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OVERSIGHT OF IRS' LEGAL BASIS FOR EXPANDING OBAMACARE'S TAXES AND SUBSIDIES

HEARING

BEFORE THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

JULY 31, 2013

Serial No. 113–61

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.fdsys.gov
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

85–358 PDF WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
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OVERSIGHT OF IRS' LEGAL BASIS FOR EXPANDING OBAMACARE'S TAXES AND SUBSIDIES

Wednesday, July 31, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:43 a.m., in Room 2154, Rayburn House Office Building, Hon. James Lankford [chairman of the subcommittee] presiding.

Present: Representatives Lankford, Gosar, McHenry, Jordan, Walberg, DesJarlais, Woodall, Issa (ex officio), Speier, Cartwright, Cardenas, and Lujan Grisham.

Staff Present: Alexia Ardolina, Assistant Clerk; Brian Blase, Senior Professional Staff Member; Caitlin Carroll, Deputy Press Secretary; John Cuaderes, Deputy Staff Director; Linda Good, Chief Clerk; Meinan Goto, Professional Staff Member; Tyler Grimm, Senior Professional Staff Member; Christopher Hixon, Deputy Chief Counsel, Oversight; Mark D. Marin, Director of Oversight; Emily Martin, Counsel; Scott Schmidt, Deputy Director of Digital Strategy; Sarah Vance, Assistant Clerk; Peter Warren, Legislative Policy Director; Jaron Bourke, Minority Director of Administration; Yvette Cravins, Minority Counsel; Jennifer Hoffman, Minority Communications Director; Adam Koshkin, Minority Research Assistant; and Suzanne Owen, Minority Health Policy Advisor.

Mr. LANKFORD. Good morning. Committee will come to order. Like to begin this hearing by stating, the Oversight Committee statement. We exist to secure two fundamental principles. First, Americans have the right to know the many Washington takes from them is well spent. And, second, Americans deserve an efficient, effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to taxpayers because taxpayers have the right to know what they get from their government. We work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

We are starting a little bit different this morning. Our Democratic colleagues had a meeting with the President this morning from 10:00 to 11:00 here on the Hill. So they will be joining us in

just a moment. They have gone through written testimony as well, but they will miss much of the oral testimony at the very beginning here.

Ranking Member Ms. Speier will actually go last in this order. I will give my opening statement, we will receive the opening statement from our four witnesses, then Ms. Speier will come and give her opening statement as well. So it will be slightly different than is what is typical. But we are grateful for everyone to be here.

Today's hearing continues the subcommittee's oversight of the administration's implementation of Obamacare. While the substance discussed during today's hearing may be complicated, the principles involved are not. Congress makes laws. The President and the executive branch are responsible for carrying those laws out as they were written. At issue today is an example of the administration rerouting the law to meet political objectives.

In 2010, Democrats with overwhelming majorities in both Chambers of Congress passed a law that expanded the scope of the Federal Government control and involvement over America's healthcare choices through a complex scheme of mandates, rules, taxes, and subsidies. To encourage States to set up a State-based exchange, the Senate and House created a subsidy for individuals only in States that operate their own health exchange. In section 1311 of the Affordable Care Act, a health insurance exchange is defined specifically as a governmental agency or nonprofit entity that is established by a State. In section 1401 of the law, the subsidy is provided monthly when the taxpayer is covered by a qualified health plan that was enrolled through an exchange established by the States under section 1311.

As the Congressional Research Service legal analyst has made clear, the language is straightforward. According to the CRS, a strictly textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS' authority to issue the premium tax credits is limited only to situations in which the taxpayers enrolled in 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.

At the time of Congress passed Obamacare, the administration confidently predicted it would become more popular and States would willingly create their own exchanges. However, 34 States have refused to participate, and left building the exchanges to the Federal Government. Therefore, the impact of the IRS and the Treasury rule that extends tax credits to individuals in Federal exchanges is substantial. First, CBO has established that roughly 75 percent of the cost of subsidies will be new Federal spending. As a result, this rule will add hundreds of billions of dollars of Federal spending, which was not authorized by Congress in the statute.

Second, the subsidies are tied to the law's employer mandate so that employers face large tax penalties if their workers receive subsidies. Therefore, the IRS and Treasury's rule directly harms many employers and workers in States that choose not to create an exchange.

