23, 2012), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf ("Commentators requested that the final regulations treat a taxpayer whose household income exceeds 400 percent of the FPL for the taxpayer's family size as an applicable taxpayer if, at enrollment, the Exchange estimates that the taxpayer's household income will be between 100 and 400 percent of the FPL for the taxpayer's family size and approves advance credit payments. Other commentators advocated allowing taxpayers with household income above 400 percent of the FPL for their family size to be treated as eligible for a premium tax credit for the months before a change in circumstances affecting household income occurs or for the months for which the taxpayer receives advance payments. The final regulations do not adopt these comments because they are contrary to the language of section 36B limiting the premium tax credit to taxpayers with household income for the taxable year at or below 400 percent of the FPL for the taxpayer's family size."); Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30378 (May 23, 2012), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf ("Commentators requested that the final regulations allow an individual who may be claimed as a dependent by another taxpayer to qualify as an applicable taxpayer for a taxable year if, for the taxable year, another taxpayer does not claim the individual as a dependent. The final regulations do not adopt this comment because it is inconsistent with section 36B(c)(1)(D), which provides that a premium tax credit is not allowed to any individual for whom a deduction under section 151 is ''allowable to another taxpayer'' for the taxable year."); Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30379 (May 23, 2012), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf ("Commentators requested that the final regulations define eligibility for government-sponsored programs as actual enrollment for individuals suffering from end stage renal disease who become eligible for Medicare as a result of their diagnosis. Other commentators requested this treatment for any individual suffering from an acute illness who becomes eligible for a government-sponsored program…Section 36B(c)(2)(B) establishes a clear structure under which eligibility for government-sponsored minimum essential coverage in a given month precludes including an individual in a taxpayer's coverage family for purposes of computing the premium assistance amount for that month. In keeping with the statutory scheme, the final regulations do not adopt these comments."); Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30384 (May 23, 2012), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf ("Commentators suggested that the final regulations adopt a safe harbor for individuals and families who can demonstrate that they accurately reported any changes in income or family size to the Exchange and that their advance payments were properly computed based on the information available at the time the payments were made. Commentators suggested that taxpayers who experience changes in circumstances during the year, including taxpayers whose household income for the taxable year exceeds 400 percent of the FPL, should be allowed to prorate the repayment limitations based on the portion of the year the taxpayer receives advance payments. Other commentators asked that taxpayers who would experience a hardship as a result of repaying excess advance payments be exempt from the repayment requirement or that the IRS should disregard changes that cause income to slightly exceed 400 percent of the FPL. Commentators also suggested that taxpayers be allowed to compute their premium tax credit using the largest family size of the household during the year rather than the family size reported on the tax return. The statute sets forth clear rules for reconciling advance credit payments, which are not consistent with the suggestions made by the commentators. Accordingly, the final regulations do not adopt these comments.").

without statutory authority. Those expenditures completely swamp any tax reduction. Official projections show 78 percent of the budgetary impact of the tax credits and cost-sharing subsidies is new spending, with tax reduction accounting for just 22 percent.[69] Net of revenue from the employer-mandate penalties that those tax credits will trigger, new spending accounts for roughly 90 percent of the rule's budgetary impact, and tax reduction just 10 percent.[70] Roughly speaking, for every two dollars of tax reduction, the rule triggers one dollar in immediate tax increases and eight dollars of deficit spending. Since every dollar of deficit spending must eventually be financed through taxes, taxpayers will bear the burden of those eight dollars as well.

The actual cost of the rule cannot be known with certainty, as it depends on how many and which states ultimately decline to create an Exchange or to implement the law's Medicaid expansion. But its cost is certainly larger than a routine IRS rule. [71] As of December 10, 2012, over twenty state governments had declared their intention to default to a federal exchange,

[69] Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to John Boehner, Speaker of the House, Direct Spending and Revenue Effects of H.R. 6079, the Repeal of Obamacare Act, as Passed by the House of Representatives on July 11, 2012 (July 24, 2012), *available at:* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf and authors' calculations.

[70] Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to John Boehner, Speaker of the House, Direct Spending and Revenue Effects of H.R. 6079, the Repeal of Obamacare Act, as Passed by the House of Representatives on July 11, 2012 (July 24, 2012), *available at:* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf and authors' calculations.

[71] Curiously, the IRS concluded that the rule would not have a significant economic effect. See Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30378 (May 23, 2012), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf ("It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required"). Yet by authorizing tax credits in as many as 15 to 30 states without state-run exchanges, the rule clearly exceeds the statutory threshold for significant rules. The rule would seem to qualify as a "significant regulatory action" under EO 12866 and a "major rule" under the Congressional Review Act. *See* Executive Order 12,866 (defining a "significant regulatory action" as a regulation expected to have an annual effect on the economy of $100 million or more); 5 U.S.C. § 804 (2) (defining major rule as a regulation any rule with an anticipated annual cost or economic effect of $100 million or more).

including Florida,[72] New Hampshire,[73] Louisiana,[74] Wisconsin,[75] South Carolina,[76] Texas,[77] and Virginia,[78] among others.[79] Estimates by the Urban Institute suggest that had this rule been in effect in 2011, it would have cost more than $2 billion in Florida alone.[80] If no state created an Exchange, Congressional Budget Office estimates suggest the rule could cost the federal government $1 trillion or more over the next decade, offset by no more than $172 billion or more collected from penalties under the individual and employer mandates.[81] In this scenario, the rule would increase federal deficits by an estimated $828 billion.

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[72] *Scott: We Won't Comply With Medicaid Expansion*, CBS MIAMI, June 30, 2012, http://miami.cbslocal.com/2012/06/30/scott-we-wont-comply-with-medicaid-expansion/

[73] Matthew Spolar, *Lynch Signs Bill Prohibiting State Health Exchange*, CONCORD MONITOR, June 22, 2012, http://www.concordmonitor.com/article/337540/lynch-signs-bill-prohibiting-state-health-exchange?SESSefad2452e208c288985b42a449cd73d8=google.

[74] Reid Epstein, *GOP Governors Aim for Health Showdown*, POLITICO, June 29, 2012, http://www.politico.com/news/stories/0612/78024.html.

[75] *Governors React Nationwide to High Court Ruling*, STATELINE, June 28, 2012, http://www.pewstates.org/projects/stateline/headlines/governors-react-nationwide-to-high-court-health-ruling-85899402014.

[76] Rocky Dohmen, *Haley Announces 'Obamacare' Stance on Facebook*, DIGITEL MYRTLE BEACH , July 2, 2012, http://myrtlebeach.thedigitel.com/politics/haley-announces-obamacare-stance-facebook-36696-0702.

[77] Letter from Texas Gov. Rick Perry (R) to U.S. Secretary of Health and Human Services Kathleen Sebelius, July 9, 2012, http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf.

[78] Michael Martz, *Va. To Use Federal Health Exchange Option – For Now*, RICHMOND TIMES-DISPATCH, Nov. 8, 2012, http://www.timesdispatch.com/news/state_regional/govt_politics/va-to-use-federal-health-exchange-option-for-now/article_15259304-6448-572a-80dd-2110d33fc769.html

[79] *See* Kaiser Family Foundation, State Health Facts, *State Decisions For Creating Health Insurance Exchanges in 2014, as of December 10, 2012*, http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17. The states are —Alabama, Alaska, Arizona, Florida, Georgia, Kansas, Louisiana, Maine, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Virginia, Wisconsin, and Wyoming..

[80] MATTHEW BUETTGENS, JOHN HOLAHAN AND CAITLIN CARROLL, HEALTH REFORM ACROSS THE STATES: INCREASED INSURANCE COVERAGE AND FEDERAL SPENDING ON THE EXCHANGES AND MEDICAID 17 (2011), *available at:* http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf.

[81] In March 2012, the Congressional Budget Office estimated that "Exchange Subsidies and Related Spending" would cost the federal government $808 billion in new expenditures and forgone revenues from 2012 through 2022, offset by $113 billion in employer-mandate penalties and $54 billion in individual-mandate penalties. CONGRESSIONAL BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT (2012), *available at:* http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf. Those projections, which assumed the availability of tax credits in all states, provided an upper-bound estimate of the cost of the IRS rule (i.e., in the unlikely scenario that zero states established an Exchange), which we cited in a previous draft of this paper.

After the rule was proposed, commentators and several members of Congress raised concerns about the IRS' apparent lack of statutory authority.[82] In response, IRS officials and representatives of both the Treasury and HHS Departments insisted such authority was in the Act, yet cited no specific provisions to that effect.[83] A Treasury Department spokeswoman said the Department is "confident that providing tax credits to all eligible Americans, no matter where they live and whether their state runs the exchange, is consistent with the intent of the law and our ability to interpret and implement it."[84]

On November 3, 2011, two dozen members of the House of Representatives wrote IRS Commissioner Douglas H. Shulman that the proposed rule "contradicts the explicit statutory

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The potential cost of the IRS rule subsequently rose as a result of the Supreme Court's June 2012 ruling that Congress cannot deny existing federal Medicaid grants to states that refuse to implement the PPACA's Medicaid expansion, and states' responses to that ruling. If a state opts not to implement the Medicaid expansion, more of its population (specifically, individuals between 100-138 percent of the federal poverty level without an offer of insurance from an employer) becomes eligible for premium-assistance tax credits and cost-sharing subsidies. A number of states have indicated they will not implement the Medicaid expansion, while many are still examining the issue.

In July 2012, the CBO to revised its estimate of the cost of "Exchange Subsidies and Related Spending" to slightly more than $1 trillion, offset by $55 billion in individual-mandate penalties and $117 billion in employer-mandate penalties. *See* CONGRESSIONAL BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION (July 2012), *available at*: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf. The potential cost of the IRS rule will climb higher still if more states refuse to expand their Medicaid programs than the CBO assumed.

[82] Letter from David P. Roe, Representative, U.S. House of Representatives, to Douglas Shulman, Commissioner, Internal Revenue Service (Nov. 4, 2011), http://roe.house.gov/UploadedFiles/Letter_to_IRS_Commissioner_regarding_tax_credits_under_PPACA_-_11.03.11.pdf; Letter from Orrin G. Hatch, Senator, US Senate, to Timothy Geithner, Secretary, US Treasury and Douglas Shulman, Commissioner, Internal Revenue Service (Dec. 1, 2011), http://finance.senate.gov/newsroom/ranking/download/?id=d8c3f533-132c-4cec-be10-8008402c21d8.; *see also* Adler and Cannon, *Another ObamaCare Glitch*, *supra*.

[83] *See, e.g.*, Letter from Douglas H. Shulman, Commissioner, Internal Revenue Service, to David P. Roe, Representative, U.S. House of Representatives, Response to Letter Regarding Premium Tax Credits Under PPACA, (Nov. 29, 2011), *available at:* http://roe.house.gov/UploadedFiles/IRS_Response_to_letter_on_PPACA_Exchange.pdf; CENTERS FOR MEDICARE AND MEDICAID SERVICES, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, STATE EXCHANGE IMPLEMENTATION QUESTIONS AND ANSWERS 8, (November 29, 2011) (emphasis added), *available at:* http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf.

[84] *See* Sara Hansard, *Private Exchanges Could Impact Success of State Exchanges*, BNA HEALTH INSURANCE REPORT, Oct. 26, 2011.

language describing individuals' eligibility for receipt of these tax credits."[85] On November 29, Shulman responded:

> The statute includes *language that indicates* that individuals are eligible for tax credits whether they are enrolled through a State-based Exchange or a Federally-facilitated Exchange. Additionally, neither the Congressional Budget Office score nor the Joint Committee on Taxation technical explanation of the Affordable Care Act discusses excluding those enrolled through a Federally-facilitated Exchange.[86]

On November 29, the Department of Health and Human Services offered a similar defense:

> The proposed regulations . . . are clear on this point and *supported by the statute*. Individuals enrolled in coverage through either a State-based Exchange or a Federally-facilitated Exchange may be eligible for tax credits . . . Additionally, neither the Congressional Budget Office score nor the Joint Committee on Taxation technical explanation discussed limiting the credit to those enrolled through a State-based Exchange.[87]

Despite the public concerns about the proposed regulations, the IRS stayed the course. Late in the afternoon on Friday, May 18, 2012,[88] the IRS issued a final rule adopting its proposal

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[85] Letter from David P. Roe, Representative, U.S. House of Representatives, to Douglas Shulman, Commissioner, Internal Revenue Service (Nov. 4, 2011), *available at:* http://roe.house.gov/UploadedFiles/Letter_to_IRS_Commissioner_regarding_tax_credits_under_PPACA_-_11.03.11.pdf.

On December 1, Senate Finance Committee ranking member Orrin Hatch (R-UT) likewise pressed this issue in a letter to Shulman and Treasury Secretary Timothy Geithner. Sam Baker, *Hatch: IRS can't offer tax credits in federal insurance exchange*, THE HILL, Dec. 1, 2011, http://thehill.com/blogs/healthwatch/health-reform-implementation/196585-hatch-irs-cant-offer-tax-credits-in-federal-insurance-exchange; and Letter from Orrin G. Hatch, Senator, U.S. Senate, to Timothy Geithner, Secretary, Department of the Treasury and Douglas Shulman, Commissioner, Internal Revenue Service (Dec. 1, 2011), *available at:* http://finance.senate.gov/newsroom/ranking/download/?id=d8c3f533-132c-4cec-be10-8008402c21d8.

[86] Letter from Douglas H. Shulman, Commissioner, Internal Revenue Service, to David P. Roe, Representative, U.S. House of Representatives (Nov. 29, 2011), *available at:* http://roe.house.gov/UploadedFiles/IRS_Response_to_letter_on_PPACA_Exchange.pdf (emphasis added).

[87] CENTERS FOR MEDICARE AND MEDICAID SERVICES, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, STATE EXCHANGE IMPLEMENTATION QUESTIONS AND ANSWERS 8, (Nov. 29, 2011) (emphasis added), *available at:* http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf.

[88] *The Art of the Friday News-Dump*, NATIONAL JOURNAL (Aug. 12, 2011), http://www.nationaljournal.com/the-art-of-the-friday-news-dump-20110722#photo_0 ("When newsmakers release a tidbit on a Friday afternoon, chances are, it's not something that puts them in the best light. Stories dumped on Fridays, as the strategy suggests, peter out during the weekend -- or at least give the subjects more time to craft their responses.").

without significant change.[89] The agency claimed its decision was supported by legislative intent, if not the actual language of the Act :

> The statutory language of section 36B and other provisions of the Affordable Care Act *support the interpretation* that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the *relevant* legislative history *does not demonstrate that Congress intended to limit* the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is *consistent with* the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.[90]

On October 12, 2012, the Treasury Department offered this explanation of the rule in a response to a request from the chairman of the House Committee on Oversight and Government Reform:

> We interpreted the statutory language in context and consistent with the purpose and structure of the statute as a whole, pursuant to longstanding and well-established principles of statutory construction. For example, ACA section 1311 refers to an exchange being "established by a State." Congress provided in section 1321, however that where a state was not proceeding with an exchange, HHS would establish and operate "*such* Exchange within the State," making a federally-facilitated exchange the equivalent of a state exchange in *all functional respects*. Moreover, throughout the ACA, Congress refers to the exchanges as "exchanges," "exchanges established by a state," and "exchanges established under the ACA." There is *no discernible pattern* that suggests Congress intended the particular language in section 36B(b)(2)(A) to limit the availability of the tax credit.
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> In addition, the information reporting requirements of section 36B(f)(3) apply to exchanges under both ACA sections 1311 and 1321. This requirement relates to the administration of the premium tax credit. The placement of this provision in section 36B and the information required to be reported—including information related to eligibility for the credit and receipt of advance payments—*strongly suggests* [sic] that all taxpayers who enroll in qualified health plans, either through the federally-facilitated exchange or a state exchange, should qualify for the premium tax credit. Our interpretation is *consistent with* the explanation of the ACA released

[89] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30378 (May 23, 2012), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf ("Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole").

[90] *Id.* (emphases added).

> by the non-partisan Congressional Joint Committee on Taxation and with the assumptions made by the Congressional Budget Office in estimating the effects of the ACA.[91]

An October 25, 2012, letter from the Treasury Department to the chairman reiterated these points and added:

> On September 19, 2012, the Oklahoma Attorney General amended an existing civil lawsuit in the Eastern District of Oklahoma to include claims challenging Treasury regulations promulgated under section 36B. We disagree strongly with these claims, and we intend to defend the lawsuit vigorously. Ultimately, however, it will be up to the courts to determine the proper interpretation of section 36B[.][92]

These statements are notable for what they do not include. Neither agency has identified any statutory language expressly authorizing the IRS to issue tax credits through federal Exchanges or authorizing the IRS to do so via regulation. For more than a year since the IRS's interpretation was first questioned, these agencies failed to cite any statutory language in support of the rule at all. Instead, the IRS claimed various unidentified provisions of the law "support" its interpretation, that its rule is "consistent with" the Act, and that the "relevant" legislative history does not contradict its interpretation. In October 2012, Treasury officials ultimately cited a provision of the statute that they claim supports that interpretation, yet did not claim that interpretation is compelled by the text of the PPACA.

IV. Text, Legislative History, and Congressional Intent

Notwithstanding the Treasury Department's recently articulated legal theory, the IRS rule lacks statutory authority. The text of the PPACA does not authorize the IRS to offer tax credits through federal Exchanges. The plain text of the Act expressly precludes it. Section 1401's

[91] *See* Letter from Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Treasury Department, to the Honorable Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, (Oct. 12, 2012), *available from the authors on request* (emphasis on "such" in original; all other emphases added).

[92] *See* Letter from Alastair M. Fitzpayne, Assistant Secretary for Legislative Affairs, U.S. Treasury Department, to the Honorable Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, (Oct. 12, 2012), *available from the authors on request*.

language restricting tax credits to states that establish an Exchange under Section 1311 is clear and unambiguous. Nor can the rule be justified on other grounds. Neither the structure of the statute, its legislative history, nor other indicia of congressional intent support the IRS position.[93] The remainder of the statute, along with the Act's legislative history, shows the inclusion of this language was intentional and purposeful, and that the plain meaning of Section 1401 reflects Congress' intent.

The PPACA's authors strongly preferred state-run Exchanges over federal Exchanges. The statute repeatedly uses financial incentives to encourage states and others to comply with the Act's regulatory scheme. The idea of conditioning tax credits on states creating exchanges was part of this debate from the beginning. Both of the PPACA's antecedent bills thus contained the feature of withholding subsidies from residents of uncooperative states.

The PPACA's authors knew how to provide for Exchanges established by different levels of government to operate similarly, and did so when that was their intent. Similarly, they knew how to authorize tax credits in Exchanges established by levels of government other than the states, which they also did when that was their intent.

During congressional consideration, the PPACA's lead author affirmed that the law conditions tax credits on states establishing Exchanges. In addition, the legislative history strongly suggests that House Democrats were aware of this feature before they approved the

[93] Although this article often refers to congressional "intent," a body composed of 535 individuals cannot be said to have a single "intent." This is a convenient "shorthand" for how to characterize what is actually the result of negotiation, compromise, and deal-making among many lawmakers, each of whom may have his or her own specific intent with regard to the legislation. *See* Matthew C. Stephenson, *The Price of Public Action: Constitutional Doctrine and the Judicial Manipulation of Legislative Enactment Costs*, 118 YALE L.J. 2, 13 n.25 (2008) ("Characterizing the legislature, or the enacting coalition, as a unitary actor that 'knows' the effect of policies on outcomes and chooses the policy that would advance 'its' interest is a shorthand way of describing this more complex collective choice process."). Thus to say that a bill provision was intentional is to say that it is a result of this process, and was drafted as intended by some of those involved in writing and amending the bill, and not to claim that every member of Congress who supported a bill desired each provision of the bill. This is particularly so given the unfortunate tendency of some legislators to not even read the legislation upon which they express opinions and cast votes. *See generally*, Hanah Volokh, *A Read-the-Bill Rule for Congress*, 76 MO. L. REV. 135 (2011).

PPACA. While PPACA supporters in the House and Senate closely scrutinized and repeatedly amended Section 1401 through the HCERA, they left intact the relevant provisions .

Finally, even if all of the foregoing evidence demonstrating that Section 1401 accurately reflects congressional intent did not exist, PPACA supporters' approval of *this* text reveals that their intent was indeed to enact a bill that restricts tax credits to state-run Exchanges. At no point have defenders of the rule identified anything in the legislative history that contradicts the plain meaning of Section 1401.

Professor Timothy Jost argues the provisions restricting tax credits to state-run Exchanges "clearly say what Congress clearly did not mean."[94] On the contrary, the PPACA's authors meant what the statute clearly says.

A. Plain Text

The starting point for statutory interpretation is the statute's text. [95] As noted above, the PPACA authorizes two methods for establishing an Exchange within a state. Section 1311 provides that "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')" and lays out rules for state-run Exchanges.[96] In particular, for purposes of Section 1311, the Act requires that an Exchange must

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[94] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/. *Cf.* Conn. Nat'l Bank v. Germain, 503 U.S. 249, 254 (1992)("courts must presume that a legislature says in a statute what it means and means in a statute what it says there.").

[95] *See, e.g.*, Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979) ("the starting point in any case involving the meaning of a statute[ ] is the language of the statute itself."); Caminetti v. United States, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed"). *see also NFIB*, 132 S.Ct. at 2583 ("the best evidence of Congress's intent is the statutory text"); Unif. Statute & Rule Construction Act § 19 (1995) (*Primacy of Text*. The text of a statute or rule is the primary, essential source of its meaning.");Alexander Hamilton, "Final Versio of an Opinion on the Constitutionality of an Act to Establish a Bank" (1791), *in* 8 THE PAPERS OF ALEXANDER HAMILTON 97, 111 (H.C. Syrett ed., 1965) ("whatever may have been the intention of the framers of a constitution, or of a law, that intention is to be sought for in the instrument itself.").

[96] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 173 (2010).

be "a governmental agency or nonprofit entity that is established by a State."[97] Section 1304(d) clarifies, "In this title, the term 'State' means each of the 50 States and the District of Columbia."[98]

Section 1321 requires the federal government to create an Exchange in states that elect not to create their own. Specifically, if a state that either fails to create an Exchange or fails to implement the PPACA's health insurance regulations to the Secretary's satisfaction, Section 1321 requires the HHS Secretary to "establish and operate such Exchange." Section 1321 thus requires a federal "fallback" for states that do not create Exchanges of their own. State-run exchanges created under Section 1311 and federal fallback exchanges created under Section 1321 are distinct.

Section 1401 authorizes premium-assistance tax credits and makes them available only through state-run Exchanges. This section specifies that taxpayers may receive a tax credit only during a qualifying "coverage month," which occurs only when "the taxpayer is covered by a qualified health plan…that was enrolled in through an Exchange *established by the State under [S]ection 1311* of the Patient Protection and Affordable Care Act."[99] By its express terms, this provision only applies to Exchanges "established by a state" and "established . . . under Section 1311." Section 1401 further emphasizes that tax credits are available only through Section 1311 Exchanges when it details the two methods for calculating the amount of the credit. The first method bases the amount on the premiums of a qualified health plan that the taxpayer "enrolled

[97] *Id.* § 1311(d).

[98] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1304 (d), 124 Stat. 119, 172 (2010). But note that Section 1323 provides: "A territory that elects…to establish an Exchange in accordance with part II of this subtitle and establishes such an Exchange in accordance with such part shall be treated as a State for purposes of such part[.]" Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Sec. 1204, 124 Stat. 1029, 1055-1056 (2010).

[99] *Id.* (emphasis added).

in through an Exchange *established by the State under [Section] 1311* of the Patient Protection and Affordable Care Act."[100] The second method bases the amount on the premium of the "second lowest cost silver plan…which is offered *through the same Exchange* through which the qualified health plans taken into account under [the first method] were offered."[101] Both methods therefore require that taxpayers obtain coverage through a state-run Exchange. The second method also relies on the concept of an "adjusted monthly premium," which only applies to "individual[s] covered under a qualified health plan taken into account under paragraph (2)(A)"[102]—i.e., "through an Exchange *established by the State under [Section] 1311*."[103]

These clauses carefully restrict tax credits to state-created Exchanges. They either employ or refer to not one but two limiting phrases: "by the State" and "under Section 1311." Either phrase by itself would have been sufficient to limit availability of tax credits to state-run Exchanges, as (1) states can only establish Exchanges under Section 1311 and (2) that section provides no authority for any other entity to establish Exchanges.[104] The repeated use of both phrases makes the meaning and effect of the language abundantly clear.[105]

Indeed, Section 1401 either employs or refers to this restrictive language a total of seven times.[106] Even though the appearance of those phrases in the "coverage month" definition is sufficient to restrict tax credits to state-run Exchanges, *every* reference to Exchanges in Section

[100] *Id.* § 1401 (emphasis added).

[101] *Id.* (emphasis added).

[102] *Id.*

[103] *Id.* (emphasis added).

[104] Section 1311 does authorize "regional" or other interstate Exchanges that "may operate in more than one State if each State in which such Exchange operates permits such operation." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311(f). Since interstate Exchanges satisfy both the "established by the state" and "under section 1311" requirements, Section 1401 authorizes tax credits through these Exchanges as well.

[105] Even if one were to conclude that federal exchanges established under Section 1321 could be considered Section 1311 exchanges, they would still not be exchanges "established by a state." *See infra* Part IV.C.

[106] *Id.* § 1401.

1401's tax-credit eligibility rules is to an Exchange "established by the State under [S]ection 1311."

The Act contains no parallel language authorizing tax credits in Exchanges established by the federal government under section 1321. Nor does it contain language authorizing the IRS to issue tax credits through the "functional equivalent" of a Section 1311 Exchange.

Courts are to "give effect, if possible, to every clause and word of a statute, avoiding, if it may be, any construction which implies that the legislature was ignorant of the meaning of the language it employed."[107] To treat federal fallback exchanges as equivalent to state exchanges established under Section 1311 is to ignore the PPACA's repeated reference to exchanges "established by the State" and render this latter language into mere surplusage.[108] Further, as Professor James Blumstein notes, under the familiar canon of *expressio unius est exclusio alterius*, "the ACA's granting of subsidies for income-qualified enrollees under state exchanges established under Section 1311 is to be construed not to grant comparable subsidies for income-qualified enrollees under federal exchanges established under Section 1321."[109]

The painstaking repetition of the phrase "established by the State" makes the plain meaning of the statute abundantly clear. As the Congressional Research Service has written:

> [A] strictly textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS's authority to issue the premium tax credits is limited only to situations in which the taxpayer is enrolled in

[107] *Montclair v. Ramsdell*, 107 U.S. 147, 152 (1883); *see also* NFIB, 132 S. Ct. at 2583 ("Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally." (citing Russello v. United States, 464 U.S. 16, 23 (1983)).

[108] *See, e.g.*, Duncan v. Walker, 533 U.S. 167, 174 (2001) ("We are . . . 'reluctan[t] to treat statutory terms as surplusage' in any setting" (citation omitted)); Jones v. U.S., 529 U.S. 848, 857 (2000) ("Judges should hesitate ... to treat statutory terms in any setting as surplusage" (citation and internal quotation omitted)). This principle is well established, and has been articulated repeatedly since the Marshall Court. *See, e.g.*, Sturges v. Crowninshield, 17 U.S. (4 Wheat) 122, 202 (1819) (per Marshall, C.J.)

[109] James F. Blumstein, testimony, House Ways & Means Committee Health Subcommittee, Implementation of Health Insurance Exchanges and Related Provisions, Wednesday, September 05, 2012, http://waysandmeans.house.gov/uploadedfiles/house_ways_and_means_testimony92112.pdf.

> a state-established exchange. Therefore, an IRS interpretation that extended tax credits to those enrolled in federally facilitated exchanges would be contrary to clear congressional intent, receive no *Chevron* deference, and likely be deemed invalid.[110]

Section 1402 authorizes cost-sharing subsidies for "an individual who enrolls in a qualified health plan…offered through *an* Exchange."[111] This language would appear more inclusive. But Section 1402 also stipulates that "[n]o cost-sharing reduction shall be allowed under this [S]ection with respect to coverage for any month *unless the month is a coverage month* with respect to which a [premium assistance tax] credit is allowed to the insured[.]"[112] In other words, Section 1402 explicitly and exclusively ties cost-sharing subsidies to premium-assistance tax credits, which Section 1401 explicitly and exclusively ties to state-run Exchanges created under Section 1311.

There is a discernible pattern here. Congress tightly crafted the eligibility rules for premium-assistance tax credits and cost-sharing subsidies so that they would be conditioned on each state's implementation of an Exchange. The statute provides no authority for the IRS to offer either entitlement through federal Exchanges created under Section 1321. Because cost-

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[110] Memorandum from Jennifer Staman and Todd Garvey, Congressional Research Service, on the Legal Analysis of Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act" (July 23, 2012), *available at*: http://www.statereforum.org/sites/default/files/premium_credits_and_federally_created_exchanges_copy.pdf. But note the CRS qualified that conclusion: "However, given the…alternative interpretive arguments that may suggest a more inclusive construction—including legislative history, legislative purpose, and context—a more searching analysis of Congress's intent in enacting the provision may lead to a less clear result." We discuss those alternative arguments below. *See also* Stuart Taylor, Jr., *Analysis: Health Exchanges And The Litigation Landscape*, KAISER HEALTH NEWS, Nov. 29, 2012, http://www.kaiserhealthnews.org/Stories/2012/November/29/health-law--litigation-and-exchanges.aspx ("As even some health law supporters concede, the claim that Congress denied to the federal exchanges the power to distribute tax credits and subsidies seems correct as a literal reading of the most relevant provisions."); John D. Kraemer & Lawrence O. Gostin, *The Power to Block the Affordable Care Act: What are the Limits?* 308 J. AMER. MED. ASS'N 1975, 1975 (2012) ("Due to an apparent oversight, the ACA only explicitly offers subsidies in state-operated exchanges").

[111] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1402, 124 Stat. 119, 221 (2010) (emphasis added).

[112] *Id.* (emphasis added).

sharing subsidies are available only where premium-assistance tax credits are available, the remaining discussion will focus primarily on tax credits.

B. Preference for State-Run Exchanges

The language, structure, legislative history, and congressional debate over the PPACA demonstrate that its authors preferred state-run Exchanges to federal Exchanges. From the outset, the Act directs states to establish Exchanges, and many PPACA's supporters presumed that all states would create exchanges of their own.

The text of the PPACA suggests that Congress sought universal state cooperation. Section 1311(b) provides that "each state *shall* . . . establish an American Health Benefit Exchange" by 2014.[113] The Act further details various requirements state-run Exchanges must meet. This was not accidental. The Senate Finance Committee, where the relevant PPACA language originated, wrestled with the question of whether states or the federal government should take the lead in creating exchanges and that advocates of state-run exchanges prevailed. A November 2008 "white paper" issued by chairman Max Baucus (D-MT) endorsed a single, federal exchange: "The Baucus plan would ensure that every individual can access affordable coverage by creating a nationwide insurance pool called the Health Insurance Exchange."[114] The committee subsequently heard testimony from a broad coalition endorsing state-run rather than federal exchanges.[115] When Sen. Baucus introduced his "chairman's mark" in September 2009, it

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[113] *Id.* § 1311(b). (emphasis added).

[114] MAX BAUCUS, REFORMING AMERICA'S HEALTH CARE SYSTEM: A CALL TO ACTION iv (Nov. 12, 2008), *available at:* http://finance.senate.gov/download/?id=916b0ea3-96dc-4c7a-bb35-241fa822367e.

[115] *See Roundtable Discussion on Expanding Health Care Coverage, Before the S. Comm on Finance*, 111th Cong., (May 5, 2009) (Testimony of Stuart M. Butler), *available at:* http://www.finance.senate.gov/imo/media/doc/Stuart%20Butler.pdf:

> There is broad support for the concept of a health insurance exchange to improve the functioning of a competitive market for plans…But should an exchange be at the national level, or at the state level, and should there be overlapping exchanges? A national exchange may seem attractive but it is accompanied by many problems…The solution would be for the federal government to do two things. First, set out broad

directed states to establish exchanges and provided for a federal fallback exchange.[116] Advocates of state-established exchanges prevailed in the Finance Committee and later in both chambers of Congress. It is unlikely that the PPACA would have passed the Senate without this provision.[117]

The congressional debate emphasized state-run Exchanges over federal Exchanges. We surveyed eight Senate committee hearings and markups,[118] the Finance Committee chairman's

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> objectives for exchanges, and allow states to propose designs for state or regional exchanges to be certified by the federal government.

Roundtable Discussion on Expanding Health Care Coverage, Before the S. Comm on Finance, 111th Cong., (May 5, 2009) (Testimony of Len M. Nichols), *available at*: http://www.finance.senate.gov/imo/media/doc/Len%20Nichols.pdf:

> Do note, however, these new exchanges could be organized at the state or even substate levels. It is not necessary (or wise) to have one national exchange/marketplace…Insurance market rules governing the new marketplaces should be uniform across the country, but the exchanges themselves could be organized on a national, state, or sub-state level. It is important to remember that all health markets (like politics) are local. Competing against Kaiser in San Francisco or Group Health in Seattle is different than competing against Blue Cross of Arkansas in Little Rock. Exchange managers and oversight boards can and should bring local expertise and flexibility to the overall federal superstructure.

Roundtable Discussion on Expanding Health Care Coverage, Before the S. Comm on Finance, 111th Cong., (May 5, 2009) (Testimony Of Scott Serota), *available at:* http://www.finance.senate.gov/imo/media/doc/Scott%20Serota.pdf:

> [C]reating a federal 'connector' would be complex, costly and time-consuming. Creation of a federal connector could also undermine state regulation and authority, creating conflicting federal-state rules that would result in regulatory confusion and adverse selection. A state-based approach would accomplish the goals of a federal connector while ensuring current consumer protections afforded by state oversight and assuring faster implementation at lower costs by avoiding the creation of a new federal bureaucracy. To encourage states to establish State Insurance Marts, federal funding should be provided to offset the cost of development.

[116] *Chairman's Mark: America's Healthy Future Act of 2009, Scheduled for Markup By the Senate Committee on Finance On September 22, 2009*, p. 11, http://finance.senate.gov/download/?id=a2b7dd18-544f-4798-917e-2b1251f92abb. ("States must establish an exchange that complies with the requirements set forth in the Federal law. If a state does not establish an exchange within 24 months of enactment, the Secretary of HHS shall contract with a non-governmental entity to establish a state exchange that complies with the Federal legislation.").

[117] *See* Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO, January 25, 2010, http://www.politico.com/livepulse/0110/Nelson_National_exchange_a_dealbreaker.html; Patrick O'Connor & Carrie Budoff Brown, *Nancy Pelosi's Uphill Health Bill Battle*, POLITICO, January 9, 2010, http://dyn.politico.com/printstory.cfm?uuid=11026320-18FE-70B2-A8DEC2E6CF44594F.

[118] *Full Committee Hearing - Healthcare Reform: Before Senate Comm. on Health, Education, Labor, & Pensions*, 111th Cong. (2009); *What Women Want: Equal Benefits for Equal Premiums: Full Comm. Hearing Before Senate Comm. on Health, Education, Labor, & Pensions, 111 Cong.* (2009); *Affordable Health Choices Act: Executive Session Before Senate Comm. on Health, Education, Labor, & Pensions*; 111th Cong. (2009); *Open Executive Session to Consider an Original Bill Providing for Health Care Reform: Hearing Before Senate Comm. on Finance*, 111th Cong. (2009); *Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the Senate*

mark of the America's Healthy Future Act of 2009,[119] and the House and Senate floor debates over the PPACA.[120] In those venues, Democratic members of Congress and their staffs made 117 references to "state Exchanges" or state-established Exchanges, three references to federal Exchanges, and 359 non-specific references to Exchanges. Republican members of Congress, all of whom opposed the PPACA, mentioned state or state-established Exchanges forty-one times and federal Exchanges seven times in these venues. The emphasis on state-run Exchanges reflects the PPACA's emphasis. When Republicans spoke of federal Exchanges, it was typically to raise the specter of a federal takeover of health care—a specter that PPACA supporters downplayed by emphasizing that exchanges would be created and run by the states.[121] Further reflecting the Act's preference for state-run Exchanges, the Joint Committee on Taxation's technical explanation of the revenue provisions in PPACA and HCERA made fifteen references to state Exchanges, zero references to federal Exchanges, and fifty-one non-specific Exchange references.[122]

Comm. on Finance, 110th Cong. (2008); *Finance Committee Field Hearing at St. Patrick Hospital in Missoula, MT: High Health Care Costs: A State Perspective: Before the Senate Comm. on Finance*, 110th Cong. (2008); *Health Care Reform: An Economic Perspective: Before the Senate Comm. on Finance*, 110th Cong. (2008); and *The President's Fiscal Year 2010 Health Care Proposals: Before the Senate Comm. on Finance*, 111th Cong. (2009).

[119] SENATE COMMITTEE ON FINANCE, CHAIRMAN'S MARK, AMERICA'S HEALTHY FUTURE ACT OF 2009 (2009).

[120]We searched the *Congressional Record* during the periods that each chamber was considering the PPACA: the Senate Record between June 1, 2009 and March 30, 2010, and the House Record between January 19, 2010 and March 22, 2010.

[121] *See, e.g.*, Senate Democratic Policy Committee, *Fact Check: Responding to Opponents of Health Insurance Reform*, Sept. 21, 2009, *available at*: http://dpc.senate.gov/reform/reform-factcheck-092109.pdf ("There is no government takeover or control of health care in any [S]enate health insurance reform legislation…*All* the health insurance exchanges, which will create choice and competition for Americans' business in health care, are run by states."(emphasis added)).

[122] JOINT COMM. ON TAXATION, TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND ACCORDABLE CARE ACT (March 21, 2010).

C. Financial Incentives

Further evidence of this preference is that the PPACA's authors created large financial incentives to encourage states to establish Exchanges. The Act authorizes the Secretary of Health and Human Services to provide unlimited funding for states to cover the start-up costs of establishing Exchanges.[123] (As of July 2012, the Secretary had issued a total of $1.007 billion in Exchange grants to states.[124] The Secretary has announced these "start-up" grants will be able through 2019.[125]) In contrast, PPACA's authors failed to authorize any funding for HHS to create federal Exchanges.[126] Unlimited start-up grants and a lack of funding for federal Exchanges appear not only in PPACA, but also in both antecedent bills reported by the Finance and HELP committees.[127]

Making credits and subsidies available solely through state-run Exchanges is thus consistent with the PPACA's modus operandi of using financial incentives to elicit desired behavior. Under the Act, individuals who fail to obtain health insurance must pay a penalty. Large employers that fail to offer required health benefits likewise must pay a penalty.

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[123] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 177-178 (2010). See especially Memorandum from the Congressional Research Service, on Federal Grants For Planning and Establishment of Health Insurance Exchanges Under Section 1311(a) of the Patient Protection and Affordable Care Act (Feb. 7, 2011).

[124] Kaiser Family Foundation, State Health Facts, *Total Health Insurance Exchange Grants, 2012*, (July 26, 2012), http://statehealthfacts.kff.org/comparetable.jsp?ind=964&cat=17 ($1,007,493,875 has been awarded as of July 26, 2012).

[125] *See* Michael F. Cannon, *HHS Offers to Pay Six Years of Operating Costs for Some States' Obamacare Exchanges*, CATO@LIBERTY, July 3, 2012, http://www.cato-at-liberty.org/hhs-offers-to-pay-six-years-of-operating-costs-for-some-states-obamacare-exchanges/.

[126] Michael F. Cannon, *President's Budget Shows Feds Can't Create ObamaCare 'Exchanges'*, CATO@LIBERTY, Feb. 13, 2012, http://www.cato-at-liberty.org/presidents-budget-shows-feds-cant-create-obamacare-exchanges/; J. Lester Feder, *Sebelius: Exchange funding request was anticipated*, POLITICO PRO, Feb. 14, 2012, https://www.politicopro.com/go/?id=9220 [subscription only].

[127] The America's Healthy Future Act of 2009 (S. 1796), section 2237(c). Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 3101(a), pp. 53-56, (2009).

Many statutes seek to encourage state cooperation by threatening to cut off funding to recalcitrant states.[128] The PPACA contains this feature in other provisions, such as the Medicaid expansion.[129] Under the Act as passed, states that failed to expand their Medicaid programs to everyone below 138 percent of the federal poverty level would have lost all federal Medicaid grants, which account for 12 percent of state revenues.[130] The Act imposes a "maintenance of effort" requirement on states' Medicaid programs that only lifts upon certification of an Exchange "established by the State under section 1311."

States that opt to establish an Exchange may receive unlimited start-up funds from HHS—if, "as determined by the Secretary," a state makes adequate progress toward establishing an Exchange, implements other parts of the Act, and "meet[s] such other benchmarks as the Secretary may establish."[131] This feature—conditioning the continued availability of start-up funds on state cooperation—appears in the HELP committee bill as well.[132] It is scarcely a departure for the Act to condition the availability of tax credits and cost-sharing subsidies on state cooperation.

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[128] *See generally* Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't,* 96 MICH. L. REV. 813, 858-865 (1998).

[129] *See NFIB*, 132 S.Ct. at 2581-82 (describing Medicaid expansion).

[130] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 2001, 124 Stat. 119, 271-275 (2010) as amended by the Health Care and Education Reconciliation Act of 2010. Even after the Supreme Court's ruling in *NFIB v. Sebelius* invalidating this requirement, the Act conditions new federal Medicaid grants on states expanding their Medicaid programs. CINDY MANN, JOAN C. ALKER, AND DAVID BARISH, MEDICAID AND STATE BUDGETS: LOOKING AT THE FACTS 6 (May 2008), *available at:* http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf+publications%2Fabout+medicaid%2Fnasbo+final+5-1-08.pdf ("It is often reported that states spend, on average, almost 22 percent of their state budgets on Medicaid, but this figure can be misleading because it considers federal as well as state funds. On average, federal funds account for 56.2 percent of all Medicaid spending.")

[131] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 173 (2010). The Act does not seek to induce state cooperation with the exchange provisions by withholding funding for operating Exchanges, however, because it only authorizes funding to assist with start-up costs. Once the Exchanges are established, the states must finance administration on their own.

[132] The Finance Committee bill contained language almost identical to PPACA. The HELP Committee bill explicitly withheld credits from residents of states that refused or were slow to create their own health insurance Gateways. Choices Act, S. 1697, 111th Cong. Sec. 3104(d), pp. 106-107, (2009).

The language in Sections 1401 and 1402 restricting credits and subsidies to state-created Exchanges is more than just consistent with the rest of the Act. It is integral to Section 1311's directive that states "shall" create an Exchange. As it likely creates a larger financial incentive than the Medicaid "maintenance of effort" requirement, it is the primary sanction imposed on states that do not establish Exchanges.[133] It thus animates Section 1311's "shall." To ignore it as the IRS has would sap that directive of most of its force.

As noted above, the federal government cannot actually force states to create Exchanges, as this would constitute unconstitutional commandeering.[134] The federal government can, however, utilize a combination of positive and negative incentives to induce state cooperation—in this case, subsidies for creating Exchanges and the threat of a federally run Exchange if a state does not create one on its own.

Such incentives are common. Various federal programs, including Medicaid, condition the receipt of federal funding on state acceptance of the federal government's conditions.[135] In this context, limiting the availability of tax credits to insurance purchased in state-run Exchanges can be seen as just one more inducement for state cooperation: the PPACA threatens states with the loss of tax credits for state residents if they do not create an Exchange.[136]

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[133] The PPACA's "maintenance of effort" provision requires states to maintain aspects of their Medicaid programs as they were in 2010, which can be a costly proposition, and only lifts this requirement once "the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational." *See* 42 U.S.C. § 1396a(a)(74) and § 1396a(gg). There are real questions about whether the maintenance-of-effort provisions are enforceable under *NFIB v. Sebelius*, in which the Supreme Court held that Congress may not impose retroactive conditions on federal Medicaid funds or condition those funds on state participation in a new program. *See, e.g.*, Ralph Lindeman, *ACA Opponents Eyeing New Challenge To Law's Maintenance-of-Effort Requirement*, BNA HEALTH CARE DAILY REPORT, Oct. 26, 2012..

[134] *See infra*

[135] Additional examples include the No Child Left Behind Act, the Safe Drinking Water Act, and the Clean Air Act.

[136] The PPACA is not the first law to offer to reduce the tax burden on private parties in order to encourage state cooperation with federal policy. In *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937), the Supreme Court upheld

This idea of using conditional tax credits to avoid the commandeering problem was part of the debate well before PPACA supporters first introduced any legislation. In early 2009, Professor Jost wrote:

> Congress cannot require the states to participate in a federal insurance exchange program by simple fiat. This limitation, however, would not necessarily block Congress from establishing insurance exchanges. Congress could invite state participation in a federal program, and provide a federal fallback program to administer exchanges in states that refused to establish complying exchanges. Alternatively it could exercise its Constitutional authority to spend money for the public welfare (the "spending power"), either *by offering tax subsidies for insurance only in states that complied with federal requirements* (as it has done with respect to tax subsidies for health savings accounts) or by offering explicit payments to states that establish exchanges conforming to federal requirements.[137]

This solution to the commandeering problem appeared in both the bill produced by the Senate Finance Committee and the bill produced by the Senate HELP Committee. Congress could not compel every state to create an exchange, but it could use tax credits to create incentives for state cooperation.

D. Antecedent Bills

Both the Finance bill and the HELP bill withheld subsidies from taxpayers whose state governments failed to establish an Exchange or otherwise failed to implement the law in accord with federal dictates.

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federal legislation "predicating tax abatement on a State's adoption of a particular type of unemployment policy." *NFIB*, 132 S.Ct. at 2603. *See also* New York v. United States, 505 U.S. 144 (1992) (upholding law that authorized surcharges on importation of low-level radioactive waste from noncompliant states).

[137] Timothy S. Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Institute, Georgetown University Legal Center, no. 23, April 27, 2009, *available at* http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1022&context=ois_papers. The earliest known version of this paper was posted online by the Robert Wood Johnson Foundation on January 1, 2009 (http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/01/health-insurance-exchanges.html).

The PPACA's closest antecedent was the Finance Committee-reported "America's Healthy Future Act of 2009" (S. 1796).[138] The relevant language in PPACA is nearly identical to that of the Finance bill. The four ways Section 1401 confines tax credits to state-run Exchanges appear almost verbatim in the Finance bill.[139]

The HELP bill even more explicitly withheld credits in states that failed to implement its requirements, and it employed that strategy to encourage state cooperation even if the federal government created the Exchange. If a state sought to establish its own "Gateway" (i.e., Exchange) then the HELP bill provided that "any resident of that State who is an eligible individual shall be eligible for credits"—but only after the Secretary determined that the state had (1) created a qualified Gateway, (2) enacted legislation imposing various health insurance regulations on the state's individual and small-group markets, and (3) enacted legislation subjecting its state and local governments to the bill's employer mandate. If a state failed to meet these criteria, its residents would be ineligible for credits.[140] When an "establishing state" fell out

[138] U.S Library of Congress: Thomas, *Bill Summary & Status, 111th Congress, S. 1796, All Information*, 2009, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:SN01796:@@@L&summ2=m&; America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009), http://www.gpo.gov/fdsys/pkg/BILLS-111s1796pcs/pdf/BILLS-111s1796pcs.pdf.

[139] Like the PPACA, the Finance bill would have created a new section 36B in the Internal Revenue Code that offers two methods for determining the amount of a taxpayer's premium assistance tax credit. Under the first method, found in 36B(b)(2)(A)(i), the bill bases the credit amount on the premiums for health plans "which were enrolled in through *an Exchange established by the State under subpart B of title XXII of the Social Security Act*," a clear and exclusive reference to state-run Exchanges. S. 1796, p. 147. Emphasis added. (But note there is no "subpart B" of the proposed title XXII. The parts in that title take capital letters while the subparts take numbers. Since *Part* B of the proposed title XXII directs states to create Exchanges, however, this appears to be an immaterial scrivener's error.) The second method uses the "adjusted monthly premium" for "the second lowest cost silver plan in the individual market which is offered through *the same Exchange*." S. 1796, new IRC section 36B.(b)(3)(B)(i), p. 149. Emphasis added. The definition of "adjusted monthly premium" again refers to "qualified health benefits plan taken into account *under paragraph (2)(A)(i)*." S. 1796, p. 150. Emphasis added. Finally, the bill also ties "coverage months" to state-run Exchanges by defining them as months in which a taxpayer "is covered by a qualified health benefits plan described *in subsection (b)(2)(A)(i)*." S. 1796, p. 152. Emphasis added.