My State of Oklahoma is one of those States. The leaders in my State decided to protect their own employers and workers from the

employer mandate tax penalties and protect future generations of Americans will face increasing debt by not creating a State exchange. That was their option within the law. But now the IRS and Treasury's rule has invalidated my State's decision, harming employers and workers in my State and added to the Federal deficit. Because of the significance of this rule, this committee, along the Ways and Means Committee, has conducted oversight for over a year, focusing on the process and factors the IRS and Treasury have considered. The evidence we have gathered is consistent. The IRS was given an enormous role in implementing many Obamacare provisions, but the issue of whether tax credits will be available in Federal exchanges, doesn't appear that it was even considered or given substantial time or attention. Prior to the proposed rule, the IRS only had a single, weak reason for supporting their interpretation, that the designation that the Secretary create a Federal exchange in States that choose not to operate their own was enough to authorize subsidies in those States at well. After several media commentators pointed out the IRS rule was inconsistent with the statute, Treasury assigned one individual to gather additional information. Rather than doing an unbiased review of the statute and legislative history, it appears this individual only sought out information to support the predetermined conclusion that the tax credits would also be available for Federal exchanges. At three briefings with committee staff, IRS and Treasury officials could not remember details and could not provide evidence for factors that they may have considered. There is virtually no evidence to support Treasury's assertion that they carefully considered the language of the statute in the legislative history.

For example, in a letter to Chairman Issa on October 12, 2012, Assistant Secretary for Tax Policy Mark Mazur stated that there is no discernible pattern for how Congress used the term "exchange" in Obamacare. During the course of those briefings, IRS and Treasury employees admitted that they didn't organize or categorize the usages of "exchanges" in any way to look for a pattern.

Today I hope to gain a bit more clarification from Emily McMahon, the Deputy Assistant Secretary for Tax Policy, about IRS and Treasury's careful consideration of this statute to bring some light to this conversation.

I also look forward for hearing from several witnesses on the first panel, including my own good friend, Scott Pruitt, the attorney general of our State, and all of your perspective on this IRS rule. I look forward to our conversation today.

As I mentioned before, the ranking member's comments will come at the conclusion of our opening statements. All members will also have an additional 7 days to put their records—their opening statements on the record.

Mr. LANKFORD. We will now recognize our first panel.

Mr. LANKFORD. The Honorable Scott Pruitt, the attorney general for the State of Oklahoma.

Scott, glad you are here. Thanks for being here.

Dr. Charles Willey is the chief executive officer for Innovare Health—Innovare Health Advocates Incorporated.

Mr. Simon Lazarus is the senior counsel of the Constitutional Accountability Center.

Thanks for being here.

Mr. Jonathan Adler is professor of law at Case Western Reserve University, and author of "Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the Affordable Care Act," published in Health Matrix Journal of Law and Medicine.

Gentlemen, thank you all for being here.

Pursuant to committee rules, all witnesses will be sworn in before they testify.

If you would please rise and raise your right hand. Thank you.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Thank you. You may be seated.

Please let the record reflect all the witnesses answered in the affirmative.

In order to allow time for discussion, I will ask you to limit your testimony to 5 minutes. Your entire written statement will be made part of the record. I will give a little mercy if you go a little beyond 5, but you get bonus points if you go less than 5, how about that?

Attorney General Pruitt, you are first up to bat, sir. Be glad to receive your testimony.

STATEMENT OF THE HONORABLE E. SCOTT PRUITT

Mr. PRUITT. Chairman Lankford, Ranking Member Speier, and members of the subcommittee, good morning.

And thank you for inviting me to appear before you today to present concerns on the implementation of Affordable Care Act and the legal and economic implications of actions taken by the U.S. Internal Revenue Service, the Treasury Department, and the U.S. Department of Health and Human Services.

This is a critical issue for Oklahoma and for every one of the 34 States that chose not to establish a State healthcare exchange, a choice that was provided to us by Congress and affirmed by the United States Supreme Court. Because of the serious ramifications facing our States, I appreciate the attention that this subcommittee is giving to these concerns and to this matter.

First, I would like to be clear about my intentions today regarding healthcare policy and the law. My comments will not focus on the need for healthcare reform or the wisdom and the policy choices embodied in the ACA. Our responsibility as attorneys general is to preserve the rule of law, is to give meaning and effect to that which you have passed in Congress, while protecting the rights and interest of our citizens.

When Congress passed the Healthcare Act, they provided States a choice. That choice is whether to establish a State healthcare exchange or to opt for a Federal exchange. The ACA included with that choice a set of consequences and benefits that States had to consider. As the chairman indicated, our policy makers did, in fact, go through that process in a very deliberative fashion.