[140] See Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 3104(d), p. 104, (2009).

of compliance, the HELP bill went so far as to revoke credits that state residents had already been receiving.[141]

If a state formally requested that HHS establish a Gateway for the state (such states were called "participating states"), the HELP bill authorized the federal government to do so, and authorized credits within the federal Gateway. But the bill again withheld those credits if the state failed to satisfy (2) or (3).

If state officials opted neither to be an "establishing state" nor a "participating state," then the HELP bill again authorized the federal government to create a Gateway for the state, authorized credits within that federal Gateway, imposed the bill's health insurance regulations on the state, and deemed the state to be a "participating state." However, the bill still withheld credits unless state officials complied with (3).[142]

This history demonstrates that restricting tax credits to state-run Exchanges was a deliberate policy choice. The authors of these provisions sought to limit the availability of credits to state-run exchanges. The PPACA, the Finance bill, and the HELP bill all explicitly withheld credits from individuals as a means of encouraging state officials to implement the law. None of the three bills allowed residents of a state to receive credits absent cooperation by state officials. Some PPACA supporters may have preferred to provide tax credits for the purchase of health insurance in federally run Exchanges, but other proponents felt otherwise. It is the latter group that prevailed.

[141] "If the Secretary determines that a State has failed to maintain compliance with such requirements, the Secretary may revoke the determination," thereby revoking eligibility for credits. Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 3104, p. 105, (2009).

[142] Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 3104, p. 107, (2009).

E. Authorial Intent

Statements by one of the PPACA's primary authors, Senate Finance Committee Chairman Max Baucus (D-MT), provide additional persuasive evidence that the language of Section 1401 making tax credits condition on a state establishing an Exchange was an essential part of the bill.

During Finance Committee deliberations over the Baucus bill, which became the PPACA without pertinent alteration, Sen. John Ensign (R-NV) asked Chairman Baucus, "How do we [in this committee] have jurisdiction over changing state laws on coverage," such as through the bill's requirements that states establish Exchanges and adopt the bill's insurance regulations, when such matters are "only in the jurisdiction of the HELP Committee and not in the jurisdiction of this committee?" Baucus responded that the bill conditions the availability of tax credits on states complying with those directives.[143] Specifically, Senator Baucus explained that the requirements Ensign mentioned are among the "conditions to participate in the Exchange," and that "an Exchange…essentially *is* tax credits," which "are in the jurisdiction of this committee."[144] In other words, the reason the Finance Committee could impose requirements on state-run Exchanges was because tax credits were conditional on state compliance.

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[143] Indeed, Section 1321 requires the Secretary to establish an Exchange within a state if a state fails to create one itself, or if the state fails to adopt the Act's insurance regulations. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1321(c), 124 Stat. 119, 186 (2010). The Act therefore conditions tax credits on states adopting those regulations as well.

[144] In this colloquy, excerpted and lightly edited here, Sen. Baucus backs into an admission that his bill conditions tax credits on state officials creating an Exchange.

> **Senator Ensign:** Is this bill, the underlying premise in this bill that…we are making states change their laws, their coverage laws? Aren't we doing that? And so why would not most of the coverage rules in this bill, underlying bill, be…only in the jurisdiction of the HELP Committee and not in the jurisdiction of this committee?...On certain minimum plans, exchanges. All those coverage things are state laws…How do we have jurisdiction over changing state laws on coverage?...
>
> **The Chairman:** There are conditions to participate in the Exchange.
>
> **Senator Ensign:** That is right.
>
> **The Chairman:** For setting up an Exchange.

Conditioning the tax credits on state compliance provided the jurisdictional hook the Committee needed to direct states to create Exchanges and otherwise alter their health insurance laws. If the Finance Committee bill had authorized tax credits in both state-run and federal exchanges, then the Committee would not have had jurisdiction to impose regulatory requirements on state-run Exchanges. The operation of state exchanges would have been outside the Committee's bailiwick, and arguably immune from federal oversight altogether.[145] The fact that Section 1401 provided the Finance Committee this jurisdictional hook further demonstrates that the PPACA's authors intentionally restricted tax credits to state-run Exchanges.

It is irrelevant that the need for that jurisdictional hook evaporated when the Finance bill cleared committee, or that other members of Congress may have preferred a different outcome. The text that the Finance Committee approved is the text that the House and Senate passed, and that the president signed. Nor is it plausible to argue the IRS rule is justified because congressional intent subsequently changed; the language did not.[146]

In our extensive search of the PPACA's legislative history, this comment by Sen. Baucus is the *only* instance we found of a member of Congress discussing whether tax credits would be available in federal exchanges, and it flatly contradicts the IRS's position. In contrast, the IRS

> **Senator Ensign:** These would be conditions to participate—
>
> **The Chairman:** And states—an Exchange is, essentially is tax credits. Taxes are in the jurisdiction of this committee.

Executive Committee Meeting to Consider an Original Bill Providing for Health Care Reform: Before the S. Comm. on Finance, 111th Cong. 326 (2009), *available at*: http://www.finance.senate.gov/hearings/hearing/download/?id=c6a0c668-37d9-4955-861c-50959b0a8392. We encourage readers to watch the video of the colloquy. *Executive Committee Meeting to Consider an Original Bill Providing for Health Care Reform: Before the S. Comm. on Finance* (C-SPAN broadcast Sept. 23, 2009), at 2:53:21, http://www.c-spanvideo.org/program/289085-4.

[145] As noted above, the federal government cannot commandeer state governments to implement federal policy. By the same token, the federal government cannot direct state governments *qua* state governments. Absent the creation of federal incentives, the only inducement for state cooperation would be the threatened creation of a federal exchange.

[146] As noted below, several revisions were made to Section 1401 through the HCERA, yet the language relevant here was not changed. *See infra*.

and its defenders have identified nothing from the legislative history that supports the IRS rule. Senator Baucus's own words show both that the plain meaning of Section 1401 accurately reflects congressional intent, and that the IRS rule undermines congressional intent by discouraging states from creating Exchanges.

F. Non-Equivalence

Further evidence that the plain meaning of Section 1401 reflects congressional intent is that PPACA supporters knew how to craft language ensuring that Exchanges created by different levels of government would operate identically, yet opted not to create such equivalence with respect to the availability of tax credits in state-run versus federal Exchanges.

Contrary to the Treasury Department's claim that the Act makes "a federally-facilitated exchange the equivalent of a state exchange in all functional respects," the Act does not provide that an Exchange established by the federal government under Section 1321 is a Section 1311 Exchange, or shall be considered a Section 1311 Exchange, or is functionally equivalent to a Section 1311 Exchange. Instead, Title I of the Act imposes various requirements on state-created Exchanges, which Section 1321 incorporates and imposes on federal Exchanges by reference. First, Section 1321(a) mentions "the requirements under this title…with respect to the establishment and operation of Exchanges…; the offering of qualified health plans through such Exchanges; the establishment of the reinsurance and risk-adjustment programs…; and such other requirements as the Secretary determines appropriate."[147] Section 1321(c) then provides that if a state either fails to create an Exchange or to implement the Act's health insurance regulations to the Secretary's satisfaction, "the Secretary shall…establish and operate such Exchange within the State and…take such actions as are necessary to implement such other requirements."

[147] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1321(a)(1), 124 Stat. 119, 172 (2010).

Section 1321 does not deem Exchanges established by the federal government to have been established under Section 1311. It takes the requirements imposed on state-created Exchanges and incorporates them into Section 1321. Section 1311 and Section 1321 remain distinct.

Nor does Section 1321 create full equivalence between Exchanges established by the federal government and those established by states. Section 1321 instead imposes on federal Exchanges the same requirements that Title I imposes on state-created Exchanges. Those requirements include the eligibility restrictions (contained in Section 1401) that Title I imposes on premium-assistance tax credits. In no way does Section 1321 alter or conflict with those restrictions.

Moreover, the language of Section 1321 is a far cry from the explicit Exchange-equivalence language found in the health care bills Congress rejected and elsewhere in the PPACA. The House-passed "Affordable Health Care for America Act" (H.R. 3962), for example, created a single federal Exchange for all states, and allowed states to opt out by creating their own Exchange. To ensure that certain aspects of state-run and federal Exchanges would operate in an identical manner, H.R. 3962 contained the following language: "any references in this subtitle to the Health Insurance Exchange or to the Commissioner in the area in which the State-based Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the head of such Exchange, respectively."[148]

The HELP bill likewise contained explicit equivalence language: "A Gateway shall be a governmental agency or nonprofit entity that is established by a State, in the case of an establishing State…; or the Secretary, in the case of a participating State[.]"[149] Even with this language, as discussed above, the HELP bill allowed for state and federal Gateways to function

[148] Affordable Health Care for America Act, H.R. 3962, 111th Cong. Sec. 308(e), pp. 208-209, (2009).

[149] Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 3101(b), p. 56, (2009).

differently based on a state's level of cooperation, as it explicitly withheld subsidies in non-compliant states.

The PPACA contains equivalence language as well, but not with regard to federal Exchanges. The Act provides that Exchanges established by U.S. territories shall be equivalent to state-run Exchanges. Section 1323, as added by HCERA, provides that "[a] territory that elects . . . to establish an Exchange in accordance with part II of this subtitle"—Part II includes Section 1311, but not Section 1321—"and establishes such an Exchange in accordance with such part shall be treated as a State for purposes of such part[.]"[150] Section 1323 also explicitly authorizes and appropriates funds for "premium and cost-sharing assistance to residents of the territory obtaining health insurance coverage through the Exchange[.]"[151] This language shows PPACA supporters knew how to create equivalence between Section 1311 Exchanges and other Exchanges when that was their intent. Congress created full functional equivalence for exchanges established by federal territories but not for exchanges established by the federal government.[152]

The HCERA also added information-reporting requirements to the Act. [153] These provisions explicitly require both Section 1311 Exchanges and Section 1321 Exchanges to report

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[150] Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Sec. 1204, 124 Stat. 1029, 1055-1056 (2010).

[151] *Id.* § 1204 (b), (c).

[152] As a general rule, if Congress adopts particular language in one part of a statute, but omits it in another, it is presumed Congress acted "intentionally and purposely in the disparate inclusion or exclusion." *See* Russello v. United States, 464 U.S. 16, 23 (1983).

[153] Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Sec. 1004, 124 Stat. 1029, 1035 (2010) and the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1401, 124 Stat. 119, 219 (2010) (adds Sec. 36B (f) to the Internal Revenue Code). Congress has amended this subsection through subsequent legislation. See Pub. L. No. 112-9, Sec. 4, 125 STAT. 36-37 (2011).

I.R.C § 36B (f), as added to the PPACA by HCERA:

> (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

an array of information pertaining to the purchase of health insurance plans, including the level of coverage purchased, identifying information about the purchaser, the premium paid, and the amount of any advance payments of tax credits and cost-sharing subsidies.

Supporters of the IRS rule maintain these reporting requirements show that Congress sought to make federal and state-run exchanges equivalent with respect to tax credits. The Treasury Department writes, "The placement of this provision in section 36B and the information required to be reported…strongly suggests [sic] that all taxpayers who enroll in qualified health plans, either through the federally-facilitated exchange or a state exchange, should qualify for the premium tax credit."[154] Professor Jost writes, "In this later-adopted legislation amending the earlier-adopted ACA, Congress demonstrated its understanding that federal exchanges would administer premium tax credits."[155] Alternatively, supporters of the

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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

[154] Mark Mazur letter, Oct 12, 2012.

[155] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

IRS' position maintain this reporting requirement introduces sufficient ambiguity to permit the IRS to resolve the claimed ambiguity by offering tax credits in federal Exchanges.[156]

On the contrary, these reporting requirements do not suggest, let alone require, that state-created and federal Exchanges are functionally equivalent with respect to tax credits. Rather, these requirements support, rather than undermine, the plain meaning of Section 1401. They likewise advance the Act's goal of encouraging states to create Exchanges. Nothing about these requirements suggest that Congress erred in limiting tax credits and subsidies to the purchase of health insurance in state-run exchanges.

This reporting requirement is the only provision in the statute that expressly refers to both state-run Exchanges (Section 1311) and federal Exchanges (Section 1321). This shows that Congress knew to reference both Sections where that was their intent, something Congress did not do when authorizing tax credits.[157] To the extent this paragraph creates equivalence between state-run and federal Exchanges, that equivalence extends only so far as the paragraph's information-reporting requirement.[158]

The reporting requirement is clear and straightforward. The paragraph refers to "the credit under this [S]ection" a total of four times. Since this paragraph resides in Section 36B, which authorizes tax credits solely in Exchanges "established by the state under [S]ection 1311,"

[156] The claim that the IRS' interpretation of the Act on this question should receive *Chevron* deference is discussed *infra* Part IV.C..

[157] *See* Russello v. United States, 464 U.S. 16, 23 (1983) ("Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion."); *see also NFIB*, 132 S.Ct. at 2583 (same).

[158] Some defenders of the IRS rule argue Section 1321 contains equivalence language because, after reference to exchanges created under Section 1311, it directs the federal government to create "such exchanges" where states do not. This claim is addressed *infra* Part IV.C.

it plainly requires federal Exchanges to report zero advance payments as they also report other information.

There are valid reasons why Congress would require federal Exchanges to report that and other information about their enrollees. Imposing these reporting requirements on both types of Exchanges serves to ensure a degree of uniformity in the information provided to the federal government. That not every requirement would seem equally applicable to both state and federal Exchanges is not anomalous. It is easier for Congress to draft and enact a single set of reporting requirements than to enact two separate provisions. Applying these reporting requirements to federal Exchanges enables those Exchanges and the Treasury Secretary to notify individual taxpayers of the tax credits for which they would *become* eligible, and to publicize to state officials the number of taxpayers who would benefit, if the state were to establish its own Exchange. The reporting requirement thus advances the PPACA's goal of encouraging states to establish Exchanges. Finally, it was necessary for Congress to state explicitly that these requirements would apply to both state-created and federal Exchanges. Since Section 1401 precludes tax credits in federal Exchanges, administrators of federal Exchanges might otherwise think that Congress did not want them to compile and report that information.

The text of the reporting requirements even allows that tax credits would not be available through federal Exchanges. The paragraph provides that state and federal Exchanges must provide information about "any" tax credits an individual receives. "Any," as used here, is conditional. That an Exchange is obligated to report "any" advance payments made means that *if* such payments are made they must be reported. It does not suggest, let alone require, that such payments will be made in all entities covered by the provision, any more than this language

suggests that all individuals who purchase insurance within Exchanges must be eligible for premium assistance.

The fact that the HCERA's authors made no changes to Section 1401's language restricting tax credits to state-run Exchanges corroborates that the plain meaning of Section 1401 accurately reflects congressional intent that state-created and federal Exchanges would not be equivalent in this respect, and demonstrates that the reporting requirements are not evidence of any contrary intent. The HCERA's authors scoured Section 1401, amending it seven times (and Section 1402 five times) but left the language restricting tax credits to state-run Exchanges undisturbed.[159] It would be difficult to argue that the HCERA's authors noticed that state and territorial Exchanges were not equivalent in this respect, but somehow failed to notice the same asymmetry between state and federal Exchanges.

The plain meaning of these reporting requirements is thus consistent with the rest of Section 1401 and the overarching goals of the law, as is the directive that the Secretary "shall prescribe such regulations as may be necessary to carry out the provisions of this section." The PPACA draws absolutely no equivalence between state-run and federal Exchanges when it comes to offering tax credits. Indeed, the only time it mentions state and federal Exchanges together is when it enables the Secretary to inform people of that fact.

Another chapter of the PPACA's legislative history provides evidence that members of Congress did not consider state and federal Exchanges under that law to be equivalent. As congressional leaders and Obama administration officials attempted to merge the House- and Senate-passed bills in late 2009 and early 2010, eleven U.S. representatives—all Texas Democrats—authored a letter to President Obama, House Speaker Nancy Pelosi (D-CA), and

[159] See Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029, 1030-1032, 1034-1035 (2010).

House Majority Leader Steny Hoyer (D-MD) expressing their strong opposition to the Senate bill's approach to Exchanges.[160]

The letter did not explicitly address whether the bill restricted tax credits to states that established Exchanges. Yet the authors clearly saw a difference between state-created and federal exchanges under the Senate bill. If states failed to create Exchanges, they wrote, residents of those states would not "receive[] *any* benefit" and "millions of people will be left *no better off* than before Congress acted."[161]

The authors of that letter believed that under the PPACA, recalcitrant states could block the law's benefits.[162] It seems implausible that these members would say taxpayers in states with federal Exchanges would see zero benefit if they believed that billions of dollars of tax credits and subsidies would flow into those states. Nonetheless, all eleven cosigners subsequently voted for the PPACA, without any modifications to the language restricting tax credits to state-created Exchanges.[163]

G. Revealed Intent

Even if—contrary to the clear language of the statute, its legislative history, and the admission of the statute's sponsor and principal author—PPACA supporters somehow shared a

[160] U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans, My Harlingen News, Jan. 11, 2010, http://www.myharlingennews.com/?p=6426.

[161] *Id.* (emphasis added).

[162] A contemporaneous report on the letter framed the issue the same way: "[The Texas Democrats] worry that because leaders in their state oppose the health bill, they won't bother to create an exchange, leaving uninsured state residents with *no way to benefit* from the new law." Julie Rovner, House, Senate View Health Exchanges Differently, NPR, January 12, 2010, http://www.npr.org/templates/story/story.php?storyId=122476051. Emphasis added.

[163] FINAL VOTE RESULTS FOR ROLL CALL 165, March 21, 2010, http://clerk.house.gov/evs/2010/roll165.xml.

tacit understanding that tax credits would be available in federal Exchanges, their actions reveal that their intent was to enact a law without tax credits in federal Exchanges.

Following Scott Brown's election, congressional Democrats faced two options. The first was to merge the House- and Senate-passed bills in a manner that made enough changes to secure the support of one Senate Republican, thus enabling proponents to invoke cloture on a conference report. This option was problematic. Not only was there no guarantee that Democrats could peel away one senator from the GOP bloc, but doing so could have moved the conference report far enough to the center that House Democrats likely would have rejected it. The second option was to have the House pass the PPACA, thus sending the bill directly to the president's desk, and have the House and Senate make limited amendments to the PPACA through the reconciliation process.

Congressional Democrats chose the latter strategy. This was in no small part because, while a "regular order" strategy would have moved the PPACA to the center to appease one or another GOP senator, the "reconciliation" strategy would move it to the left to appease House Democrats.

PPACA supporters thus made a quite deliberate choice to pass a bill with which none of them were completely satisfied, and to use the reconciliation process to make only limited amendments, because a more satisfactory conference report would have failed. They made a decision that, whatever the PPACA's remaining shortcomings, passing it with limited amendments was the best they could do under the circumstances.[164] An "imperfect" bill was

[164] *See* Letter from 47 health care scholars to Nancy Pelosi, Speaker of the House, et al., (Jan. 22, 2010), *available at:* http://graphics8.nytimes.com/images/2010/01/22/health/adopt_senate_bill_final.2.pdf. ("Both houses of Congress have adopted legislation that would provide health coverage to tens of millions of Americans, begin to control health care costs that seriously threaten our economy, and improve the quality of health care for every American. These bills are imperfect. Yet they represent a huge step forward in creating a more humane, effective, and sustainable health care system for every American. We have come further than we have ever come before. Only two steps remain. The House must adopt the Senate bill, and the President must sign it… Some differences between

better than no bill. It may well be the case that, as Professor Jost writes, "the Senate Bill was not supposed to be the final law."[165] Yet it became their only option. If what they passed was a bill without tax credits in federal Exchanges, then that is *exactly* what they intended. If they had intended to pass a bill authorizing tax credits in federal Exchanges, there would have been no law.

H. An Error of Miscalculation

The statute and the lack of any support for the IRS rule in the legislative record put defenders of the IRS rule in the awkward position of arguing that it was so obviously Congress' intent to offer tax credits in federal Exchanges that over the course of almost a year of debate over the PPACA, it never occurred to anyone to express that intent out loud.

A better explanation is that the PPACA's authors miscalculated when they assumed states would establish Exchanges. *The New York Times* reports, "When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange," and that "running them will be a herculean task that federal officials never expected to perform."[166] Prior to enactment, HHS Secretary Kathleen Sebelius proclaimed states were "very eager" to create Exchanges and predicted most would quickly do so.[167] The end

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the bills, such as the scope of the tax on high-cost plans and the allocation of premium subsidies, should be repaired through the reconciliation process… The Senate bill accomplishes most of what both houses of Congress set out to do; it would largely realize the goals many Americans across the political spectrum espouse in achieving near universal coverage and real delivery reform.").

[165] Jost, HEALTH AFFAIRS BLOG, *supra.*

[166] Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, NY TIMES, Aug. 5, 2012, *available at:* http://www.nytimes.com/2012/08/05/us/us-officials-brace-for-huge-task-of-running-health-exchanges.html. *See also* http://thehill.com/blogs/healthwatch/health-reform-implementation/269137-obama-faces-huge-challenge-in-setting-up-health-exchanges. ("It's a situation no one anticipated when the Affordable Care Act was written. The law assumed states would create and operate their own exchanges[.]")

[167] *Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2011: Hearing Before the H. Comm. on Appropriations*, 111th Cong. 170-171 (Mar. 10, 2010) (Statement of Kathleen Sebelius, Secretary, Department of Health and Human Services), *available at:* http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg58233/pdf/CHRG-111hhrg58233.pdf.

result would "very much be a State-based program."[168] Shortly after signing the law, President Obama predicted, "by 2014, each state will set up what we're calling a health insurance exchange."[169] If the PPACA's failure to authorize tax credits in federal Exchanges represents an error at all, it is that miscalculation.

Such a miscalculation would be consistent with the widespread view among supporters that the public would grow to support the law over time,[170] or the view that the challenge brought against the law by state attorneys general was so lacking in merit that federal courts should sanction the attorneys general.[171] Having created an enormous incentive for states to establish Exchanges, it likely never occurred to some of the Act's authors that states would refuse. This interpretation also explains why the PPACA authorizes no funding for HHS to create federal Exchanges.[172] Its authors did not anticipate that such funds would be necessary.[173]

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[168] *Id.*

[169] Barack Obama, U.S President, Remarks on Health Insurance Reform in Portland, Maine (Apr. 1, 2010), *available at*: http://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-portland-maine.

[170] See, for example, Naftali Bendavid, *Reid: Voters Like Health Law If They Understand It*, WASHINGTON WIRE, Aug. 4, 2010, http://blogs.wsj.com/washwire/2010/08/04/reid-voters-like-health-law-if-they-understand-it/ (Quoting Senate Majority Leader Harry Reid (D): "It's very obvious that people have a lack of understanding of our health care reform bill…The more people learn about this bill, the more they like it…The trend is turning all over America today…Once you explain what's in the bill, the American people of course like it."); See also Susie Madrak, *Gov. Ed Rendell: The More People Learn About the Health Care Bill, the More They Like It*, CROOKS AND LIARS, Mar. 28, 2010, http://crooksandliars.com/susie-madrak/gov-ed-rendell-more-people-learn-abou (Quoting former Pennsylvania Gov. Ed Rendell (D): "As more and more people get to understand what's in this bill, people are going to like it.").

[171] *See* Timothy S. Jost, *Sanction the 18 state AGs*, THE NATIONAL LAW JOURNAL, Apr. 12, 2010, http://www.law.com/jsp/nlj/legaltimes/PubArticleFriendlyLT.jsp?id=1202447759851&slreturn=1:

> As we all know, Rule 11 of the Federal Rules of Civil Procedure requires an attorney filing a pleading in federal court to certify that "the claims, defenses, and other legal contentions are warranted by existing law" and "the factual contentions have evidentiary support." The court can sanction an attorney who violates this rule, including an obligation to pay the costs and reasonable attorney fees of the opposing party…This complaint not only represents shockingly shoddy lawyering but should be recognized by the courts for what it in fact is: A pleading whose key claims are without support in the law and the facts. The attorneys who brought this case — solely for political purposes — should have to bear personally the cost of defending this litigation that they are imposing on federal taxpayers.

[172] J. Lester Feder, *HHS May Have to Get 'Creative' on Exchange*, POLITICO, Aug. 16, 2011, http://www.politico.com/news/stories/0811/61513.html#ixzz1zaMlZBtO.