Among the outcomes of the State choosing not to establish a State exchange is a consequence of no subsidies flowing into that State. That law also provided a benefit of no penalties in the employer mandate arena for large employers. Our Governor, Mary

Fallin, and other Statewide stakeholders thoughtfully and thoroughly reviewed the options provided them under the Affordable Care Act and ultimately chose not to establish a State healthcare exchange.

But after that decision was made, the IRS finalized a rule that would strip States of the main benefit of their choice, no large employer penalty. Congress provided this choice to States, and now the IRS is attempting to take that away by rule. The IRS is acting as a super-legislative body in this capacity by enacting regulations that Congress did not authorize.

Their actions conflict with the ACA. And when informed of this, the regulators ignored public warnings and concerns that pointed out the problem. In fact, many months before the rule went final in May of 2012, the record was made as early as November of 2011 with respect to these concerns. The IRS does not have the authority to expand access to subsidies beyond what is clearly written in the law. As the chairman indicated, that's billions of dollars that will be flowing, unauthorized by Congress.

The regulation appears geared more toward enacting the agency's own policies than in faithfully following implementation of the law passed by Congress. This is why in September of last year, I filed a lawsuit in the Eastern District of Oklahoma challenging the IRS rule and its lack of authority under the Affordable Care Act. Our unique position allowed us to lead the charge against rogue agencies misusing the law to advance their own agenda.

As we stated in our lawsuit, Oklahoma's position has been clear from the very beginning, that the large employer penalty not only violates the law when implemented in States without a State healthcare exchange, but it cripples businesses with burdensome and onerous requirements and penalties. For a medium-sized company, already struggling to meet the needs of its thousands of employees, the penalty equates to millions annually when one of its employees qualifies for a subsidy under Subpart A.

Until now, the Obama Administration has argued in court that the mandate is uncomplicated and easy. But its recent sudden reversal and delay of the mandate clearly demonstrates and acknowledges that the large employer mandate is, in fact, a complex, job-killing, and harmful mandate in businesses, and again, Oklahoma is considered a large business under the statute.

Exactly where these burdens fall is a serious matter. And if the ACA exempts employers in States forgoing the establishment of their own exchange, that exemption should be recognized and enforced, and we appreciate the committee's focus on that. These issues are very important to the great State of Oklahoma because we value our State's economic stability and growth and the rule of law. Our fight continues on behalf of Oklahoma citizens to confront the administration when it seeks to overreach its authority and circumvent the law.

We hope to obtain relief in this matter through the courts, but we also welcome Congressional oversight being brought to bear on these agencies. I look forward to answering any questions you may have.

And I thank you for the time this morning, Mr. Chairman.

Mr. LANKFORD. Thank you.

[Prepared statement of Mr. Pruitt follows:]

Dear Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee,

Thank you for providing a forum where I may present my concerns regarding the regulations enacted by the IRS and Department of Health and Human Services to implement the Affordable Care Act ("ACA"). The Department of Health and Human Services defines an exchange to include any state-established or federally-facilitated health insurance exchange, and the IRS adopted the Department's definition for its entire set of regulations implementing the ACA. This definition overlooks the critical differences between state-established and federally-facilitated exchanges under the ACA's subsidy provisions in Section 36B of the Internal Revenue Code. The statute provides subsidies for certain individuals who buy insurance on a state-established exchange but not on a federally-facilitated exchange. These subsidies have significance outside of just spending taxpayers' money: the federal government's payment of a subsidy may trigger a substantial penalty for the payee's employer. The State of Oklahoma's decision—as well as decisions by 34 other states—not to establish an exchange should have prevented substantial federal spending as well as significant compliance costs both for the states as employers and for private employers. The conflict between the statute's provisions and the IRS's definitions led to my office choosing to litigate the matter, and it warrants your concern.

The ACA's Exchanges, Subsidies, and "Shared Responsibilities"

Title I, Subtitle D, Parts II and III of the ACA call for the creation and operation of markets, referred to in the Act as "Exchanges," where individuals may purchase health insurance. Section 1311 of the ACA provides for the establishment of an Exchange by a State. 21. Section 1321(c) of the ACA provides for a federally-facilitated Exchange.

In the case of an individual who meets certain criteria including a household income requirement, Title I, Subtitle E, Part I, Subparts A and B of the ACA effectively provide for

subsidizing that individual's health insurance coverage if the individual purchases it on an Exchange established by a State. The subsidy consists of an "advance payment" from the Treasury under the conditions established in Sections 1401, 1411 and 1412 of the Act to the issuer of the health insurance coverage. The Treasury makes the advance payment in an amount equal to an estimate by the Exchange of the size of the tax credit to be taken against the payee's income tax under Section 36B of the Internal Revenue Code. Section 36B(b) provides a formula for computing the amount of the Premium Tax Credit for each month of the taxable year.

Section 1501 of the ACA added Section 4980H to the Internal Revenue Code. Section 4980H potentially applies to any "applicable large employer," defined as an employer that employed on average 50 or more full-time equivalent employees on business days during the prior year. The requirements imposed on a large employer under Section 4980H trigger if and only if an "advance payment" has been or could have been made or a "premium tax credit" has been or could be allowed to or on behalf of one of the employer's full time employees. When Section 4980H triggers with respect to a large employer, it imposes a significant assessment that may be as much as $2,000 for every full-time employee at the company less a thirty employee allowance. The only way the employer may avoid the payment is to have arranged in advance to make available insurance coverage to full-time employees and their dependents. The insurance must provide "minimum essential coverage" that meets a regulation-set "minimum value" through an "eligible employer-sponsored plan" at a cost satisfying standards of "affordability" under the Act. In addition, the Act imposes other significant obligations such as detailed reporting requirements on employees.

Section 4980H thus imposes significant compliance costs and possibly even direct payment obligations on employers. Yet Section 4980H only triggers when the Treasury makes an

advance payment or an individual takes a premium tax credit. Under the ACA, these events should only occur when individuals purchase insurance on an Exchange established by a State.

The IRS Regulation and Oklahoma's Litigation

On May 18, 2012, Treasury issued a final regulation that incorporated the definition of "Exchange" found in final regulations issued by the Department of Health and Human Services on March 25, 2012. The Department of Health and Human Services defines "Exchange" to include a federally-facilitated Exchange, which would be broader than just the category of State-established Exchanges. Thus, the Treasury can be expected to permit advance payments on behalf of individuals who have not enrolled in insurance through an Exchange established by a State. Further, the Treasury and the IRS can be expected to permit some individuals to take premium tax credits under Section 36B of the Internal Revenue Code despite not having enrolled in insurance through a State-established Exchange.

Not only does this result conflict with the ACA, but the regulators ignored public comment pointing the problem out. Public comments in response to the proposed regulations stated clearly that the regulations would cause advance payments to be made and premium tax credits to be allowed even if individuals only had coverage through federally-facilitated exchanges. For example, one comment noted that

> [n]owhere within the [statute] is an Exchange created under Section 1321 mentioned regarding eligibility of the premium tax credit. Again, the IRS does not have the authority to expand access to a premium tax credit beyond what is clearly written within PPACA.

The Treasury brushed aside critical comments with only the most cursory analysis. Nowhere does the notice indicate that the Treasury considered contrary evidence or legal considerations. Thus, the Treasury's regulation appears geared more toward enacting the agency's own policies than acting as a faithful agent of Congress.

My office had previously filed a lawsuit against various officials in the federal government out of concerns that the ACA contained unconstitutional provisions and conflicted with the Oklahoma Constitution's guarantee that a person may not be coerced into participation in any health care system. While the United States Supreme Court's opinion in *National Federation of Independent Business v. Sebelius* dealt with some of the issues raised by my office, the IRS's flawed, unconsidered regulations became final after the Supreme Court had already begun deliberation. Fortunately, because my office did not join the larger set of lawsuits before the Supreme Court last year, we had the opportunity to amend our complaint on September 19, 2012, to obtain relief. Rather than correct its improper regulations, the federal government moved to dismiss the State of Oklahoma's complaint. The outcome of that motion is currently pending in district court in the Eastern District of Oklahoma.

We have also filed a notice to the court concerning the administration's recent decision to delay implementation of Section 4980H for a year. The administration's justification for the delay cited numerous complaints from employers about the burdens imposed on them by the ACA. The delay therefore confirms my office's concerns: exactly where these burdens fall is a serious matter, and if the ACA exempts employers in states foregoing the establishment of their own Exchanges, that exemption should be recognized and enforced. The ACA represents one of the most sweeping reforms of an entire corner of American industry—actually, American life—ever contained in one bill. Regulators implementing such a broad statute should not take limitations imposed by Congress lightly. We hope to obtain relief through the justice system, but we also welcome Congressional oversight being brought to bear on these agencies.