V. Assessing Other Potential Legal Rationales for the IRS Rule

As demonstrated above, neither the text, purpose, structure, nor history of the PPACA support the IRS rule. That does not end the arguments in favor of the rule, however. Insofar as the language of the PPACA would seem to bar the IRS rule, commentators have suggested several additional rationales in defense of the administrative extension of tax credits and subsidies to federal exchanges. *First*, some suggest that the language of Section 1401 was a "scrivener's error" that the IRS, and any reviewing court, would be justified in disregarding. *Second*, some suggest the plain text of Section 1401 should be disregarded because it would produce "absurd results" that undermine the purpose and intent of the PPACA. *Third*, some argue that, insofar as the text of Section 36B is ambiguous or unclear, particularly when read in light of subsequent amendments, the IRS should receive deference for its interpretation under the *Chevron* doctrine. *Fourth*, some argue that statutes should be read in light of evaluations by Congressional agencies, such as the Congressional Budget Office, and that such an approach would support the IRS rule. Each of these arguments has a superficial plausibility. None withstands scrutiny.

A. Scrivener's Error

One possible argument in defense of the IRS rule is that the text of the PPACA contains a simple mistake that the IRS can and should disregard. Specifically, the claim is that Section 1401's failure to reference federal Exchanges created pursuant to the authority in Section 1321 was an error made in the drafting or transcribing of the legislation, and does not reflect legislative intent. Professor Timothy Jost, for instance, has argued that the textual limitation of

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[173] To paraphrase another famous miscalculation, the PPACA's authors believed that when they reached states capitols, they would be greeted as liberators. *See Anti-war Ad Says Bush, Cheney, Rumsfeld & Rice "Lied" About Iraq*, FACTCHECK, Sept. 25, 2005, http://www.factcheck.org/iraq/print_anti-war_ad_says_bush_cheney_rumsfeld.html (Quoting Vice President Dick Cheney on the eve of the U.S.-led invasion of Iraq: "We will be greeted as liberators.").

tax credits and subsidies to state-run (i.e., Section 1311) Exchanges is a "drafting error" that "is obvious to anyone who understands" the PPACA.[174] If the "error" is, in fact, "obvious," then it may be the sort of error that a federal agency (and reviewing courts) should disregard as a "scrivener's error."[175]

A "scrivener's error" is supposed to be just that—a purely clerical error that could be attributed to a failed transcription or something of that sort.[176] Common examples are an error in punctuation that, when read literally, alters the meaning of a statutory provision or a mistaken cross-reference to the wrong subsection in a statute—say, mistaking "(i)" for "(ii)" or "Section 36B(B)(I)(b)" for "Section 36(B)(I)(b)." These are the sorts of mistakes a legislator could easily miss when reviewing 2,000 pages of statutory text or that could even be introduced into a statute when it is amended or transcribed —hence the name "scrivener's error."

To establish that a statutory provision is a scrivener's error typically requires showing that it is *implausible*, not merely unlikely, that a statutory provision was drafted as its authors intended. As the Supreme Court explained in *U.S. National Bank of Oregon v. Independent Insurance Agents of America*, this will only be shown in the "unusual" case in which there is

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[174] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/; *see also* Robert Pear, *Brawling Over Health Care Moves to Rules on Exchanges*, N.Y. TIMES, July 7, 2012 ("Some supporters of the law say Congress may have made a mistake in drafting this section."). Professor Jost has since abandoned this argument. *See* Timothy Jost, *Tax Credits in Federally Facilitated Exchanges Are Consistent with the Affordable Care Act's Language and History*, HEALTH AFFAIRS BLOG, July 18, 2012 ("I agree with Cannon and Adler that the courts are unlikely to find the 'established by the state' language a 'scrivener's error.'").

[175] *See* ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 234 (2012) ("No one would contend that the mistake cannot be corrected if it is of the sort sometimes described as a 'scrivener's error.'" (citing Daniel A. Farber, *Statutory Interpretation and Legislative Supremacy*, 78 GEO. L.J. 281, 289 (1989) ("If the directive contains a typographical error, correcting the error can hardly be considered disobedience.").

[176] In *U.S. National Bank of Oregon v. Indep. Insur. Agents of Amer.*, for example, a "scrivener's error" – in this case mistaken punctuation that changed the statute's meaning -- was characterized as "a mistake made by someone unfamiliar with the law's object and design." 508 U.S. 439, 462 (1993). According to Justice Antonin Scalia a scrivener's error may be found "where on the very face of the statute it is clear to the reader that a mistake of expression (rather than of legislative wisdom) has been made." ANTONIN SCALIA A MATTER OF INTERPRETATION: FEDERAL COURTS AND THE LAW 20 (1997). *See also* Andrew Gold, *Absurd Results, Scrivener's Errors and Statutory Interpretation*, 75 U. CIN. L. REV. 25, 56-60 (2006).

"overwhelming evidence from the structure, language, and subject matter of the law" that Congress could not have consciously adopted the language in the statute.[177] Similarly, in *Appalachian Power Co. v. EPA*, the D.C. Circuit explained that:

> We will not . . . invoke this rule to ratify an interpretation that abrogates the enacted statutory text absent an extraordinarily convincing justification because . . . the court's role is not to correct the text so that it better serves the statute's purposes, for it is the function of the political branches not only to define the goals but also to choose the means for reaching them . . . . Therefore, for the [agency] to avoid a literal interpretation . . ., it must show either that, as a matter of historical fact, Congress did not mean what it appears to have said, or that, as a matter of logic and statutory structure, it almost surely could not have meant it.[178]

Further, the showing must be exceedingly strong for a reviewing court to disregard the statute's text, as the legislature is always free to correct its own mistakes. As Justice Kennedy noted for a unanimous court in *Lamie v. U.S. Trustee*, "If Congress enacted into law something different from what it intended, then it should amend the statute to conform it to its intent."[179] Where a "scrivener's error" is found, an implementing agency or reviewing court is justified in disregarding the literal text of the statute insofar as this is necessary to correct the mistake, but no farther. The discovery of a scrivener's error is not a justification for writing a statute anew.[180]

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[177] 508 U.S. 439, 462 (1993).

[178] 249 F.3d 1032 (D.C. Cir. 2001) (internal quotations and citations omitted); *see also* U.S. v. X-Citement Video, 513 U.S. 64, 82 (1994) (Scalia, J., dissenting) (the "sine qua non" of the doctrine "is that the meaning genuinely intended but inadequately expressed must be absolutely clear; otherwise we might be rewriting the statute rather than correcting a technical mistake.").

[179] 540 U.S. 526, 542 (2004); *see also* U.S. v. Granderson, 511 U.S. 39, 68 (1994) ("It is beyond our province to rescue Congress from its drafting errors and to provide for what we might think . . . the preferred result.").

[180] As the U.S. Court of Appeals for the D.C. Circuit explained:

> Lest it "obtain a license to rewrite the statute," however, we do not give an agency alleging a scrivener's error the benefit of *Chevron* step two deference, by which the court credits any reasonable construction of an ambiguous statute. Rather, the agency "may deviate no further from the statute than is needed to protect congressional intent."

Appalachian Power Co. v. EPA, 249 F.3d 1032, 1043 (D.C. Cir. 2001) (internal citation omitted).

Given the PPACA's unusual (and somewhat hurried) legislative history, one could anticipate that there are scrivener's errors of one sort or another in the Act. As Justice Stevens observed, "a busy Congress is fully capable of enacting a scrivener's error into law,"[181] and the Congress that passed the PPACA was extraordinarily busy. Sure enough, some such errors can be found in the Act. For example, there is a textbook scrivener's error in the very clause where PPACA restricts tax credits to state-run Exchanges. Section 1401 amended the Internal Revenue Code to make taxpayers eligible for premium-assistance tax credits if they enroll in a qualified health plan "through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act."[182] Obviously, the authors inadvertently omitted the word "section" before "1311." The Act contains dozens of references to "Section 1311," including a reference elsewhere in Section 1401 that uses identical language but includes the word "section."[183] The omission of "section" is a clear scrivener's error. It is an error of transcription, and the language is open to no other interpretation.

Another textbook scrivener's error exists in the section of the PPACA that creates the Independent Payment Advisory Board.[184] Subsection (f)(1) details the requirements for a type of joint resolution mentioned in "subsection (e)(3)(B)."[185] Yet subsection (e)(3)(B) makes no mention of joint resolutions. The authors clearly meant to refer to subsection (e)(3)(A). It is there that the Act first mentions the joint resolution in question. Subsection (e)(3)(A) even contains a cross-reference: it states that the joint resolution is "described in subsection (f)(1)."[186] The use of

[181] Koons Buick, Pontiac, GMC, Inc. v. Nigh, 543 U.S. 50, 65 (2004) (Stevens concurring).

[182] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1401, 124 Stat. 119, 213 (2010).

[183] *Id.*

[184] *Id.* § 3403(f)(1); 42 U.S.C. § 1395kkk.

[185] 42 U.S.C. § 1395kkk(f)(1).

[186] 42 U.S.C. § 1395kkk(e)(3)(A)(ii).

"(B)" instead of "(A)" is a clear scrivener's error. It is an error of transcription, and is open to no other interpretation.

In contrast to these provisions, the failure to authorize tax credits for insurance purchased through federal exchanges is not a "scrivener's error." As noted above, there is a plausible rationale for the way the statute is written and ample evidence that the language of the statute provides for what at least some of its authors intended. Either alone would be sufficient to defeat a scrivener's error claim. The alleged error here is also more significant than the sort typically recognized as a scrivener's error. Section 1401 specifically references the sort of Exchanges eligible for tax credits (those "established by the State") and the relevant Section (1311). It makes no mention of federally run Exchanges or Section 1321. A legislator reviewing the relevant language could not claim that they did not realize the statutory cross-reference excluded federal Exchanges because the clear text of the statute does as well.

There is also no evidence we have been able to identify to suggest that the failure to reference Section 1321 in Section 1401 could have been an error of transcription or something of that sort. We have been unable to identify text in any previous iteration of the law—something equivalent to the IRS rule's "or 1321"—which a legislative staffer or someone else might have mistranscribed or inadvertently dropped in order to produce the result the IRS rule seeks. In every material respect, the final versions of the PPACA's relevant provisions are identical to previous drafts of the Finance Committee bill. However many such errors there may be in the Act, the failure to authorize tax credits for the purchase of health insurance in federally run Exchanges is not among them.

Further, in order to establish the existence of a scrivener's error that could be corrected by agency regulation, the IRS would have to do more than show that Congress "clearly did not

mean"[187] to create a presumably undesirable scenario in which the PPACA's "community rating" price controls and individual mandate would take effect but the tax credits would not. The IRS would have to meet the more difficult test of showing that Congress *could not* have intended to produce such a result. Supporters of the rule would have to show, as Professor Jost claims, "There is no coherent policy reason why Congress would have refused premium tax credits to the citizens of states that ended up with a federal exchange."[188]

The IRS cannot meet this test either. The record clearly shows that PPACA supporters had a coherent policy reason for withholding tax credits from uncooperative states. They considered it a viable means of encouraging states to implement the law.[189] Not only is it plausible that Congress wanted to restrict tax credits to state-run Exchanges, that restriction is an essential part of the Act because it is the primary means of enforcing the directive that states "shall" create Exchanges. The HCERA's explicit authorization of tax credits and subsidies through territorial Exchanges, the HELP bill's explicit authorization of credits through federal Gateways, and the rest of the legislative history further show that PPACA's authors made a deliberate policy choice. The record further shows that PPACA supporters contemplated and even created scenarios like what would exist in federal Exchanges, where community-rating price controls would operate without tax credits or subsidies to mitigate the resulting instability.[190] Such a policy may not be wise or fair. It may even undermine the goal of

[187] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

[188] *Id*.

[189] As noted, the use of tax credits for this purpose was also suggested by academics supportive of the PPACA. *See* Jost, *supra* note __.

[190] *See infra*.

expanding health insurance coverage to the uninsured. But it is a sufficiently plausible account of congressional intent to defeat a claim of a scrivener's error.[191]

The feature that the IRS rule seeks to "correct" fails both parts of the scrivener's-error test. Omitting an entire clause or paragraph authorizing two new entitlements is not an error of transcription. It is not equivalent to omitting the word "section" when referring to Section 1311, nor to mistyping "(B)" where only "(A)" makes sense. Further, there is a perfectly reasonable explanation for why the PPACA would mean what it says: the PPACA's authors sought to offer tax credits and subsidies as an incentive to encourage states to create Exchanges. For purposes of the scrivener's-error test, it is sufficient to show that this interpretation is plausible. The PPACA's legislative history, as recounted above, shows this explanation is not only plausible, but is actually the best explanation available.

B. Absurd Results

A related argument for discarding the plain meaning of the statutory text is that a literal application of the text will produce such an absurd result that Congress could not have intended it.[192] As the Supreme Court explained in *United States v. Ron Pair Enterprises*, if "'the literal application of a statute will produce a result demonstrably at odds with the intentions of its

[191] *See, e.g.*, *Lamie*, 540 U.S. (noting potential reasons Congress may have desired the result the alleged error created).

[192] *See, e.g.*, United States v. X–Citement Video, Inc., 513 U.S. 64, 68–69 (1994) (rejecting the "most natural grammatical reading" of a statute to avoid "absurd" results). The most famous, or perhaps infamous, application of this rule is Holy Trinity Church v. United States, 143 U.S. 457, 459–60 (1892) ("It is a familiar rule, that a thing may be within the letter of the statute and yet not within the statute, because not within its spirit nor within the intention of its makers. . . . If a literal construction of the words of a statute be absurd, the act must be so construed as to avoid the absurdity."). Since *Holy Trinity*, courts have become decidedly less willing to find that the plain language of a statute produces "absurd results" justifying an agency departure from the statutory text. *See generally*, John Manning, *The Absurdity Doctrine*, 116 HARV. L. REV. 2387 (2003); *see also* Andrew Gold, *Absurd Results, Scrivener's Errors and Statutory Interpretation*, 75 U. CIN. L. REV. 25 (2006).

drafters,' . . . the intention of the drafters, rather than the strict language, controls."[193] In such cases, an implementing agency or reviewing court would be justified in construing a statute in such a way as would prevent the absurd result. Again, however, this argument requires more than demonstrating that a literal application of the statutory text would be undesirable or objectionable to some portion of those who supported or advocated the law's passage. It requires that the result would be truly "absurd" or unimaginable.[194]

To avail itself of the "absurd results" doctrine, the IRS could argue that denying tax credits to otherwise qualifying individuals who reside in states that fail to create their own Exchanges would produce such absurd consequences that it is inconceivable that the Act would mean what it says. The only potential absurd results argument is that denying tax credits in federal exchanges would compromise the PPACA's stated goal of increasing access to affordable health insurance, particularly if a large number of states were to refuse to create their own Exchanges. The same can be said of the Medicaid expansion. As written, the statute threatened to withhold all funding for the Medicaid expansion and pre-existing Medicaid programs from noncompliant states. Had any state refused to cooperate under these terms, enforcing the statute would compromise the PPACA's goal of expanding coverage. Indeed, it would result in the loss of coverage for existing Medicaid beneficiaries. Yet there is no question that Congress intended to give states this choice, creating a risk that recalcitrant states could undermine achievement of the PPACA's stated goal of expanding coverage.

[193] 489 U.S. 235, 242 (1989) (*quoting* Griffin v. Oceanic Contractors, Inc., 458 U.S. 564, 571 (1982)).

[194] *See, e.g.*, Garcia v. United States, 469 U.S. 70, 75 (1984) ("only the most extraordinary showing of contrary intentions" can justify ignoring statutory text); United States v. Wiltberger, 18 U.S. (5 Wheat.) 76, 96 (1820) (Marshall, C.J.) ("The case must be a strong one indeed, which would justify a Court in departing from the plain meaning of words . . . in search of an intention which the words themselves did not suggest.").

One consequence of the PPACA imposing the community-rating requirement on health insurance sold in federal Exchanges without the presumably stabilizing influence of tax credits would be to destabilize insurance markets, as health insurance premiums would rise, causing many healthy purchasers to exit the market. Yet the mere existence of unwanted effects from a statutory reform is insufficient to show that a statute will produce truly "absurd" results, let alone demonstrate that the language is different than that intended by Congress. In this case, the allegedly "absurd" result is a consequence of how states respond to the PPACA, and not the text itself.

No legislation pursues a single goal without regard for costs or competing priorities.[195] However much legislators seek to pursue a particular goal, they may still conclude a statute "should reach so far and no farther."[196] Trade-offs are omnipresent, and there is rarely a statute that does not contain some provision that tampers with or moderates the statute's overall goal. Further, and perhaps more importantly, a law reflects a deal or compromise made among multiple legislative blocs, and rarely embodies all of one bloc's preferences.[197] This is particularly true when, as here, legislation passes without a vote to spare. Thus there is no reason to privilege one group's preferences or stated intent over the plain meaning of the statute that it approved. And, as already suggested, there is an entirely plausible explanation for the statutory structure that Congress adopted: conditioning the availability of tax credits on state creation of an Exchange was a method of encouraging state cooperation.[198]

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[195] *See* Frank H. Easterbrook, *Statutes' Domains*, 50 U. CHI. L. REV. 533, 541 (1983) ("No matter how good the end in view, achievement of the end will have some cost, and at some point the cost will begin to exceed the benefits.").

[196] *Id*.

[197] *See* William M. Landes & Richard A. Posner, *The Independent Judiciary in an Interest-Group Perspective*, 18 J.L. & ECON. 875, 876 (1975); George J. Stigler, *The Theory of Economic Regulation*, 2 BELL. J. ECON. & MGMT. SCI. 3, 3 (1971).

[198] This structure also served to provide the Senate Finance Committee with jurisdiction over the bill. *See infra*.

Even though restricting tax credits to state-run Exchanges could frustrate the law's goal of expanding health insurance coverage, this would not be a sufficiently "absurd" result to justify disregarding the plain text of the Act. The plain meaning of Section 1401 is not absurd for the same reason it is not implausible that Congress could have meant what it said: the lack of tax credits in federal Exchanges is just one manifestation of PPACA supporters' willingness to induce adverse selection in insurance markets in pursuit of other goals.

Indeed, the Exchange provisions are but one example of Congress doing exactly that through the PPACA. In at least two other instances, Congress displayed an even higher tolerance for iatrogenic instability than what it created in federal Exchanges. One example is the Act's imposition of community-rating price controls on health insurance for children. The Act imposed these price controls with neither a mandate nor subsidies to encourage low-risk individuals to remain in the market. This provision took effect on September 23, 2010—six months after the PPACA's enactment, and more than three years before families with children would become subject to the individual mandate or be eligible for tax credits or subsidies. As a result, thirty-nine states reported that at least one carrier left the child-only market, and in seventeen of those states the market completely collapsed. In some cases, the PPACA caused the market to collapse before the price controls even took effect.[199]

A second example is a new government-run long-term care insurance program authorized by PPACA and known as the Community Living Assistance Services and Supports Act, or CLASS Act. By law, premiums in that program may not vary according to an applicant's risk. Congress neither imposed a mandate requiring low-risk individuals to participate in this

[199] U.S. SENATE, COMM. ON HEALTH, EDUCATION, LABOR AND PENSIONS, RANKING MEMBER REPORT: HEALTH CARE REFORM LAW'S IMPACT ON CHILD-ONLY HEALTH INSURANCE POLICIES (Aug. 2, 2011), *available at*: http://www.help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf.

program, nor created tax credits or subsidies to encourage low risks to participate. Prior to enactment, independent observers warned that the community-rating price controls would induce adverse selection and make the program highly unstable,[200] a reality the Obama administration acknowledged in 2011.[201] Congress enacted it anyway.

Finally, this feature also appeared in both of the PPACA's antecedents.[202] For example, the situation the PPACA creates in states that fail to create Exchanges is exactly the same situation the HELP bill would have created in states that failed to implement that bill's employer mandate. Many members of Congress supported both bills.

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[200] CENTERS FOR MEDICARE AND MEDICAID SERVICES, OFFICE OF THE ACTUARY, ESTIMATED FINANCIAL EFFECTS OF THE 'AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009' (H.R. 3962), AS PASSED BY THE HOUSE ON NOVEMBER 7, 2009 (Nov. 13, 2009), *available at*: http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/HR3962_2009-11-13.pdf. *See also* AMERICAN ACADEMY OF ACTUARIES, CRITICAL ISSUES IN HEALTH REFORM COMMUNITY LIVING ASSISTANCE SERVICE AND SUPPORTS ACT (CLASS) (Nov. 2009), *available at:* http://www.actuary.org/pdf/health/class_nov09.pdf; CENTERS FOR MEDICARE AND MEDICAID SERVICES, OFFICE OF THE ACTUARY, ESTIMATED FINANCIAL EFFECTS OF THE 'PATIENT PROTECTION AND AFFORDABLE CARE ACT,' AS AMENDED (Apr. 22, 2010), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf); DEP'T OF HEALTH AND HUMAN SERVICES, OFFICE OF THE CLASS ACTUARY, ACTUARIAL REPORT ON THE DEVELOPMENT OF CLASS BENEFIT PLANS 33-35 (Sept. 20, 2011), *available at*: http://aspe.hhs.gov/daltcp/reports/2011/class/appO.pdf ("It is not a coincidence that many experts have maintained that adverse selection is the major obstacle for the CLASS program. Any workable design must address it in order to receive certification as an actuarially sound plan").

[201] Sam Baker, *HHS decision erases nearly $100B of projected savings from reform law*, THE HILL'S HEALTHWATCH, Oct. 14, 2011, http://thehill.com/blogs/healthwatch/health-reform-implementation/187727-hhs-decision-erases-nearly-100b-of-projected-savings-from-reform-law ("The Obama administration's decision Friday to scrap a controversial insurance program wiped out nearly $100 billion of the projected savings from the healthcare reform law. Officials at the Health and Human Services Department announced they will no longer try to implement the CLASS program, which was designed to provide insurance for long-term care. By suspending the CLASS Act, HHS also erases about 40 percent of the savings the healthcare reform was supposed to generate for the government.").

One might argue that the CLASS Act is not an apt example of PPACA supporters' tolerance for adverse selection, because the law requires it to be self-sustaining and HHS has suspended implementation due to the Department's inability to develop a sustainable model for the program. But if the IRS were to claim Congress would not have enacted community-rating price controls without also subsidizing low-risk consumers, the CLASS Act is an example of Congress doing just that. Moreover, the non-partisan Congressional Research Service has written that federal courts could order HHS to implement the CLASS Act even if it is not sustainable. See Avik Roy, *Congressional Research Service: Courts Could Force HHS to Implement CLASS Act, Despite Its Insolvency*, FORBES, Feb. 1, 2012, http://www.forbes.com/sites/aroy/2012/02/01/congressional-research-service-courts-could-force-hhs-to-implement-class-act-despite-its-insolvency/.

[202] Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 190 and Sec. 191, pp. 228-281, (2009). ; Affordable Health Choices Act, S. 1697, 111th Cong. Sec. 101, pp. 8-30, (2009); America's Healthy Future Act of 2009, S. 1796, 111th Cong. Sec. 1001, pp. 14-24 (2009).

These examples show that the lack of tax credits in federal Exchanges is consistent with the high tolerance for adverse selection evident elsewhere in the Act, and reinforces that this is not the sort of "absurd" result that would justify ignoring clear statutory text. Congress clearly contemplated allowing community-rating price controls to operate in the absence of credits or subsidies that might mitigate the resulting instability. Because the PPACA does more to mitigate adverse selection in federal Exchanges than in either the child-only market or the CLASS Act—Congress imposed an individual mandate that would take effect at the same time federal Exchanges would begin operations—there is nothing about the lack of tax credits in federal Exchanges to suggest a departure from congressional intent, absurd or otherwise.

Even if the consequences of enforcing the plain language of Section 1401 would strike *some* as "absurd," this does not give the IRS "license to rewrite the statute."[203] Rather, where an agency concludes that literal enforcement of the statutory text would thwart congressional intent "it may deviate no further from the statute than is needed to protect congressional intent."[204] This, in turn, calls upon a reviewing court to consult other sources of legislative intent so as to ensure that the law in question is applied as intended.[205]

[203] *See* Mova Pharm. Corp. v. Shalala, 140 F.3d 1060, 1068 (D.C. Cir. 1998).

[204] *Id.*

[205] *See* Public Citizen v. U.S. Department of Justice, 491 U.S. 440, 454 (1989)("Where the literal reading of a statutory term would 'compel an odd result,' we must search for other evidence of congressional intent to lend the term its proper scope.").

C. *Chevron* Deference

Another argument in support of the IRS rule is that the IRS should receive *Chevron* deference in its interpretation of the relevant provisions.[206] According to Professor Jost, the IRS' interpretation should prevail because *Chevron USA v. Natural Resources Defense Council*[207] requires that an agency's "official construction of an ambiguous statute should be accorded deference by any reviewing court."[208] Thus even if Section 1401 appears to be clear and unambiguous when read in isolation, the IRS could argue that the text and structure of the law as a whole creates sufficient ambiguity about the operation of this provision to trigger *Chevron* deference.[209] So, for instance, Professor Jost argues the HCERA "creates an ambiguity in the law that the IRS can resolve through its rule-making power."[210] Here again, arguments in defense of the IRS rule falter.

Chevron outlined a two-step inquiry for courts to apply when evaluating agency interpretations of federal statutes. First, the reviewing court considers the statutory text to determine "whether Congress has directly spoken to the precise question at issue."[211] If so, the statute controls, "for the court, as well as the agency, must give effect to the unambiguously

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[206] *See, e.g.*, Kraemer & Gostin, *supra* note __, at 1975 (suggesting courts would defer to regulation authorizing tax credits in federal exchanges.

[207] 467 U.S. 837 (1984).

[208] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept.11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

[209] The Supreme Court has endorsed the idea that statutory provisions should be read in light of the entire statutory structure. *See, e.g.*, Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000) (A court must . . . interpret the statute "as a symmetrical and coherent regulatory scheme"). (internal quotation omitted)).

[210] David Hogberg, *Companies Could Challenge ObamaCare Employer Fines*, INVESTOR'S BUSINESS DAILY, Sept. 16, 2011, http://news.investors.com/article/585053/201109161746/companies-could-challenge-obamacare-employer-fines.htm.

[211] *Chevron*, 467 U.S. at 842.

expressed intent of Congress."[212] If the reviewing court concludes that the statute is "silent or ambiguous," however, and determines that interpretive authority has been delegated to the agency, the court must defer to the agency's statutory interpretation, so long as it "is based on a permissible construction of the statute."[213] At this second step, the agency's interpretation is given "controlling weight" unless it is "arbitrary, capricious, or manifestly contrary to the statute."[214]

Although there has been some suggestion that *Chevron* is not applicable to IRS or even Treasury Department regulations, the Supreme Court has recently reaffirmed that this approach applies "with full force in the tax context."[215] "Filling gaps in the Internal Revenue Code plainly requires the Treasury Department to make interpretive choices for statutory implementation,"[216] but the Treasury Department (and the IRS) are entitled to no extra leeway or special treatment. Further, while *Chevron* is quite permissive to agency interpretations, such deference *only* applies once a court has concluded a statute is ambiguous. The reviewing court owes the agency "no deference" on the question of whether a statute is ambiguous in the first place.[217]

But ambiguity alone does not trigger *Chevron* deference.[218] As the Supreme Court has made clear in recent years, most notably in *United States v. Mead Corp.*,[219] the basis for according deference to agency interpretations of ambiguous statutes is the conclusion that

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[212] *Id.* at 842-43.

[213] *Id.* at 843.

[214] *Id.* at 844.

[215] *See* Mayo Foundation for Medical Education and Research v. United States, 131 S.Ct. 704, 713 (2011).

[216] *Mayo Fdn*, 131 S.Ct. at 713.

[217] *See* Amer. Bar Assn. v. FTC, 430 F. 3d 457, 468 (D.C. Cir. 2005)("The first question, whether there is such an ambiguity, is for the court, and we owe the agency no deference on the existence of ambiguity.") (internal citation omitted); *see also* Ry. Labor Exec. Ass'n v. Nat'l Mediation Bd., 29 F.3d 655, 671 (D.C.Cir.1994) (en banc).

[218] *See* Michigan v. EPA, 268 F.3d 1075, 1082 (D.C.Cir.2001) ("Mere ambiguity in a statute is not evidence of congressional delegation of authority.") (citations omitted).

[219] 533 U.S. 218 (2001).

Congress has delegated such interpretive authority to the agency. *Chevron* applies only "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority."[220] Further, notes Professor Adrian Vermeule, "the default rule runs against delegation. Unless the reviewing court affirmatively finds that Congress intended to delegate interpretive authority to the particular agency at hand, in the particular statutory scheme at hand, *Chevron* deference is not due and the *Chevron* two-step is not to be invoked."[221]

The IRS' primary argument is that its interpretation is "consistent with" the statute and that there is no evidence in "the relevant legislative history" to "demonstrate that Congress intended to limit the premium tax credit to State Exchanges."[222] In effect, the IRS is arguing that since the PPACA does not preclude the agency's interpretation, that interpretation should control.

This rationale for the rule cannot satisfy *Chevron* step one. To claim that an agency action is consistent with a statute is not even an assertion, much less a showing of ambiguity. A lack of evidence (in the "relevant" legislative history) that Congress intended to forbid an agency action is likewise not enough to demonstrate a statutory ambiguity, let alone to justify *Chevron* deference. Agencies have no inherent powers, only delegated ones.[223] Agencies, including the

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[220] *Mead*, 533 U.S. at 226–27; *see also* Adams Fruit Co. v. Barrett, 494 U.S. 638, 649 (1990); Dunn v. Commodity Futures Trading Comm'n, 519 U.S. 465, 479 n.14 (1997) (explaining that *Chevron* deference "arises out of background presumptions of congressional intent" (citing Smiley v. Citibank (S.D.), 517 U.S. 735, 740–41 (1996))); Merrill & Hickman, at 863 (observing that "[t]he Court . . . has rather consistently opted for the congressional intent theory" as the legal foundation for *Chevron* deference).

[221] *See* Adrian Vermeule, *Introduction:* Mead *in the Trenches*, 71 GEO. WASH. L. REV. 347, 348 (2003).

[222] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30378 (May 23, 2012), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf.

[223] *See* Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208 (1988) ("It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress."); La. Pub. Serv. Comm'n v. FCC, 476 U.S. 355, 374 (1986) ("[A]n agency literally has no power to act . . . unless and until Congress confers power upon it.").

IRS, "are creatures of statute . . . [that] may act only because, and only to the extent that, Congress affirmatively has delegated them the power to act."[224] When Congress is silent on a question—such as whether an agency has authority to issue tax credits, authorize entitlement spending in the form of refundable credits or cost-sharing subsidies, or levy taxes on employers—one should presume that the authority does not exist.

The D.C. Circuit has expressly rejected the proposition that *Chevron* step one is satisfied "any time a statute does not expressly *negate* the existence of a claimed administrative power."[225] In *American Bar Association v. Federal Trade Commission*, for example, the court forcefully rejected the FTC's claim that it could interpret a statute to provide a source of regulatory authority because "no language in the statute" expressly provided otherwise.[226] Similarly, in *Railway Labor Executives' Association v. National Mediation Board*, the D.C. Circuit rejected the proposition that an agency could "*presume* delegation of power from Congress absent an express *withholding* of such power."[227] As the Court explained:

> To presume . . . that *Chevron* step two is implicated any time a statute does not expressly *negate* the existence of a claimed administrative power (*i.e.* when the statute is not written in "thou shalt not" terms), is . . . flatly unfaithful to the principles of administrative law.[228]

Even if the IRS were able to satisfy *Chevron* step one by convincing a court that the relevant portions of the PPACA are sufficiently ambiguous to justify an IRS interpretation, the IRS rule would still fail. Reaching step two of the *Chevron* test does not give agencies free rein. For an agency's interpretation to prevail at step two, it must still be consistent with the relevant

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[224] American Bus Ass'n v. Slater, 231 F.3d 1, 9 (D.C. Cir. 2000) (Sentelle, j., concurring).

[225] Ry. Labor Executives' Ass'n v. Nat'l Mediation Bd., 29 F.3d 655, 671 (D.C. Cir. 1994); *see also* Am. Bar Ass'n v. FTC, 460 F.3d 457, 468 (D.C. Cir. 2005)(same).

[226] *Am. Bar Ass'n*, 430 F.3d at 468.

[227] *Ry. Labor Executives' Ass'n*, 29 F.3d at 659 (emphasis in original).

[228] *Id.* at 671.

statutory text. Thus, even if the IRS could demonstrate that the PPACA is ambiguous, it would have to argue that its rule is consistent with what Congress actually enacted and the President signed into law. As the foregoing discussion of the statute's text, structure, and history should make clear, this would be difficult. The IRS's interpretation is decidedly inconsistent with the statute's repeated and consistent use of language restricting tax credits to Exchanges "established by the state under [S]ection 1311."

Suppose, however, the IRS were able to convince a reviewing court that the PPACA is ambiguous on whether it limits tax credits to state-based Exchanges. The IRS would also need to demonstrate that this ambiguity was evidence of an implicit delegation of authority to interpret the statute in a way that would authorize the creation of new tax credits, new entitlement spending, and new taxes on employers and individuals, beyond the purview of the traditional legislative appropriations process. This is not the sort of authority one should lightly presume Congress delegated to an agency.[229] To paraphrase the Supreme Court, Congress does not hide such "elephants in mouseholes."[230]

If an ambiguity of that sort were sufficient to trigger full *Chevron* deference to this sort of agency action, ambiguities in tax-related statutes could become so substantial a fount of IRS power that it would raise difficult constitutional questions.[231] Article I, Section 8 vests all legislative power in the Congress, and Article I, Section 9 provides that "No Money shall be

[229] The framers of the Constitution considered the power to tax so dangerous that they required that "All Bills for raising Revenue shall originate in the House of Representatives" because that chamber is closest to the people. *U.S. Const.* art. I, § 7. Yet the IRS would maintain that Congress delegated such authority to a federal agency despite the lack of express statutory language to that effect.

[230] *See* Whitman v. Am. Trucking Ass'ns, 531 U.S. 457 (2001)

[231] *See* Jonathan T. Molot, *Reexamining Marbury in the Administrative State: A Structural and Institutional Defense of Judicial Power over Statutory Interpretation*, 96 NW. U. L. REV. 1239, 1282 (2002) ("If administrators were given final authority on issues of statutory construction this shift in power would substantially undermine our constitutional commitment to representative government.").

drawn from the Treasury, but in Consequence of Appropriations made by Law."[232] For an agency to claim unilateral authority to interpret a statute so as to draw money from the Treasury—in this case, through entitlement spending in the form of refundable tax credits and cost-sharing subsidies—is to assert authority of questionable constitutional validity. The same applies to the taxing power, which the Constitution likewise reserves solely to Congress.[233] It is a longstanding principle that courts are to avoid those statutory interpretations that would raise difficult constitutional questions.[234] This is true even where a statute is sufficiently ambiguous that it might otherwise justify *Chevron* deference.[235]

It would be one thing if Congress were to expressly delegate authority to the IRS to provide premium assistance under general conditions that the IRS could then clarify and define. Here, however, the IRS is claiming the authority to authorize tax credits and entitlement spending beyond the express limits imposed by Congress. Yet the IRS' position is not that its interpretation is compelled by the PPACA, only that it is "consistent with" it. This means the decision to provide such tax credits and cost-sharing subsidies is being made not by Congress, where such power has been vested, but by the IRS. The IRS position, at heart, is that Congress has enacted an ambiguous statute and thereby delegated to the IRS the discretionary authority to decide whether or not tax credits, subsidies, and taxes are authorized in states that do not establish Exchanges. This is authority Congress would not grant lightly, and is certainly not the

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[232] U.S. CONST. art. I, § 8, § 9.

[233] U.S. CONST. art. I, § 8. *See also* Skinner v. Mid-America Pipeline Co., 490 U.S. 212, 223 (1989) (noting "Congress must indicate clearly its intention to delegate" authority to impose taxes or fees).

[234] *See, e.g.,* Edward J. DeBartolo Corp. v. Florida Gulf Coast Building & Constr. Trades Council, 485 U.S. 568, 575 (1988) ("where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress."); Bowen v. Georgetown University Hospital, 488 U.S. 204, 208-09 (1988).

[235] *See* Solid Waste Agy North. Cook Cty. v. U.S. Army Corps of Engineers, 531 U. S. 159 (2001) ("Where an administrative interpretation of a statute invokes the outer limits of Congress' power, we expect a clear indication that Congress intended that result.").

sort of authority to be found in an alleged ambiguity within statutory text. Thus even if one were to conclude Section 1401 of the PPACA is ambiguous, it would still not justify deference to the IRS.

Supporters of the rule point to language in the PPACA granting the IRS authority to promulgate regulations to implement the law as authority for the IRS rule. Professor Jost, for example, argues, "Section 36B(g) gives the Secretary of the Treasury the responsibility of issuing regulations to implement section 36B. This includes the authority to reconcile ambiguities in the statute, such as the inconsistency" created by the information-reporting requirement.[236]

Though subsection 36B(g) of the Internal Revenue Code grants the Secretary the power to "prescribe such regulations as may be necessary to carry out the provisions of this section,"[237] it does not vest the Secretary with the power to issue this rule. It is not necessary to impose unauthorized taxes, issue unauthorized tax credits, dispense unauthorized subsidies to private health insurance companies, or create two unauthorized entitlements for individuals, in order to implement the one entitlement section 1401 does authorize, or to carry out its reporting requirement. Nor is it necessary to *alter* the "aggregate amount[s] of any advance payment[s] of such credit or reductions"[238] in order to *report* on those amounts, as 36B(f) requires, or otherwise to carry out the provisions of this section.

[236] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

[237] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1401, 124 Stat. 119, 219 (2010).

[238] Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Sec. 1004, 124 Stat. 1029, 1035 (2010) (amends I.R.C. § 36B(f)).

D. "Such Exchange"

Supporters of the IRS rule claim to have found language in Section 1321 that either provides a sufficient statutory basis for the rule or introduces sufficient statutory ambiguity to trigger *Chevron* deference. As noted above, section 1321 provides that if a state fails to create the "required Exchange" or fails to create an Exchange that complies with federal requirements, "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."[239] The Treasury Department writes that this language makes "a federally-facilitated exchange the equivalent of a state exchange in all functional respects."[240] Professor Jost elaborates:

> By "such Exchange" Congress meant the "required exchange" mandated by [S]ection 1311. Thus when several subsequent sections refer to "an Exchange established by the State under [S]ection 1311," including the provisions of Internal Revenue Code [S]ection 36B . . . they are referring both to state exchanges and to "such exchanges" established within states by the Secretary.[241]

In this account, Section 1321's reference to "such exchange" either shoehorns Section 1321 Exchanges into Section 1311, or at least creates sufficient ambiguity to allow for the interpretation offered by the IRS. Neither claim can be squared with the statute.

Professor Jost cites the definition of Exchanges the PPACA inserts into Section 2791(d) of the Public Health Service Act:[242]

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[239] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1321(c), 124 Stat. 119, 186 (2010).

[240] *See* Letter from Mark J. Mazur, Assistant Secretary for Tax Policy, U.S. Treasury Department, to the Honorable Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, (Oct. 12, 2012), *available from the authors on request*. *See also* Sam Bagenstos, *The Legally Flawed Rearguard Challenge to Obamacare*, BALKINIZATION, Nov. 27, 2012, http://balkin.blogspot.com/2012/11/the-legally-flawed-rearguard-challenge.html.

[241] Jost, HEALTH AFFAIRS BLOG, *supra*.

[242] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 264 (2010) (Amends 42 U.S.C. § 300gg–91(d)).

> Section 1563(b) of the ACA states: "The term 'Exchange' means an American Health Benefit Exchange established under [S]ection 1311 of the Patient Protection and Affordable Care Act." Section 1311 literally requires that the states "shall" establish an American Health Benefits Exchange by January 1, 2014. Because the Constitution prohibits the federal government from literally requiring states to establish exchanges, however, [S]ection 1321(c), provides that "the [HHS] Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State." Under the ACA's definition of exchange, the term 'Exchange' in [S]ection 1321 exchange means a [S]ection 1311 exchange.[243]

He presents this as the plain meaning of Section 1321, rather than an ambiguity-based argument, because he maintains there are no conflicts between Section 1401 and any other part of the statute.[244]

A plain reading of the statute cannot support this claim. First, in each of the above-mentioned examples of equivalence language—the HELP Committee bill, the House bill, the PPACA's authorization of tax credits in territorial Exchanges, and the information-reporting requirement—Congress explicitly mentioned the two types of Exchange between which it sought to draw equivalence, and explicitly delineated the scope of that equivalence. The definition of "Exchange" in Section 1563 does neither.

Second, as noted earlier, Section 1401 expressly and repeatedly restricts tax credits to Exchanges "established by the State under [S]ection 1311." The text of Section 1321 does not support the claim that a Section 1321 Exchange *is* a Section 1311 Exchange. Section 1321 Exchanges are distinct. They are authorized by a separate section of the statute (1321) that incorporates Title I's other Exchange requirements into that section. The fact that Congress

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[243] *IRS: Enforcing ObamaCare's New Rules and Taxes, Before The House Comm. on Oversight and Government Reform*, 111th Cong. 3 (Aug. 2, 2012) (Testimony of Timothy S. Jost), *available at*: http://oversight.house.gov/wp-content/uploads/2012/08/Jost-Testimony.pdf. Note that the PPACA contains three separate Sections 1563.

[244] *IRS: Enforcing ObamaCare's New Rules and Taxes, Before The House Comm. on Oversight and Government Reform*, 111th Cong. 3 (Aug. 2, 2012) (Note: unofficial transcript), *video available at*: http://oversight.house.gov/hearing/irs-enforcing-obamacares-new-rules-and-taxes/ (begins at 58:46).

mentioned them separately when amending the PPACA with the HCERA confirms that Congress saw them as distinct. The Act contains no language providing that Section 1311 and 1321 Exchanges shall be equivalent with regard to tax credits. Quite the contrary: Section 1321 delineates the scope of that equivalence by providing that both types of Exchange are subject to the requirements of Title I, which includes the eligibility restrictions on tax credits.

Third, even if a Section 1321 Exchange were deemed to be a Section 1311 Exchange, it would still not be an Exchange "established by a State." Section 1401 repeatedly requires that recipients of tax credits must be enrolled in health insurance through an Exchange that is "established by a state." Section 1311 lists among its "requirements" that, for purposes of that section, "An Exchange shall be a governmental agency or nonprofit entity that is established by a State."[245] However else a Section 1321 may be like a Section 1311 Exchange, it cannot be an Exchange "established by a State."

The IRS's claim that federal Exchanges may distribute tax credits reduces to the absurd claim that the federal government can establish an Exchange that is "established by a state." Such a notion "violates [the] canon of statutory construction . . . that every provision of a congressional enactment should be given effect"[246] because it would strip multiple provisions in Sections 1311 and 1401 of their plain meaning.

This "such Exchange" defense of the IRS rule also contradicts another argument the Treasury Department and Professor Jost offer in defense of the rule: that "Congress demonstrated its understanding that federal exchanges would administer premium tax credits"[247]

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[245] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311(d)(1), 124 Stat. 119, 176 (2010).

[246] *IRS: Enforcing ObamaCare's New Rules and Taxes*, *Before The House Comm. on Oversight and Government Reform*, 111th Cong. 3 (Aug. 2, 2012), *available at*: http://oversight.house.gov/wp-content/uploads/2012/08/Jost-Testimony.pdf.

[247] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

when the HCERA imposed the same information-reporting requirements on Exchanges established under both Section 1311 and 1321.[248] If, as Professor Jost claims, a "[S]ection 1321 exchange means a [S]ection 1311 exchange," there would have been no need for Congress to mention both Section 1311 and Section 1321 Exchanges in the information-reporting requirements. If a Section 1311 Exchange *is* a Section 1311 Exchange, then including Section 1321 would have been redundant. The "such Exchange" theory prevents this provision from being given effect as well.

Professor Jost is nevertheless correct that there is no conflict between Section 1401 and Section 1321 or any other provision of the statute. Section 1321's command that the Secretary shall establish "such Exchange"[249] directs the federal government to create Exchanges that are identical to Section 1311 Exchanges, except where Congress has provided otherwise.

E. The "CBO Canon"

A rather novel defense of the IRS rule is that the IRS has authority to issue it because it is consistent with the manner in which the Congressional Budget Office (CBO) scored the PPACA.[250] Specifically, the argument is that the CBO score, including the revenue analysis of the law by the Joint Committee on Taxation, are evidence that the law was ambiguous and can be interpreted to support the IRS regulation. As Professor Jost explains:

> the Joint Committee on Taxation and Congressional Budget Office assumed that the tax credits will be available through the federal

[248] Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Sec. 1004, 124 Stat. 1029, 1035 (2010).

[249] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1321(c), 124 Stat. 119, 186 (2010).

[250] *See* Abbe Gluck, *The "CBO Canon" and the Debate Over Tax Credits on Federally Operated Health Insurance Exchanges*, BALKINIZATION, July 10, 2012, *available at*: http://balkin.blogspot.com/2012/07/cbo-canon-and-debate-over-tax-credits.html. *See also* Shulman letter, *supra*.

> exchange. This is how the IRS and HHS have interpreted the law . . . and is clearly what Congress intended.[251]

If the actions of the CBO and the Joint Committee on Taxation (JCT) are not enough, in themselves, to demonstrate Congressional intent, Professor Abbe Gluck argues that there should be an "interpretive presumption" that statutory ambiguities "should be construed in the way most consistent with the assumptions underlying the congressional budget score on which the initial legislation was based."[252] According to Gluck, because Congress "drafts in the shadow" of CBO budget scores, the CBO score "offers better evidence of congressional 'intent' than other commonly consulted non-textual tools, including legislative history."[253] Alternatively, if the CBO score is not evidence that the statute supports the IRS rule, the existence of a CBO score consistent with the rule could at least suggest that the statute is sufficiently ambiguous to allow for the rule.

This theory of statutory construction raises interesting questions, none of which need be addressed here. The CBO score of the PPACA's Exchange provisions is entirely consistent with the plain text of the statute and the prevailing assumptions about how these provisions would operate in practice.[254] The JCT and CBO produced revenue and spending estimates that assumed tax credits would be available in all fifty states. But this is not the same as "assum[ing] that the tax credits will be available through the federal exchange," and neither the CBO nor JCT stated

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[251] Timothy Jost, *Implementing Reform: Funding And Flexibility For States On Exchanges*, HEALTH AFFAIRS BLOG, Nov. 30, 2011, http://healthaffairs.org/blog/2011/11/30/implementing-reform-funding-and-flexibility-for-states-on-exchanges/. IRS Commissioner Douglas Shulman has also made this argument. *See* John Gramlich, *GOP Prepares Efforts to Challenge IRS Rule on Health Insurance Subsidies*, CQ TODAY, July 10, 2012.

[252] Gluck, *supra*.

[253] *Id.*

[254] Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, NY TIMES, Aug. 5, 2012, *available at:* http://www.nytimes.com/2012/08/05/us/us-officials-brace-for-huge-task-of-running-health-exchanges.html ("When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange[.]").

such an assumption when conducting their analysis. Indeed, the CBO has acknowledged it did not conduct a legal analysis of whether the statute authorizes tax credits through federal Exchanges.[255] Thus its cost projections can hardly be considered authoritative. Like many of the PPACA's supporters, it appears the CBO and JCT simply assumed that every state would create its own exchange, and incorporated that miscalculation in their projections. Further evidence for this interpretation, if more were needed, is that the CBO made no mention of the hundreds of millions of dollars it would take to establish and operate federally run Exchanges (just as Congress didn't authorize those funds).[256] The CBO simply assumed every state would establish its own Exchange and did not even consider the question of what would happen if they did not. There is no basis for relying upon CBO or JCT budget projections to overturn or alter the plain meaning of the PPACA's text.

VI. Standing to Challenge the IRS Rule

The fact that the IRS rule exceeds the scope of the authority Congress delegated the agency and is contrary to law does not necessarily mean there is recourse. It can be particularly difficult to challenge IRS implementation of a statute, particularly where, as here, the IRS' alleged malfeasance consists of granting tax benefits and federal subsidies to others. As Professor Jost initially argued, "there will be no judicial review of this determination. It is not possible to conceive of a person who would be injured in fact by this interpretation of the rule

[255] *See* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43752-letterToChairmanIssa.pdf. *See also* http://oversight.house.gov/wp-content/uploads/2012/12/2012-11-30-DEI-to-Elmendorf-CBO-PPACA-tax-credits.pdf.pdf.