Thank you for affording me the opportunity to present these concerns. Please see attached some of our key filings from the litigation, including our amended complaint, our response to the federal government's motion to dismiss, and notices we have filed with the court.

E. SCOTT PRUITT
ATTORNEY GENERAL OF OKLAHOMA

Mr. LANKFORD. Dr. Willey.

STATEMENT OF CHARLES WILLEY, MD

Dr. WILLEY. Mr. Chairman and members of the committee, good morning. And thank you for your service to the great American taxpayer, the forgotten man.

I am Charles Willey, an internal medicine physician in my 29th year in St. Louis. My care of patients has me aggressively leading them to long-term health. My healthcare team is responsible and accountable for both the economic—both the clinical and the economic outcome of our care of our patients.

Since 1992, we've been prepaid for population health management one person at a time. In effect, we are paid to keep our Medicare beneficiaries happy, healthy, active, and energetic for life. We intervene early and often. We spend whatever time and resource necessary to bring them to long-term health. Our result is 5-star quality and satisfaction and a medical cost ratio of 60 percent.

Now, this is happening on a scale of 40,000 members in the Medicare Advantage plan that I founded in St. Louis in 2003. Witness that being healthy costs less than being sick. Ladies and gentlemen, please understand the implication if all Medicare beneficiaries were cared for in this method, you could freeze the revenue to the Medicare program, cut nothing, and solve the greatest financial crisis of our time, the $70 trillion obligation to the current payers of the Medicare tax.

We achieve this by aligning the incentives of the health plan, the physicians—and the physicians with the long-term health of the patient. It is crucial that Medicare Advantage also liberates us from much of the destructive regulation found in regular Medicare Stark law and the SEC.

Now I have set about to replicate these methods for my employees and those of other medical practices and businesses in my town. Unfortunately, Obamacare increases destructive regulation, does nothing about the legions of ambulance-chasing lawyers, and creates new entitlement to become and remain sick. It is treating these problems caused by government with more government.

As an employer of 56 healthcare workers, it is doubly important that their health plan give them economic responsibility for health decisions and short-term reward for becoming and remaining healthy because I need them to model and teach this to my customers, our customers, the patients. In the our company health plan, we have gradually been increasing the deductible, while expanding our health savings account.

Now Obamacare would limit our deductible to $2,000, whereas, we would make it as high as the maximum HSA contribution and help our employees fund it. This gives our staff ownership and a high motivation to avoid unnecessary costs by shopping wisely for necessary healthcare services and by becoming healthy so service is not necessary.

Our benefit design would also have a higher premium and copayments for smoking, being obese, for not complying with diabetes recommendations and control. These policies are good for our employees' health and good for their savings accounts as well.

Now, Obamacare calls these policies discriminatory and prohibits them. This is a clear example of government promoting and maintaining illness, preventible illness.

Discrimination against illness, through no fault of ones own, like ovarian cancer, is unacceptable. But it is good to be candid about unhealthy behavior because that will motivate the behavior to stop. To do otherwise is enabling, much like the spouse or parent of an alcoholic. The lack of courage to oppose the self-destructive behavior actually promotes and maintains the illness, increasing the probability of greater illness, disability, even premature death, and increases cost.

This is how Obamacare is making entitlement of becoming and remaining sick. It codifies obesity, cigarette smoking, ongoing substance abuse, and other choices, unhealthy choices, to be not discriminated against in benefit design. My plan for my employees would lead them to health. But I can't offer it under the employer mandate.

Now, the IRS is blatantly ignoring the law and rewriting it to include the subsidy in the State—in the Federal exchanges, triggering a penalty against me, the employer. Missouri opted out of the State-based exchange, therefore protecting my employees from unhealthy benefit design and higher cost and protecting my company from the onerous fines. I am not a criminal. I don't need to be fined for helping my employees achieve health and save for the future.

The Federal Government's mandates discourage personal responsibility necessary for good health and enables self-inflicted illness. The Oregon Medicaid expansion enabled beneficiaries to resume smoking, since they could again afford cigarettes, and there were no disincentives. These are the reasons my company and other health advocates has joined Halbig v. Sebelius to overturn the usurpation of your Congressional authority by the IRS in rewriting the law.

I have dedicated my career to reforming healthcare from the marketplace. With relief from this illegal aspect of the law, we at Innovare Health Advocates could continue our plans for a very high quality, low-cost healthcare plan for many non-Medicare people in our—in our town.

Our experience in patient care, including understanding the economics of that care, cannot be replaced by nameless, faceless, faraway bureaucrats. This