[256] For example, in a letter to the ranking member of the House Appropriations Committee, the CBO detailed the administrative costs to the federal government of implementing the PPACA, but made no mention of Exchange-implementation costs. Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Rep. Jerry Lewis, H.R. 3590, Patient Protection and Affordable Care Act, Additional information about potential effects on discretionary spending (May 11, 2010), *available at:* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/114xx/doc11490/lewisltr_hr3590.pdf.

such that they could present a case or controversy under Article III."[257] In the normal case, this could be true. Given how Section 1401 interacts with the rest of the PPACA's intricate regulatory structure, however, there could be standing to challenge the IRS rule.[258]

A plaintiff must have Article III standing in order to challenge the legality of a federal agency action in federal court. Specifically, under *Lujan v. Defenders of Wildlife*, the "irreducible constitutional minimum of standing" has three parts.[259] *First*, the "plaintiff must have suffered an 'injury in fact,'" that is both "actual or imminent" and "concrete and particularized."[260] *Second*, there must be a "causal connection between the injury and the conduct complained of."[261] *Third*, there must be a sufficient likelihood that the "the injury will be 'redressed by a favorable decision.'"[262] When an individual or corporation is the subject of a government action, standing is relatively easy to satisfy. A plaintiff always has standing to challenge a government action that is directed against him. So, for instance, an individual or corporation would have standing to challenge the imposition of allegedly illegal tax assessed against them.[263]

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[257] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept. 11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

[258] Professor Jost has since acknowledged this point. *See* Jost, HEALTH AFFAIRS BLOG, *supra* ("The only viable challengers to the law are employers who may in the future have to pay an exaction because they fail to offer their employees insurance (or affordable or adequate insurance) and their employees consequently end up receiving tax credits in the federal exchanges."). Though he may be wrong about employers being the only viable challengers. See *infra*.

[259] 504 U.S. 555, 560 (1992). *See also* NE Fla. Chap. of Associated Gen. Contractors of Amer. v. City of Jacksonville, Fla., 508 U.S. 656, 663 (1993) (restating the minimum requirements of Article III standing articulated in *Lujan*); U.S. v. Hays, 515 U.S. 737, 742–43 (1995) (same); Bennett v. Spear, 520 U.S. 154, 162 (1997) (same); Steel Co. v. Citizens for a Better Envt, 523 U.S. 83, 102–03 (1998) (same); Friends of the Earth, Inc. v. Laidlaw Envtl Svcs, Inc., 528 U.S. 167, 180–81 (2000) (same).

[260] *Id.*

[261] *Id.*

[262] *Id.* at 561 (quoting Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26, 38 (1976)).

[263] While standing is easy to establish in such cases, there may be other barriers to obtaining prompt judicial review. The Anti-Injunction Act, for example, provides that, as a general rule, "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person." 26 U.S.C. § 7421(a). This

The Supreme Court has repeatedly held that, with few exceptions not relevant here,[264] federal taxpayers lack Article III standing to challenge the allegedly illegal or even unconstitutional expenditure of federal funds. In *DaimlerChrysler Corp. v. Cuno*, for example, the Court held unanimously that taxpayers lacked Article III standing to challenge a state's award of preferential tax credits to a local manufacturer. [265] As the Court explained in *Frothingham v. Mellon*, a taxpayer's interest in the federal treasury is indistinct, "minute and indeterminable," and "the effect upon future taxation, of any payment out of the funds, so remote, fluctuating and uncertain."[266] As a consequence, a taxpayer's alleged injury from the illegal expenditure of federal funds is not "concrete and particularized," nor is it "actual or imminent."[267]

The logic that precludes taxpayer standing to challenge the allegedly illegal expenditure of taxpayer dollars is "equally applicable" to tax credits and other targeted tax preferences.[268] As Chief Justice Roberts explained for the Court in *Cuno*, a federal taxpayer would lack standing to challenge a tax credit or exemption; "[i]n either case, the alleged injury is based on the asserted effect of the allegedly illegal activity on public revenues, to which the taxpayer contributes."[269] As a consequence, individual taxpayers or even taxpayer organizations would lack standing to

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restriction can prevent judicial review of a tax before it is collected, but does not affect a plaintiff's Article III standing to sue.

[264] These exceptions concern challenges legislative appropriations alleged to violate the First Amendment's prohibition on the establishment of religion. *See, e.g.*, Hein v. Freedom from Religion Foundation, Inc., __ U.S. __ (2007). Whether this exception is coherent or not is another question. *See* Jonathan H. Adler, *God, Gaia, the Taxpayer and the Lorax: Standing, Justiciability, and Separation of Powers after* Massachusetts *and* Hein, 20 REGENT U. L. REV. 175 (2008).

[265] 547 U.S. 332 (2006).

[266] 262 U.S. 447, 487 (1923).

[267] *Cuno*, 547 U.S. at 344.

[268] *Id.* at 343.

[269] *Id.* at 344.

challenge the legality of the IRS' decision to offer tax credits and subsidies to those who purchase health insurance on federally run Exchanges.

These barriers would not preclude a legal challenge to the IRS rule, however. First, the issuance of a tax credit for the purchase of a qualifying health insurance plan in a federal Exchange triggers the penalty for the so-called "employer mandate."[270] Specifically, under Section 1513, when an employee of a company with more than fifty employees receives a tax credit for purchasing insurance on an Exchange, the employer is assessed a penalty of up to $2,000 per worker.[271] If the federal government lacks the legal authority to offer tax credits through a federal Exchange, then any employer that would be penalized as a result of one of those tax credits should have standing to challenge the IRS rule. Such an employer would have to demonstrate that it is covered by the employer mandate, does not provide a qualifying level of health insurance to its employees, and is located in a state that has opted not to create an Exchange. Insofar as the employer-mandate penalty is considered to be a tax, it could be subject to the Anti-Injunction Act, which prevents taxpayers from challenging the legality of a tax before that tax is assessed.[272] If so, this would only affect the timing of such a suit, and would not prevent a suitable employer from establishing standing to challenge the rule.

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[270] As far as the authors are aware, the first person to makes this point was Professor James Blumstein. *See*, David Hogberg, *Companies Could Challenge ObamaCare Employer Fines*, INVESTOR'S BUSINESS DAILY, Sept. 16, 2011, http://news.investors.com/article/585053/201109161746/companies-could-challenge-obamacare-employer-fines.htm.

[271] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1513, 124 Stat. 119, 253-256 (2010) as revised by the Health Care and Education Reconciliation Act of 2010.

[272] Whether the penalty would be considered a tax for Anti-Injunction Act purposes is not clear. In *NFIB v. Sebelius*, the Court unanimously concluded that the act did not bar suit against the "individual mandate," even though a majority of the Court upheld the mandate as a tax. Nat'l Fed'n Indep. Bus. v. Sebelius, 567 U.S. __, __ (2012) ("Congress can, of course, describe something as a penalty but direct that it nonetheless be treated as a tax for purposes of the Anti-Injunction Act. For example, 26 U. S. C. §6671(a) provides that "any reference in this title to 'tax' imposed by this title shall be deemed also to refer to the penalties and liabilities provided by" subchapter 68B of the Internal Revenue Code. Penalties in subchapter 68B are thus treated as taxes under Title 26, which includes the Anti-Injunction Act. The individual mandate, however, is not in subchapter 68B of the Code.").

Certain religious employers would have an additional incentive to challenge the IRS rule. The PPACA mandates that all health plans provide first-dollar coverage for preventive services. HHS has defined this standard to include all forms of contraception approved by the federal Food and Drug Administration. Employers from certain religious denominations have objected to this mandate because they consider such forms of contraception to be immoral. Dozens of employers have filed suit claiming the contraceptives mandate violates their conscience rights as protected by the federal Religious Freedom Restoration Act and the First Amendment.[273] Such employers have an additional incentive to challenge the IRS rule. If the direct challenges to the contraceptives mandates fail, then blocking the IRS rule would enable those employers to stay true to their consciences and avoid the contraceptives mandate by dropping their employee health benefits without penalty.

Second, many individuals could be able to challenge the rule on the grounds that the issuance of unauthorized tax credits in federal Exchanges exposes them to penalties under the individual mandate. As noted above, the individual mandate exempts non-compliant taxpayers from penalties if their "required contribution" exceeds 8 percent of household income. Under the statute, if a state does not establish an Exchange, the "required contribution" equals the premium for the lowest-cost plan available to the taxpayer through the federal Exchange, because there are no tax credits to reduce the "required contribution" below that premium. If the IRS nevertheless issues unauthorized tax credits through a federal Exchange, then those tax credits could reduce a taxpayer's "required contribution" below the threshold, exposing her to penalties. In 2016, those penalties can range from $695 for some individuals to $2,085 for families of four.

[273] *See, e.g.*, Legatus v. Sebelius, __ F.Supp.2d __, 2012 WL 5359630 (E.D. Mich. 2012); Wheaton College v. Sebelius, -- F. Supp. 2d __, 2012 WL 3637162 (D.D.C. 2012); *see also* David Gibson, *Catholic groups file suit over HHS birth control mandate*, WASH. POST, May 21, 2012 (noting "dozens" of Catholic institutions had filed suit against the so-called "contraception mandate").

Individuals could establish standing by demonstrating that they live in a state that will not establish an Exchange by 2014, that they would qualify for the affordability exemption in the absence of tax credits, and that the IRS rule would deny them the exemption. To satisfy that last element, individuals would have to show they are between 100 and 400 percent of the federal poverty level, that they will not have "minimum value coverage" in 2014 (either because they are uninsured or because they purchase less coverage than the mandate requires), and that they do not receive an offer of "minimum value" and "affordable" coverage from an employer. More than half of currently uninsured Americans, or approximately 15 million individuals, meet those criteria.[274] Each is a potential plaintiff, assuming their states do not establish Exchanges. The 27 to 31 states that had by December 12, 2012, signaled their intent not to establish an Exchange are home to some 7.5 million to 9.4 million potential plaintiffs.[275] In addition, many insured

[274] Kaiser Family Foundation, State Health Facts, *Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL)*, http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=136&cat=3&sub=40; Lisa Dubay and Allison Cook, "How Will the Uninsured be Affected by Health Reform?" Kaiser Commission for Medicaid and the Uninsured Issue Paper No. 7971, August 2009, p. 7, http://www.kff.org/healthreform/upload/7971.pdf; and authors' calculations.

[275] *See* Kaiser Family Foundation, State Health Facts, *State Decisions For Creating Health Insurance Exchanges in 2014, as of December 12, 2012*, http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17. The 27 states are —Alabama, Alaska, Arizona, Arkansas, Delaware, Georgia, Illinois, Kansas, Louisiana, Maine, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming. This group includes six states—Arkansas, Delaware, Illinois, Michigan, North Carolina, and West Virginia—that have opted for a "partnership" Exchange, which HHS categorizes as a Section 1321 Exchange. *See* Department of Health and Human Services, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule*, 45 FEDERAL REGISTER 18325 (March 27, 2012), *available at:* http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf ("A Partnership Exchange would be a variation of a Federally-facilitated Exchange. Section 1321(c) of the Affordable Care Act establishes that if a State does not have an approved Exchange, then HHS must establish an Exchange in that State; the statute does not authorize divided authority or responsibility. This means that HHS would have ultimate responsibility for and authority over the Partnership Exchange."). The number of states that have refused to establish an Exchange, and therefore the number of potential plaintiffs, is arguably higher than the Kaiser Family Foundation's count suggests. The KFF's count omits at least four states—Florida (1.1 million potential individual plaintiffs), Indiana (242,000), Pennsylvania (442,000), and Virginia (354,000)—whose governors have refused to establish Exchanges. *See* Kaiser Family Foundation, Health Reform Source, *State Exchange Profiles: Florida* (November 14, 2012), *available at:* http://healthreform.kff.org/State-Exchange-Profiles/florida; Teresa Tanoos, *Indiana Gov-Elect Mike Pence Declines Health Insurance Exchanges*, INDIANAPOLIS HEALTH EXAMINER (November 16, 2012) *available at:* http://www.examiner.com/article/indiana-gov-elect-mike-pence-declines-health-insurance-exchanges; Amy Worden, *Corbett Rejects Pa.-Based Health-Insurance Exchange*, PHILADELPHIA INQUIRER (December 12, 2012) *available at:* http://www.philly.com/philly/news/breaking/20121212_Corbett_rejects_Pa_-based_health-

individuals could establish standing if, for example, they purchase a high-deductible health plan that fails to satisfy the mandate because it has an actuarial value below 60 percent.[276]

The Anti-Injunction Act is unlikely to impede a challenge brought by individual taxpayers. The Supreme Court unanimously concluded in *NFIB v. Sebelius* that the individual mandate penalty, while it may be considered a tax for constitutional purposes, is not a tax for Anti-Injunction Act purposes.[277] Thus a challenge brought by individual taxpayers should be able to receive immediate adjudication.

States that choose not to establish an Exchange that satisfies the PPACA's requirements should also have standing to challenge the IRS rule. States have sovereign interests that are often sufficient to establish standing to challenge federal actions.[278] Specifically, where the federal government acts on states as states, and directly affects state interests, states may have standing to challenge such actions in federal court.[279] So, for instance, where a statute creates a regulatory mechanism that acts on state governments, an objecting state has standing under the

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insurance_exchange.html; and Steve Contorno, *McDonnell Won't Set Up Virginia Health Exchange*, WASHINGTON EXAMINER (December 11, 2012) *available at:* http://times247.com/articles/mcdonnell-won-t-make-va-insurance-exchange. Adding those states increases the number of potential individual plaintiffs to 9.7 million. Authors' calculations.

[276] Under the statute, self-funded employers in states that do not establish Exchanges would remain free to offer plans that do not satisfy the "minimum value" standard. *See* http://www.americanbenefitscouncil.org/documents/hcr_ehb_summary-cm020112.pdf.

[277] *See NFIB*, at __.

[278] *See*, *e.g.*, Massachusetts v. EPA, 549 U.S. 497 (2006) (challenge to Environmental Protection Agency's refusal to regulate greenhouse gases under the Clean Air Act); South Dakota v. Dole, 483 U.S. 203 (1987) (challenge to federal statute conditioning portion of highway funding on adoption of minimum drinking age); Oregon v. Mitchell, 400 U.S. 112 (1970) (challenge to Voting Rights Act Amendments of 1970); South Carolina v. Katzenbach, 383 U.S. 301 (1966) (challenge to portions of Voting Rights Act). *See generally*, Stephen Vladeck, *States' Rights and State Standing*, 46 U. RICH. L. REV. 845 (2012).

[279] *See* Vladeck, *supra* note 278, at 848 ("when a state truly is the federal stakeholder against the federal government, state standing is not just appropriate, but necessary").

Administrative Procedure Act to challenge federal regulatory actions that compromise state interests in violation of the authorizing statute.[280]

In *Virginia ex rel. Cuccinelli v. Sebelius* the U.S. Court of Appeals for the Fourth Circuit rejected Virginia's standing to challenge the individual mandate because Virginia could not assert any interests beyond seeking to protect Virginia citizens.[281] Here, however, states could claim that the IRS rule directly affects state interests created by the PPACA. The health care law, as written, gives states a choice of whether to create an Exchange that complies with the Act's requirements in return for start-up funds, tax credits, subsidies, and tax penalties on employers and a greater number of individual residents. The IRS rule, however, eliminates the choice by providing for tax credits, subsidies, and tax penalties without regard to whether a state creates its own exchange. Insofar as this rule eliminates a choice that the statute reserved to the states, an objecting state should have standing to challenge the legality of the rule.[282]

Litigation over the IRS rule is not merely hypothetical. As this article goes to press, a lawsuit challenging the IRS filed by the State of Oklahoma is pending in federal court.[283] Additional suits, either by other states, employers seeking to avoid the tax penalties, or individuals subjected to greater penalties for refusing to obtain qualifying health insurance, may follow.

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[280] Wyoming ex rel. Crank v. United States, 539 F.3d 1236 (10th Cir. 2008).

[281] 656 F.3d 253 (4th Cir. 2011). Virginia also enacted a statute, the Virginia Health Care Freedom Act, VA. CODE ANN. § 38.2–3430.1:1 (Cum. Supp. 2011), that would be preempted by the PPACA in a failed effort to claim standing.

[282] *Cf. Wyoming ex rel. Crank*, 539 F.3d.

[283] *See* infra note 13.

VII. Conclusion

The IRS rule's attempt to offer premium-assistance tax credits through federal Exchanges lacks validity because the IRS lacks the legal authority to create entitlements where, as here, Congress has not authorized them. Congress has granted the IRS authority to offer premium-assistance tax credits and cost-sharing subsidies only through Exchanges that are "a governmental agency or nonprofit entity that is established by a State."[284] The IRS lacks the authority to offer those entitlements, to enforce the employer mandate, and in many cases to enforce the individual mandate, in states that opt for either a "federally facilitated" Exchange or a "partnership" Exchange.[285] The IRS rule unlawfully usurps Congress' exclusive powers to tax, to create new legal entitlements, to issue tax credits, and to spend federal dollars.

The Act's legislative history shows the plain meaning of the statute reflects congressional intent, and offers no evidence to support claims that the plain meaning of this statute deviates from that intent. The IRS rule neither corrects a scrivener's error, nor resolves a textual ambiguity, nor resolves an ambiguity regarding congressional intent, because there is no ambiguity. There is only a frantic, last-ditch search for ambiguity by supporters who belatedly recognize the PPACA threatens health insurance markets with collapse, which in turn threatens the PPACA.[286]

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[284] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Sec. 1311, 124 Stat. 119, 176 (2010).

[285] Timothy S. Jost, *Implementing Health Reform: A Final Rule On Health Insurance Exchanges*, HEALTH AFFAIRS BLOG, Mar. 13, 2012, http://healthaffairs.org/blog/2012/03/13/implementing-health-reform-a-final-rule-on-health-insurance-exchanges/. (The final rule "does clarify that partnership exchanges are in fact federal exchanges and that states must agree to operate both the individual and the SHOP exchange to qualify for state exchange status.").

[286] *See* Jerry Geisel, *Oklahoma lawsuit targets premium subsidy provision of health care reform law*, BUSINESS INSURANCE, October 28, 2012, http://www.businessinsurance.com/article/20121028/NEWS03/310289979:

> If premium subsidies are not available in federally established exchanges, "No one would go to those exchanges. The whole structure created by the health care reform law starts to fall apart," said Gretchen Young, senior vice president-health policy at the ERISA Industry Committee in Washington.
>
> "The health care reform law would become a meaningless law," added Chantel Sheaks, a principal with Buck Consultants L.L.C. in Washington.

Finally, because these unauthorized entitlements would trigger unauthorized penalties against employers and individuals, we find that those employers (including state governments) and individuals could meet the requisite tests for standing and challenge the constitutionality of this IRS rule in federal court.

Administrative agencies enjoy wide latitude to interpret and implement federal law. But they cannot rewrite laws to impose taxes, issue tax credits, spend federal revenue, incur new federal debt, or create new legal entitlements without congressional authorization. If the PPACA does not do all that its supporters had hoped, it is up to Congress – and not the IRS – to fix it.

FLORIDA OFFICE OF INSURANCE REGULATION
COMMUNICATIONS OFFICE

Belinda H. Miller
General Counsel

Belinda Miller is a seasoned professional with more than 20 years of insurance regulatory and receivership experience. As the Florida Office of Insurance Regulation's (Office) General Counsel, Belinda Miller directs the Legal Services Unit, which consists of 22 lawyers representing two broad functional areas, specifically regulatory actions and litigation. In addition, she provides legal counsel to the Commissioner and the Financial Services Commission regarding all matters related to the regulation of insurers. She was appointed to this role in February 2011.

Belinda began her public service career as an attorney with the Department of Insurance in 1986. During that time, she served as the Director of the Division of Rehabilitation and Liquidation, accumulating over 10 years of receivership experience. From 1999 – 2002, she worked at the Department of Insurance as Director for both the Division of Insurer Services and Legal Services. An opportunity with a private sector law firm provided her with experience as an attorney representing receivers and regulators. She returned to public service in 2003 as Deputy Commissioner of the Property & Casualty Unit for the Florida Office of Insurance Regulation (formerly known as the Department of Insurance).

Ms. Miller has represented the Commissioner on a variety of boards and working groups, and testified in court proceedings and legislative hearings on behalf of the Office. She has taught segments of legal continuing education courses sponsored by the National Association of Insurance Commissioners (NAIC) and the Regulating for Solvency program. Ms. Miller is certified by the International Association of Insurance Receivers as a Certified Insurance Receiver, qualified for appointment as deputy receiver for either property and casualty or life and health insurers. In addition, she has participated in complex investigations and resulting legal cases, and been closely involved in the supervision of financially troubled insurance companies.

Ms. Miller holds a Bachelor of Arts degree with a major in International Studies from Emory University. She received a law degree from Florida State University and been a member of the Florida Bar since 1986.

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Director of the Division of Life and Health Product Review
Jack McDermott, CPCU, FLMI, CPM, ARM

Jack McDermott assumed the position of Director of the Division of Life and Health Product Review in November of 2012. His responsibilities include overseeing the insurance forms and rates review process, representing the Office to the legislature on matters of healthcare, healthcare legislation and advising the Commissioner on emerging healthcare forms and rates issues.

Jack has 14 years experience with the Office of Insurance Regulation beginning in 1996 as a senior management analyst in the former Department of Insurance. During his career, he has served as a special project manager assisting in the development of computer applications (QUASR & METS), worked in the Life & Health Solvency section, worked for five years as a manager for Life & Health market conduct examinations and was Director of Communications from January 2010, although he assumed the "acting" role in August 2009.

He also worked in the Market Research Unit to develop statutory reports including the Freedom to Travel Report, Workers' Compensation Report, and Medical Malpractice Report. He also has conducted internal reports including a study of the National Flood program and the Florida Long-Term Care Marketplace; he most recently served as a senior policy analyst and speechwriter before assuming his current position.

Mr. McDermott received a bachelor's degree in political science with honors from Colgate University, and received a Master in Public Policy (M.P.P.) from Harvard University. He is a Chartered Property Casualty Underwriter (CPCU), a Fellow of the Life Management Institute (FLMI), a Certified Public Manager (CPM), and has an Associate in Risk Management (ARM) from the Insurance Institute of America.

WENCESLAO TRONCOSO, JD

DEPUTY COMMISSIONER – LIFE & HEALTH
FLORIDA OFFICE OF INSURANCE REGULATION

Wences Troncoso is the Florida Office of Insurance Regulation's Deputy Commissioner for Life & Health. As the Deputy Insurance Commissioner for Life & Health, Wences oversees the daily activities of the Life & Health Product Review and Life & Health Financial Oversight Units. These units provide oversight and services to insurers operating in Florida including life and health form and rate filings, licensure, and financial solvency.

Prior to being appointed Deputy Commissioner, Wences served as a supervising attorney in the Legal Division of the Florida Office of Insurance Regulation. He oversaw the transfer of responsibility for public records dissemination (Chapter 119) to the Legal Division and remained in charge of those matters. He was also responsible for training Office staff to ensure timely and accurate responses to public records requests. In addition, he was involved with company licensing, product review, and health care reform issues, including supervision and oversight of insurer solvency.

Before joining the Office of Insurance Regulation, Wences served as a Public Defender with the 2nd Judicial Circuit for two years.

Wences received his Bachelor of Science degree in Political Science from Florida State University and his Juris Doctor degree from Barry University.

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Patient Protection & Affordable Care Act (PPACA) Overview

Senate Select Committee on PPACA

January 22, 2013

Wences Troncoso
Life & Health Deputy Commissioner

Office of Insurance Regulation (Office) Objectives - PPACA

- Reduce uncertainty to help maintain a stable market
- Allow companies to expedite product approval
- Promote off-exchange competition
- Maintain consumer protection / transparency

Life & Health Product Review

Form Review - Florida is a Prior Approval State:
For all policy forms (large group, small group and individual)

- Determine compliance with Florida Statutes and Rules (e.g., policy contracts, enrollment forms, schedule of benefits)

Rate Review - Florida is a Prior Approval State:
For small group and individual policies

- Actuarial reviews of rate filings to ensure compliance with Florida Statutes and Rules

Examples of Rating Factors:
Age
Gender
Smoking status
Geographic location

Examples of Analysis Factors:
Historical loss experience
Medical trend
Insurance trend
Risk changes

Major Challenges

- Conflicts between federal/state law
- Substance of Office form & rate reviews
- Potential resource issues

Conflicts with Florida Law

Federal law vs. Florida law

Rating Examples:

Age rate banding
Gender equality in rating

Policy Form Examples:

Rescission language
Dependents to age 30

(Supplemental: Office of Insurance Regulation Preliminary Review PPACA October 12, 2012)

Current Form Review Options

Approve

Form complies with all PPACA laws and Florida laws

Form complies with only Florida laws

Disapprove

Form complies with all PPACA laws, but not Florida laws

Current Regulatory Environment

Rate Review:

- Premiums are reasonable in relation to benefits
- Rates cannot be excessive, inadequate or unfairly discriminatory

Outcome:

Disapprove based on conflicts with age/gender rating

Form Review Logistical Issues

[If Office were to Proceed with Reviews]

Influx of Filings:

- Hiring additional full-time employees (not feasible)
- Outsourcing (possible, but expensive)

Short Time-Line for Exchange Products:

- March 28, 2013 – Companies may file products with Health & Human Services (HHS)
- May 1, 2013 – Companies submission deadline for products to be filed with HHS
- July 31, 2013 – HHS deadline for products to be approved

Options

1. Expand Florida law to incorporate PPACA
    - Revise current statutes
2. Retain Florida law / Rely on federal preemption
3. Short-term use and file informational only rate & form exemption
    - Must exempt rates from substantive requirements of Florida law & rules
    - Administrative options

Rate Review Logistical Issues

[If Office were to Proceed with Reviews]

- New products without historical experience
  - New risk population
  - Uninsured
  - Pre-existing conditions
- Pent-up demand
- Federal risk redistribution programs

Advantages of Short-Term Rate & Form Exemption (Information Only Filings)

- Speed-to-Market (more products)
- Regulatory certainty
- Transparency (informational filings in I-File)
- Experience for future reviews
- Florida laws still apply for consumer protections & policy forms

Other Challenges: Filing Requirements

- Unique form & rate filing situation
  - 49 states use the System for Electronic Rate & Form Filing (SERFF) via the National Association of Insurance Commissioners (NAIC)
  - Florida uses the I-File System
- Public records issues
- State filing and Health Information Oversight System (HIOS) filings
- Potential duplicate filing issue

Question & Answer Participants

Wences Troncoso
Life & Health Deputy Commissioner

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Jack McDermott
Director Life & Health Product Review

Rebecca Matthews
Deputy Chief of Staff/Government Affairs

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
2010 (prior to 09/23/2010)			
"Grandfathered" Insurance Products – **Effective: Date of enactment -- (March 23, 2010)**	All coverage in place on the date of enactment. PPACA Sec. 1251	**Note/NAIC** • Updated by HHS: The update allows fully-insured group health plans to retain their grandfathered status if they replace existing coverage with a new policy, so long as the terms of the new policy do not violate any of the tests which would cause an existing plan to lose grandfathered status.	**FL Insurance Code** • Does not recognize "grandfathered" insurance plans for purposes of review or regulation ***Florida Health Plans*** • *Guaranteed Renewability requires treating all members within a plan the same on renewal--creates a conflict* • *Without a statutory change, GF members will not be able to be treated differently from NGF and thus will lose their GF status on renewal; therefore, the Guaranteed Renewability statute should be amended to allow a distinction between GF and NGF members.* • *The ACA mandates apply to GF and NGF plans differently upon renewal in 2014.*
Web portal to identify affordable coverage options **Effective: 07/01/10** **Secretary of HHS, in consultation with the states**	Individual Small Group Plans PPACA Sec. 1103	**Note/NAIC** • Carriers and state regulators required to file information with HHS to facilitate consumer shopping for health insurance products by state of residence	**FL Insurance Code** • No FL Insurance Code requirement to provide OIR with information filed by carriers for healthcare.gov website display. **Note/FL OIR** ***Health Insurance Oversight System (HIOS):*** • Generally, it is unclear if FL OIR has unrestricted access to all information filed through the HIOS system by carriers authorized to transact insurance in FL – which includes plan details, rates, etc. • Confidentiality is preserved at federal level. An MOU between NAIC and HHS for data access from the HIOS site, does not extend to the States. • In Florida, should an MOU be proposed, there may be additional consideration needed with respect to the application of the State's open records laws and resulting public records requests.
Health insurance consumer assistance offices and ombudsmen Effective: Date of	*PPACA Sec. 1002 /PHSA 2793*	*The Secretary of HHS shall provide $30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs.*	***FL Insurance Code*** *Not within the scope of those provisions of the Insurance Code administered by the OIR.*

Text identified as "Florida Health Plans" are carrier - comments informally communicated to the OIR – and are not an official position of the Florida Association of Health Plans.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
2010 (prior to 09/23/2010)			
enactment			
Temporary high risk pool program **Effective: 90 days after enactment** ***Floridians eligible for PCIP effective August 1, 2010*** **Secretary of HHS**	PPACA Sec. 1101	HHS has established a temporary high risk health insurance pool program. $5 billion allocated to fund pools through 2013. **Florida** • Declined to operate state-based high risk pool. Florida residents are eligible for Federal Preexisting Condition Insurance Program (PCIP) FL PCIP census as of August 31, 2012: Enrollment: 8,145 *Note: As of June 30, 2012* • **Claims paid** for FL PCIP Members: **$107,841,608** -- *Numbers do not include administrative expense associated with FL enrollees; does not include administrative expense of CCIIO.*	**FL Insurance Code** • FL current high risk pool closed since 1992 (FCHA –s. 627.648-s. 627.6498) • FL Health Insurance Plan (FHP) designed in 2004 to reestablish a high risk pool (s. 627.64872) was never made operational by the Legislature *FL Question for CCIIO?* What is status of **persons currently covered by FCHA plan**? i.e., is FHCA plan considered a "grandfathered" plan? **Note/FL OIR** The Federal PCIP program is designed to sunset by 2015 and those individuals moved back into individual market where individuals cannot be excluded for coverage because of a pre-existing condition – i.e., will become part of "pool" of all risks in the FL individual market.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
September 23, 2010			
Preexisting condition exclusions **Effective for Plan years on or after September 23, 2010**	All plans except grandfathered individual market plans PPACA Sec. 1201 & 10103(e) /PHSA 2704	A plan may not impose any preexisting condition exclusions for **children under age 1**9. *FL Note: Currently there is no child-only coverage (private or public) for age birth to one, for a family with incomes over 185% of the Federal Poverty Level (FPL)*	**FL Insurance Code** • s. 627.6045, 627.6561, and 641.31(16) • Carriers offering "child only" health policies ceased new writing in 2010; • FL law will need to be amended to comply with ACA requirements
Rescissions **Effective for Plan years on or after September 23, 2010**	All plans PPACA Sec. 1001 /PHSA 2712	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Notification must be made to policyholders prior to cancellation (30 days).	**FL Insurance Code** Generally, s. 626.9541(1)(g)3. -- unfair discrimination *Other statutes* • s.627.607 allows rescission up to 2 years. After 2 years only for fraud • FL law will need to be amended to comply with ACA requirements, including notice requirements o *Example: for individual policy* - s. 627.6043 (45/10 day notice for non-payment of premium) ***Florida Health Plans*** *Direct Conflict between ACA and FL laws* • *FL law currently allows rescissions up to 2 years after issuance of the policies and after 2 years for fraud* • *627.607 Time limit on certain defenses*
Annual Limits **Effective for Plan years beginning on or after September 23, 2010**	Annual limits: All plans except grandfathered individual market plans *Note: does not*	No annual limits for essential health benefits. • Note: Annual limits on essential benefits are limited to$2 million for plan years beginning 9/23/2012-12/31/2013 Note/NAIC • *Plans may still impose annual and*	**FL Insurance Code** Current law/rules are silent regarding most annual limits. However • There are some annual limits set for some mandated benefits: o Autism -- $36,000 per year (s. 627.6686 and s.641.31098) o Home health services, no less than $1,000 per year (s. 627.6617):

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
September 23, 2010			
	apply to health flexible spending arrangements PPACA Sec. 1001/ PHSA 2711	*lifetime limits on specific covered benefits that are not essential benefits, which have not yet been defined in regulation.* • *In the interim, "the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term."*	o Substance abuse – maximum of 44 outpatient visits at a max of $35/per outpatient visit (s.627.669) **Note/FL OIR** • Because this requirement affects plans inside and outside the exchange ... How will "actuarial equivalency" be treated for plans offered outside the exchange?
Lifetime Limits **Effective for Plan years beginning on or after September 23, 2010**	Lifetime limits: All plans *Note: does not apply to health flexible spending arrangements* PPACA Sec. 1001/ PHSA 2711	• Plans may not establish lifetime limits *on the dollar value of essential benefits.* • Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS (Waiver program for carriers, employers to seek waivers for "mini-med" plans was operational in 2010)	**FL Insurance Code** Current law/rules are silent regarding allowable annual lifetime dollar limits – *except for autism benefit* – • annual dollar limit in current FL law for autism benefits ($200,000 lifetime) may be pre-empted if autism treatments are considered an essential medical/mental health benefit • This $200,000 limit is indexed to the medical component of the consumer price index • Current law does not define essential benefits ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements*
Coverage of preventive health services **Effective for Plan years beginning on or after September 23, 2010** **Secretary of HHS**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2713	Plans must provide coverage without cost-sharing for specified preventive services, screenings, immunizations. ***Note/NAIC:*** • Plans that have a network of providers may impose cost sharing for preventive items and services delivered by out-of-network providers. • Plans may use reasonable medical management techniques for coverage of preventive items and services to	**FL Insurance Code** Current law/rules are generally silent regarding what constitutes a "preventive" service or limits/prohibitions on cost-sharing for such benefits However, there are certain provisions within the Insurance Code that will need amendment to comply with PPACA **Autism** -- behavior assessments (627.6686/641.31098) Child has to be diagnosed as having a developmental disability at 8 years of age or younger • HHS Regulation: up to age 17 **Child Health Supervision** s. 627.6416, 627.6579; 641.31(30).

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
September 23, 2010			
As of August 1, 2012 – List of Preventive Services exempt from cost-sharing requirements http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html		determine the frequency, timing, method, treatment or setting of services to the extent that they are not specified in the relevant recommendation or guideline. • If a preventive service is billed separately from an office visit, the plan may impose cost sharing on the office visit. If it is not billed separately from the office visit, then the plan may not impose cost-sharing on the visit if the primary purpose of the visit is to receive the preventive item or service. • A plan may impose cost-sharing for a treatment not described in the regulations, even if that treatment results from an item or service that is a covered preventive service.	(Immunizations, hearing, vision testing, etc.) in compliance with standards of *American Academy of Pediatrics* – • HHS: Preventive care and services ...supported by the *Health Resources and Services Administration (HERSA*) Note/OIR: Benefit is not subject to deductible requirements—s. 627.6416((1) **Newborn Hearing Screening** 627.6416, 627.6579, 641.31 (30), et.al. **Mammograms** –baseline, frequency by age groups (s.627.6418, 627.6613, 641.31095) • HHS: frequency standards may not be as specific – i.e., every 1-2 years for women aged 40 and older (FL Law: once every year beginning age 50) *"**Well-woman**"* – s.627.6472(18), 627.662(9), 641.51(11), et.al. OBGYN Annual Visit – • HHS has list of specific preventive services **Osteoporosis** Diagnosis—627.6409, 627.6691, 641.31(27) • HHS requires screening for women only after age 60 and depending on risk ***Florida Health Plans*** • All NGF plans must cover preventive services at no cost share New statutory authority needed to enforce new ACA requirements • Need statutory authority to enforce new ACA requirement • Amend current mandates to apply to GF plans only (e.g., mammograms, osteoporosis, OB/GYN visit.
Extension of adult dependent coverage **Secretary of HHS** **Effective for Plan years beginning on or after September 23,**	All plans PPACA Sec. 1001 HR 4872 §2301 /PHSA 2714	Plans that provide dependent coverage must make coverage available to adult children up to age 26. • Carriers are not required to cover children of adult dependents. • For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage.	**FL Insurance Code** • s.627.6562(1): Requires coverage up to the end of the calendar year in which the child reaches age 25 but with restrictions (must be unmarried without dependents of his/her own and must be resident or full-or part-time student, and is not eligible for other coverage; • At ss.627.602(c), 627.6562, 641.31(41): Under these same restrictions, coverage must be *offered* up to age 30. **Note/FL OIR**

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
September 23, 2010			
2010		*Note/NAIC* Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency, residency; student status, employment, eligibility for other coverage, marital status or any combination of these.	• For up to age 26, federal law is less restrictive than FL law and thus may preempt FL law restrictions applicable to dependents under age 26. • FL would appear able to enforce its restrictions on the offer of coverage from age 26-30. ***Florida Health Plans*** • *Direct Conflict between ACA and FL laws.* *See 627.6562 Dependent coverage* • *Need to remove criteria for dependent coverage such as support, residency and student status up to age 26 from current statute.* • *Criteria for ages 26-30 may continue to apply.*
Provision of additional information **Effective for Plan years beginning on or after September 23, 2010**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2715A	All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage • Other information as determined appropriate by the Secretary	**FL Insurance Code** There is no provision in FL Insurance Code to require disclosure of all of these items in a "single location" posting and/or disclosure document.
Prohibition on discrimination based on salary ***Effective for Plan years beginning on or***	*Fully insured non-grandfathered group health plans* *PPACA Sec. 1001*	*Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans.* *The Secretary of HHS will develop rules.*	***FL Insurance Code*** *As noted by NAIC, until guidance is issued, OIR could not assess the need to amend current statutes to incorporate any requirements made for fully-insured plans not governed by ERISA.*

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
September 23, 2010			
after September 23, 2010 ***Applicability suspended until guidance is issued.***	*/PHSA 2716*	*Status: IRS seeking comments, but suspends application of this provision until after regulations/guidance has been issued. (NAIC, 11/2011)*	
Appeals process – Internal and External Review Standards **Effective for Plan years beginning on or after September 23, 2010** **Secretaries of Labor and HHS**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719	Internal claims appeal process: • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: • All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Model Act or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.	**FL Insurance Code** In 2012, in SB 730, by amendment to s. 627.602, policies issued for individual health insurance are required to comply with 29 CFR s. 2560.503-1 relating to internal grievances. Similarly, at newly created s. 627.6513, the provisions of 29 CFR s. 2560.503-1 are made applicable to all group health insurance policies. **Note/FL OIR** • ***29 CFR s. 2560.503-1 is entitled "Claims Procedure***" and governs how claims for adverse determinations are to be processed. • However, it is 29 CFR s. **2590.715-2719, entitled "Internal claims and appeals and external review processes"** that actually sets forth the standards for creation/implementation of both internal and external review programs. • FL law delegates standards for compliance to specified federal regulation for internal review. – but does not grant rule-making authority to the OIR to implement the standards of the federal regulation. • SB 730 does permit the OIR to promulgate rules that adopt the NAIC Model for external Review for HMOs (only). o OIR is currently drafting the HMO rule to adopt NAIC Model Act and Regulations for External Review. ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements.*
Patient Protections **Emergency**	All non-grandfathered plans	**Emergency Services** • If a plan provides coverage for emergency services, the plan must do	**FL Insurance Code** • FL law makes emergency services coverage subject to similar standards at s. 641.513(3) and 641.31(2) governing HMOs.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
September 23, 2010			
Services **Effective for Plan years beginning on or after September 23, 2010**	PPACA Sec. 1001 /PHSA 2719A	so without prior authorization, regardless of whether the provider is a participating provider. • Emergency services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.	• FL law does NOT make this provision applicable to individual, large group, or small group indemnity plans. ***Florida Health Plans*** 641.19(6) and (9) Definitions • Direct Conflict between ACA and FL laws • The reimbursement for non-participating providers of emergency services conflicts with payment rules under FL law. • Statute should be revised to apply to GF only and section applicable to NGF should be included. • Definitions for Emergency Medical Condition and Emergency Services should be revised to align with ACA definitions for NGF plans.
Patient Protections **Primary Care Provider** **Access to OB-GYN services** **Effective for Plan years beginning on or after September 23, 2010**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719A	**Primary Care Provider** A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. **Access to OB-GYN services** A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.	**FL Insurance Code** *Primary Care Providers* • FL law makes a requirement for primary care physicians for HMOs at 641.19(13)(e). • FL law does NOT make this provision applicable to individual, large group, or small group indemnity plans. *Access to OB-GYN Services* • s. 641.19(13)(e): Requires HMOs, small group HMOs to permit a female subscriber to select an OB-GYN as her primary care provider – thus no referral authorization would be required. • FL law does NOT make this provision applicable to individual, large group, or small group street indemnity plans. ***Florida Health Plans*** Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements • New statutory authority needed to enforce new ACA requirements.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective 01/01/2011			
Medical Loss Ratios **Effective: 01/01/11**	All fully insured plans, including grandfathered plans PPACA Sec. 1001 /PHSA 2718	• Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. • Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. • All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups.	**FL Insurance Code** There is no current statutory authority to implement new MLR requirements or to govern insurer compliance with required notices related to rebate determinations.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Rate increase in excess of 10% filed on or after July 1, 2010			
Rate Review **Effective: 2010 plan year** **A rate increase in excess of 10% for increases filed on or after July 1, 2011** **The Secretary in conjunction with the states.**	All non-grandfathered fully-insured plans PPACA Sec. 1003 /PHSA 2794	Rates subject to review. A rate increase in excess of 10% for increases filed on or after July 1, 2011 If a state reviews the increase, HHS will adopt the state's determination and will post the state's final determination on its website. If an insurer elects not to implement an unreasonable increase or to implement a lower increase, it must notify the state and HHS of that fact. If the issuer implements an unreasonable increase, it must submit a final justification to HHS and prominently post the information on the company web site for at least 3 years.	**FL Insurance Code** • FL has been determined by HHS to have an effective rate review program for individual and small group policies. • HHS has determined FL does NOT have an effective rate review program for association policies (rates for out of state associations are not subject to OIR rate approval (s. 627.410(1)); • FL does NOT approve rates for large group policies with 51 or more persons per s. 627.410(6)(a). **Note/FL OIR** • HHS determination of an effective rate review system includes the requirement for a state to maintain on its website a user-friendly program to permit consumer review of proposed rate changes and to file comments prior to final state action. • The OIR has implemented access to rate filings, and continues to make information more complete and more user friendly – although additional resources for technology upgrades would facilitate these changes.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
January 1, 2012			
Accountable Care Organizations (ACOs) **(Effective January 1, 2012 for Medicare only)**		The new law provides incentives for physicians to join together to form "Accountable Care Organizations." ACOs are authorized to participate as health plans offering coverage through an Insurance Exchange.	**FL Insurance Code** • Currently, there is no FL insurance law that would apply to this risk-bearing entity. **Note/FL OIR** • ACOs are authorized for participation in the State's Medicaid Managed Care statutes (Medicaid Reform, 2011).

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Within two (2) years – September 23, 2012.			
Uniform explanation of coverage documents and standardized definitions ***In consultation with NAIC***	All plans PPACA Sec. 1001 /PHSA 2715	The Secretary must develop standards for a summary of benefits and coverage (SBC) explanation to be provided to all potential policyholders and enrollees. The SBC must be made available in a culturally and linguistically appropriate manner.	**FL Insurance Code** At s. 641.31(1) and (4) HMOs are required to provide disclosures including a member handbook. At s. 624.308, 627.642, 627.643 and 69O-154.107 FAC (Individual) there are some standards for outlines of coverage. However – if HHS adopts Regulations similar to those provided by the NAIC, FL statutes and rules would need to be amended and/or created to reflect these HHS requirements.
Ensuring quality of care **Effective: 2 years after enactment** **Secretary of HHS, in consultation with experts in health care quality and stakeholders**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2717	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan improve health outcomes.	**FL Insurance Code** • There is no current statute or rule requiring submission of this kind of information to the OIR. • Current annual reporting requirements for health and accident insurance are at s. 627.9175.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective in 2013			
Administrative simplification requirements **Rules adopted by July 1, 2011 to become effective by January 1, 2013.**	PPACA Sec. 1104 /SSA 1171	Requires the Secretary to develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information	**FL Insurance Code** It is unknown if requirements regarding the standards of exchange of medical information (and standardized billing) would require amendments to the Florida Insurance Code.
Co-Op Plans – Consumer Owned and Operated (Health Plans) **Effective: No later than 7/1/2013** **Secretary of HHS**	Co-Op Plans PPACA Sec. 1322	**C**onsumer **O**wned and **O**perated Health **P**lans (risk bearing) -- • The Secretary of HHS shall provide Co-Op plans with loans to assist with start-up costs and grants to assist with meeting solvency requirements. • Secretary must ensure that there is sufficient funding to establish at least 1 Co-Op plan in each state. • Loans must be repaid within 5 years and grants must be repaid within 15 years. $6 billion is appropriated to fund the loans and grants. **Note/NAIC** Co-Op plans may not offer coverage in a state until the state has adopted the market reforms in Subtitles A and C of this legislation.	**FL Insurance Code** **Note/FL OIR** As outlined in PPACA , a Co-Op entity in this State, as a risk-bearing entity, would be regulated by the OIR – and preliminary review suggests a Co-Op would be determined to be a form “mutual insurance company” However, if FL has not adopted “market reforms in Subtitles A and C of PPACA, it is unclear if the HHS would recognize a Co-Op planning to operate in this State.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
Preexisting condition exclusions **Effective: Plan years beginning 01/01/14 for all others**	All plans except grandfathered individual market plans PPACA Sec. 1201 /PHSA 2704	A plan may not impose any preexisting condition exclusions.	**FL Insurance Code** FL law currently permits waiting periods which may not be in compliance with HHS final rules on preexisting condition requirements for 2014. ***Florida Health Plans*** ***Direct Conflict between ACA and FL laws*** • *Pre-existing condition exclusions are prohibited except for GF individual plans.* • *Although federal law requires certificates of creditable coverage, their primary purpose is for the application of pre-existing condition exclusions. Therefore they may no longer be necessary* • *All references to pre-existing conditions should be limited to GF individual plans only: 627.6045 Preexisting condition; 627.64871 Certification of coverage; 627.6561 Preexisting conditions; 641.31071 Preexisting conditions; 641.31 (16) Health Maintenance contracts; 641.185(h); 69O-154.105. Standards for Policy Provisions; (5) Preexisting conditions; 69O-154.110. Certificate of Creditable Coverage.; 69O-154.111. Demonstration of Creditable Coverage If Certificate is not Provided*.
Fair health insurance premiums **Effective: Plan years beginning 01/01/14**	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	Premiums may only vary by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** There are currently no provisions within the Insurance Code that would impose these rating standards for plan in FLs individual, small group, or large group markets. ***Florida Health Plans*** *The most significant conflicts that need to be addressed are the differences between the ACA regulations and FL rating rules.* • *In 2014, premiums may only vary for NGF individual and small group by: (i) family size; (ii) geography; (iii) tobacco use (1.5:1); and (iv) age (3:1). Gender is no longer a permissible rating factor.* • *There is a need to limit current rating statutes and regulations to GF plans only.*

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
	/PHSA 2701		• *There is also a need for new statutes and regulations implementing the new rating rules for NGF Individual & Small group.* *Statutes: 627.620 Misstatement of age or sex; 627.6699(6) Restrictions relating to premium rates; 627.65626 Insurance rebates for health life-styles; 641.31 (40) – healthy group rebate of premium; 69O-149.0025. Definitions.;69O-149.003. Rate Filing Procedures.; 69O-149.005. Reasonableness of Benefits in Relation to Premiums.; 69O-149.0055. Healthy Lifestyle Rebate.; 69O-149.006. Actuarial Memorandum.; 69O-149.007. Annual Rate Certification (ARC) Filing Procedures.*
Guaranteed availability of coverage **Secretary of HHS** **Effective: Plan years beginning 01/01/14**	Non-grandfathered fully-insured plans. /PHSA 2702	Insures must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods. HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** • Current FL law requires guarantee issue products in the small group market (including groups of one); • FL does NOT require guarantee issue in the individual market unless the individual is HIPAA eligible (coming off COBRA, "mini-COBRA", or is not eligible for COBRA) o See s.627.6425 Renewability of individual coverage, 627.6561 – Preexisting conditions (refers to 627.6425) for Group, and 641.31071 Preexisting conditions refers to 627.6425 for Group HMOs. Mini-COBRA s. 627.6692. ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements* • *Need statute similar to the small group statute 627.6699(5) for individuals.*
Guaranteed renewability of coverage **Effective: Plan years beginning 01/01/14**	All non-grandfathered fully-insured plans. /PHSA 2703	Insurers must renew coverage or continue it in force at the option of the plan sponsor or the individual. HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** • FL Insurance Code currently provides for guarantee renewable health insurance policies and HMO contracts. o See Statutes: s.627.6425 Individual; s. 627.6571 Group; s.641.31074 Group HMOs

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
Prohibiting discrimination against individual participants and beneficiaries based on health status **Effective: Plan years beginning 01/01/14** **Secretary of HHS**	All non-grandfathered plans /PHSA 2705	A plan may not establish rules for eligibility based on any of the following health status-related factors: • Health status; Medical condition; Claims experience; Receipt of health care; Medical history; Generic information; Evidence of insurability (including conditions arising out of domestic violence); Disability; Any other health-status related factor deemed appropriate by the Secretary HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** Current FL law prohibits unfair discrimination – see s. 626.9541 (1)(g)3. However, FL law may need to be amended to comply with eventual Federal regulations. ***Florida Health Plans*** • *New statutory authority needed to enforce new ACA requirements.*
Non-discrimination in health care **Secretary of HHS** **Effective: Plan years beginning 01/01/14**	All non-grandfathered plans /PHSA 2706	Plans may not discriminate against any provider operating within their scope of practice. Does NOT require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon whether they receive subsidies, provide information to state or federal investigators, etc. HHS has not published guidance, proposed or interim regulations.	**FL Insurance Code** • Generally, statutes governing participation are related to scope of benefits provided. See s. 627.419 and s. 641.19(12), et.al. • The FL Insurance Code does not currently contain anti-discrimination provisions related to receipt of subsidies (available only through an exchange) or whether a person has provided information to a federal investigator.
(*Essential Health Benefits)* Comprehensive health insurance coverage	All non-grandfathered plans /PHSA 2707	All plans must include the essential benefits package required of plans sold in the Exchanges. All plans must comply with limitations on annual cost-sharing for plans sold in the	**FL Insurance Code** The FL Ins Code does not currently define “major medical” or “comprehensive health insurance plan.” • OIR rule does define “major medical” plan for purposes of review/approval of applicable terms, conditions, and benefits. o Rule: 690-154.106(5), FAC

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
Effective: Plan years beginning 01/01/14		Exchanges. (See §§ 1302(a) and (c).) If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21. HHS has not published complete guidance, proposed or interim regulations.	• The authority to approve contracts meeting the requirements of "essential benefits" would need to be adopted in statute with rule making authority provided to OIR. ***Florida Health Plans*** *Need (new) statutory authority to enforce new ACA requirement applicable to NGF plans for:* • *Essential Benefits* • *Small group deductible limits* • *Out-of-Pocket maximums* • *Actuarial Value* ***Mental Health*** *Direct Conflict between ACA and FL laws* • *Mental health parity (MHP) applies to the NGF individual and small group markets Mental health is an essential benefit.* • *Need to replace current MH statutes for individual, small and large group to comply with MHP and essential benefits.* • *See s. 627.668 Optional coverage for mental and nervous disorders required; exception; 627.669 Optional coverage required for substance abuse impaired persons; exception.*
Prohibition on Excessive Waiting Periods Effective: Plan years beginning 01/01/14	All group plans /PHSA 2708	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.	**FL Insurance Code** See: s. 627.6561(1)(c) • Current statutes do not contain waiting period restrictions applicable to group insurance policies.
Wellness Programs	Non-grandfathered individual	Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other	**FL Insurance Code** At s.627.6402, FL authorizes Insurance rebates for healthy lifestyles and

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
Effective: Plan years beginning 01/01/14 **Secretary of HHS**	market plans /PHSA 2705	reward upon a health status-related factor must limit such rewards to 30% of the cost of coverage. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. *Existing wellness programs established before March 23, 2010, may continue to be carried out.*	places a 10% cap of paid premium. At s. 626.9541(4) – under the Unfair Trade Practice Act – there are additional standards for wellness incentive program participation. **Note/FL OIR** Current laws need to be amended to conform with ACA requirements.
Coverage for individuals participating in approved clinical trials **Effective: Plan years beginning 01/01/14**	All non-grandfathered plans /PHSA 2709	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.	**FL Insurance Code** Does not currently contain provisions governing participation in clinical trials. However, there is an informal/extra-statutory "agreement" negotiated with carriers to assure payments continue for services/treatments that would otherwise be covered for a person in a clinical trial (Sen. Don Gatez announcement, 2011). ***Florida Health Plans*** *New statutory authority needed to enforce new ACA requirements*
Rating reforms must apply uniformly **Effective: Plan years 01/01/14**	PPACA Sec. 1252	Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.	**FL Insurance Code** FL has made no changes in rating laws governing health insurance entities regulated by the OIR.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Effective Plan Year 2014			
Insurance Exchanges	PPACA Sections 1301-1321	States or Federal Government required to establish Insurance Exchanges in every state – to become operational for plan years beginning January 1, 2014.	**FL Insurance Code** • Florida Ins Code would need amendment to clarify the OIR's regulatory role for contracts and rates associated with a Federally Facilitated or Federal Partnership Exchange model. • FL would need guidance from HHS/CCIIO regarding clarification of regulatory role of the OIR for the solvency and consumer protection provisions of FL law that would apply to entities offering plans through an Exchange. ***Florida Health Plans – Related Issues*** ***EPO certification upon application*** *Direct Conflict between ACA and FL laws* • *Prior to or at time of sale insurer must obtain insured's signature stating they received certain required information.* • *On Exchange, there will be no mechanism to obtain signature prior to sale.* • *Need to revise statute to accommodate Exchange business.* o *627.6472(10)(11) Exclusive provider organizations* ***Grace Period on Exchange*** • *New statutory authority needed to enforce new ACA requirements.* ***Agents and Brokers*** *Direct Conflict between ACA and FL laws* • *In order to engage in the solicitation of insurance an entity must be a licensed agent; Individuals that purchase directly through the Exchange may not engage an agent prior to purchase. (See 626.112)*

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Exchange Related Provisions affecting products/issuers Outside Exchange Marketplace			
Level Playing Field **Effective: 1/1/2014**	PPACA Sec. 1324	Health insurance plans shall not be subject to any of the following state or federal laws unless Co-Op plans and multistate health plans are also subject to them: • Guaranteed renewal; Rating; Preexisting conditions; Non-discrimination; Quality improvement and reporting; Fraud and abuse; Solvency and financial requirements; Market conduct; Prompt payment; Appeals and grievances; Privacy and confidentiality; Licensure, and; Benefit plan material or information	**FL Insurance Code** **Note/FL OIR** HHS and (federal) Office of Program Management (OPM) have not reached agreement as to the extent of state regulation that will govern the two "national plans" that will be offered through insurance exchanges.
Transitional reinsurance program for individual market in each state **Effective: Plan years beginning in 2014 through 2016**	All plans must pay assessments. Non-grandfathered individual plans may receive payments. PPACA Sec. 1341	State shall enact a model regulation established by the Secretary, in consultation with the NAIC that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016. Reinsurance entities must be non-profit organizations with the purpose of stabilizing premiums in the individual market for the first three years of Exchange operation. States may have more than one reinsurance entity and two or more states may enter into agreements to create entities to administer reinsurance in all such states.	**FL Insurance Code** If a state does not elect to establish a reinsurance program, the program will be administered by the HHS. **Note/FL OIR**: The reinsurance standards applicable to this program will govern the re-integration of the PCIP population back into the regulated health plan market – inside and outside an exchange program.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes
Exchange Related Provisions affecting products/issuers Outside Exchange Marketplace			
Risk adjustment **Effective: 01/01/14** **Secretary of HHS, in consultation with the States**	Non-grandfathered individual and small group plans PPACA Sec. 1343	Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees have an actuarial risk that is greater than the average actuarial risk in that state.	**FL Insurance Code** There is no statutory authority for the OIR to administer a risk adjustment program for issuers with a COA in FL. **Note/FL OIR**: The risk adjustment program will be applicable to the regulated health plan market – inside and outside an exchange program.
Establishment of risk corridors for plans in individual and small group markets ***Effective: 01/01/14—for Calendar years 2014-2016*** ***Secretary of HHS, in consultation with the States***	*Qualified health plans Non-grandfathered individual and small group plans* *PPACA Sec. 1342* *1343*	*The Secretary shall establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare PDPs.* *Plans will receive payments if their ratio of non-administrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%.* *Plans must make payments if that ratio is below 97%.*	***FL Insurance Code*** *To be administered by HHS*

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/22/13
Meeting Date

Topic PPACHA

Bill Number — *(if applicable)*

Name Anne Swerlick

Amendment Barcode — *(if applicable)*

Job Title Deputy Director

Address 2425 Torreya Dr
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E-mail

Speaking: ☐ For ☐ Against ☑ Information

Representing

Appearing at request of Chair: ☒ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/22/13
Meeting Date

Topic Obamacare

Bill Number _____ *(if applicable)*

Name John Lazquey

Amendment Barcode _____ *(if applicable)*

Job Title Owner

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E-mail jlazquey@yahoo.com

Speaking: ☐ For ☒ Against ☐ Information

Representing John Lazquey Pinestraw

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/22/13
Meeting Date

Topic Patient Protection & Affordable Health Care Act Bill Number _____ *(if applicable)*

Name Peter Lee Amendment Barcode _____ *(if applicable)*

Job Title _____

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Street

Orlando FL 32826 E-mail Peter@eastsideteaparty.org
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Representing Self

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-22-13
Meeting Date

Topic HEALTHCARE Exchange

Bill Number _____ *(if applicable)*

Name Carol Knighton

Amendment Barcode _____ *(if applicable)*

Job Title Retired

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Speaking: ☐ For ☒ Against ☐ Information

Representing _____

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Health Care

Bill Number _____ *(if applicable)*

Name EN Knighton

Amendment Barcode _____ *(if applicable)*

Job Title Retired

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Speaking: ☐ For ☒ Against ☐ Information

Representing SELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/21/2013
Meeting Date

Topic Obamacare - ACA - PPA

Bill Number _____ *(if applicable)*

Name Karen Schoen

Amendment Barcode _____ *(if applicable)*

Job Title Founder

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Speaking: ☐ For ☒ Against ☐ Information

Representing AgENDERS- and Panhandle Patriots

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-22-13
Meeting Date

Topic PATIENT PROTECTION ACT

Bill Number _____ *(if applicable)*

Name DAN STAFFORD

Amendment Barcode _____ *(if applicable)*

Job Title CONSULTANT

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DEFUNIAK SPRINGS FL. 32435
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Speaking: ☐ For ☑ Against ☐ Information

Representing WALTON COUNTY PATRIOTS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

1-22-13
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Topic PATIENT PROTECTION ACT

Bill Number _____ *(if applicable)*

Name SAM T. MULLINS

Amendment Barcode _____ *(if applicable)*

Job Title PETROLEUM GEOLOGIST / BUSINESS CO-OWNER

Address 5922 ALLENTOWN ROAD
Street

Phone (850) 626-7474

MILTON
City *State* *Zip*

E-mail src.tparty@yahoo.com

Speaking: ☐ For ☑ Against ☐ Information

Representing MY SELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Patient Protection Act

Bill Number _____ *(if applicable)*

Name Eric Witt

Amendment Barcode _____ *(if applicable)*

Job Title Tea Party

Address 5620 Windrun Place

Phone 850-232-1014

Street

Pace FL 32571

E-mail wdbutcher1@bellsouth.net

City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information

Representing SRTPP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-22-13
Meeting Date

Topic Patient Protection Act

Bill Number _____ *(if applicable)*

Name Sharon Glass

Amendment Barcode _____ *(if applicable)*

Job Title TEA Party

Address 5661 Windrun Pl

Phone 850-994-7548

Pace FL 32571
City *State* *Zip*

E-mail Southernkitty@bellsouth.net

Speaking: ☐ For ☑ Against ☐ Information

Representing Santa Rosa Tea Party Patriots

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/22/13
Meeting Date

Topic HEALTH CARE EXCHANGES

Bill Number _____ *(if applicable)*

Name JOHN BERG

Amendment Barcode _____ *(if applicable)*

Job Title RETIRED

Address 14260 W NEWBERRY RD
Street

Phone _____

GAINESVILLE FL 32669
City *State* *Zip*

E-mail _____

Speaking: ☐ For ☒ Against ☐ Information

Representing _____

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic AFFORDABLE CARE ACT

Bill Number _____ *(if applicable)*

Name LAURIE NEWSOM

Amendment Barcode _____ *(if applicable)*

Job Title OWNER / AMBULATORY SURGICAL CTR

Address 2524 NW 41 ST *Street*

Phone 352-377-7733

GAINESVILLE, FL 32606 *City* *State* *Zip*

E-mail lnewsom@eyesurgicenter.com

Speaking: ☐ For ☐ Against ☑ Information

Representing _____

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/22/2013
Meeting Date

Topic Affordable Care Act

Bill Number _____ *(if applicable)*

Name Michael Rosenthal

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 4045 Kilmartin Dr
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850-894-2362

E-mail Michael.RosenthalTLH@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/22/13
Meeting Date

Topic ACA

Bill Number _____ *(if applicable)*

Name Rod Gonzalez

Amendment Barcode _____ *(if applicable)*

Job Title Business Admin

Address 2521 NW 41 Street
Street

Phone 352-222-6433

Gainesville FL 32605
City *State* *Zip*

E-mail rodgesz2@...com

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

22 JAN 13
Meeting Date

Topic AFFORDABLE CARE ACT

Bill Number _____ *(if applicable)*

Name TERRANCE J. SHOEMAKER

Amendment Barcode _____ *(if applicable)*

Job Title MEMBER

Address 31 RUBY CIR
Street
MARY ESTHER FL 32569
City *State* *Zip*

Phone 850 362-0043

E-mail tjshoemaker@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Representing FL PANHANDEL PATRIOTS TEA PARTY

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-22-2013
Meeting Date

Topic Health Care

Bill Number _____ *(if applicable)*

Name Richard Harrison

Amendment Barcode _____ *(if applicable)*

Job Title Farmer

Address 635 Dowling Rd
Street

Phone 850-762-3366

Marianna, FL 32448
City *State* *Zip*

E-mail rharrison922@yahoo.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Concerned American Patriots, Marianna, FL

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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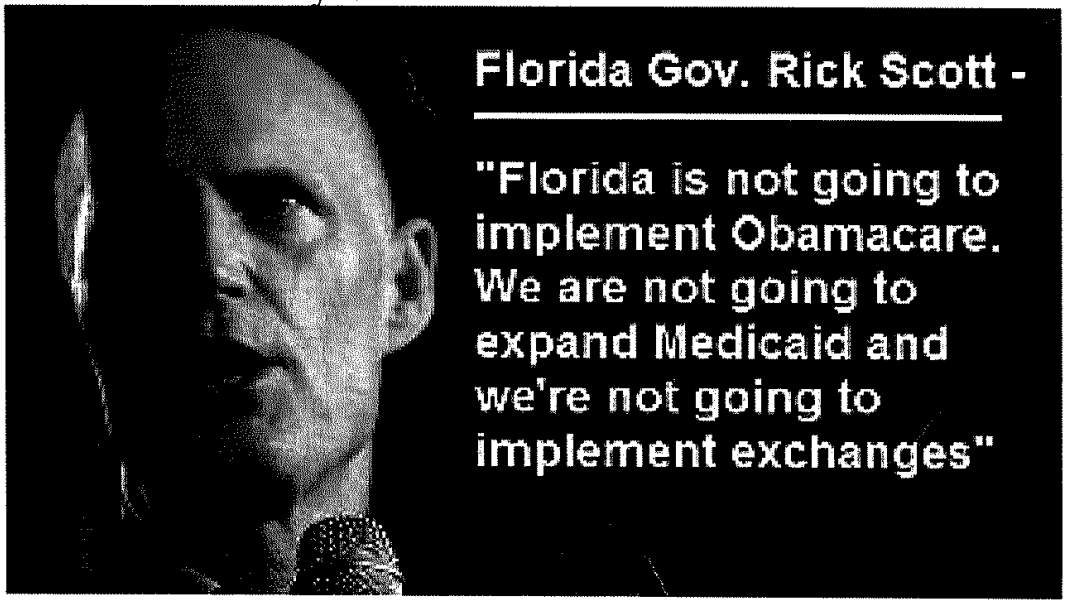
S-001 (10/20/11)

1:26 p.m. EST, June 30, 2012| in an article written by Gary Fineout, of The Associated Press, Governor Scott stated this to the people of Florida and the country...



Was this a true statement? If so, there is only one recommendation for this committee to give the Governor and that is to say NO to implementation, expanding and creating exchanges for ObamaCare in the State of Florida.

Name of Group: FL PANHANDLE PATRIOTS TEA PARTY

Located in: FT WALTON BEACH, FL (City)

Located in: OKALOOSA (County)

Number of members in group : 80 REGISTERED

1400 EMAIL NEWSLETTER/
FACEBOOK

Name of Group: Santa Rosa Tea Party Patriots

Located in: PACE (City)

Located in: Santa Rosa (County)

Number of members in group : 350

Name of Group: East Side Tea Party

Located in: Orlando (City)

Located in: Orange (County)

Number of members in group : over 1000

We support these statements by Governor Scott and ask the Florida Legislature to not participate with this Federal law. Florida is NOT Legally required to participate and should not

Name of Group: North Central FL Tea Party

Located in: LAKE CITY (City)/Live Oak

Located in: SUWANNEE (County) Columbia

Number of members in group : 800

Name of Group: AGENDERS -

Located in: Sunny Hills (City) Servicing all of Florida

Located in: Washington Co (County)

Number of members in group : 900+

Obamacare uses subsidies and Tax Credits - Free Money?
No - Increased taxes = Bad idea

Another unread, unproven, expensive program
Sorced on the people.

If the citizens demanded all legislators + State workers must participate in Obamacare as well would you implement it?

No more Fedral Programs that take over and eliminate State control.

Name of Group: WALTON COUNTY PATRIOTS

Located in: DEFUNIAK SPRINGS (City)

Located in: WALTON (County)

Number of members in group : 265

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Select Committee on Patient Protection and Affordable Care Act **Judge:**

Started: 1/22/2013 1:02:58 PM
Ends: 1/22/2013 3:01:08 PM **Length: 01:58:11**

1:03:02 PM Opening Remarks
1:03:26 PM Roll Call
1:03:41 PM Senator Gibson has excused absence
1:08:02 PM Senator Sobel w introductions
1:10:24 PM Jonathan Gruber, Ph.D., Massachusetts Institute of Technology via Skype
1:25:16 PM Senator Negron w introduction
1:27:59 PM Michael Cannon, Director of Health Policy Studies, Cato Institute
1:42:40 PM Senator Negron w comments
1:43:07 PM Dr. Gruber w follow-up
1:49:03 PM Mr. Cannon w follow-up
1:54:23 PM Senator Negron w comments and questions
1:54:54 PM Mr. Cannon to answer
1:55:50 PM Senator Negron w question
1:56:34 PM Mr. Cannon to answer
1:57:43 PM Senator Negron
1:57:46 PM Mr. Cannon
1:58:01 PM Senator Negron
1:58:04 PM Mr. Cannon
1:59:01 PM Senator Negron w comments and questions
2:00:33 PM Mr. Cannon to respond
2:01:28 PM Senator Negron
2:01:36 PM Mr. Cannon
2:01:52 PM Senator Smith w questions
2:02:06 PM Mr. Cannon to respond
2:03:05 PM Senator Smith w follow-up
2:03:27 PM Mr. Cannon
2:03:34 PM Senator Negron
2:03:40 PM Dr. Gruber w comments
2:04:09 PM Senator Sobel w questions
2:04:56 PM Dr. Gruber to answer
2:07:20 PM Senator Negron
2:07:25 PM Mr. Cannon
2:07:54 PM Dr. Gruber
2:08:06 PM Senator Negron
2:08:31 PM Mr. Cannon
2:09:50 PM Senator Negron w comments
2:10:43 PM Senator Legg w questions
2:11:13 PM Dr. Gruber to answer
2:12:50 PM Senator Simmons w questions
2:13:26 PM Dr. Gruber to answer
2:13:53 PM Mr. Cannon to answer
2:14:00 PM Senator Simmons w follow-up
2:14:12 PM Mr. Cannon to answer
2:14:25 PM Senator Simmons
2:15:31 PM Dr. Gruber
2:16:39 PM Senator Simmons
2:16:42 PM Mr. Cannon
2:18:29 PM Senator Simmons w follow-up questions
2:19:44 PM Mr. Cannon
2:20:30 PM Dr. Gruber
2:21:06 PM Senator Bean w questions
2:22:11 PM Dr. Gruber to answer

2:23:07 PM Senator Bean w follow-up
2:24:48 PM Dr. Gruber to respond
2:25:44 PM Senator Bean
2:26:01 PM Dr. Gruber
2:26:25 PM Senator Negron
2:26:30 PM Senator Grimsley w questions
2:26:52 PM Dr. Gruber
2:28:13 PM Senator Soto w questions
2:28:42 PM Dr. Gruber
2:29:42 PM Mr. Cannon
2:30:45 PM Dr. Gruber
2:30:50 PM Senator Smith
2:31:12 PM Mr. Cannon
2:33:19 PM Dr. Gruber
2:34:04 PM Senator Simmons w follow-up questions
2:34:16 PM Dr. Gruber
2:34:40 PM Senator Simmons
2:34:44 PM Dr. Gruber
2:35:08 PM Senator Simmons
2:36:12 PM Dr. Gruber
2:37:16 PM Senator Brandes w questions
2:37:43 PM Dr. Gruber to answer
2:38:24 PM Senator Negron w comments
2:39:26 PM Dr. Gruber
2:40:30 PM Senator Sobel w follow-up questions
2:41:03 PM Senator Negron
2:41:07 PM Dr. Gruber
2:41:32 PM Mr. Cannon
2:42:16 PM Senator Negron
2:42:21 PM Anne Swerlick
2:45:03 PM John Lacquey, Brandford, Florida small business owner
2:45:39 PM Peter Lee, Orlando, FL
2:49:12 PM Carol Knighton, Fruitland Park, Florida
2:51:11 PM EN Knighton, Fruitland Park, FL
2:52:59 PM Karen Schoen, Agenders Founder
2:53:39 PM Dan Stafford, Walton County FL
2:54:41 PM Sam Mullins, Milton, FL
2:55:57 PM Eric Witt, SRTPP
2:56:50 PM Sharon Glass, Pace, FL
2:58:14 PM John Beck, Gainesville, FL
2:59:31 PM Laurie Newsom, Gainesville, FL
3:00:46 PM Closing Remarks
3:00:51 PM Meeting Adjourned

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR AUDREY GIBSON
9th District

COMMITTEES:
Military Affairs, Space, and Domestic Security, *Vice Chair*
Appropriations Subcommittee on Health and Human Services
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Communications, Energy, and Public Utilities
Criminal Justice
Regulated Industries

SELECT COMMITTEE:
Select Committee on Patient Protection and Affordable Care Act

January 15, 2013

Chairman Joe Negron
Select Committee on Patient Protection & Affordable Care Act
320 Knott Building
404 South Monroe Street
Tallahassee, Fl 32399

Chairman Negron,

I respectfully ask to be excused from the Select Committee on Patient Protection and Affordable Care Act committee being held on Tuesday, January 22, 2013 at 1:00 p.m.

Thank you in advance for your time and consideration.

Sincerely,

Audrey Gibson
State Senator
Senate District 9

Cc: Steve Burgess, Staff Directors

REPLY TO:
❒ 101 E. Union Street, Suite 104, Jacksonville, Florida 32202 (904) 359-2553 FAX: (904) 359-2532
❒ 205 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5009

Senate's Website: *www.flsenate.gov*

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore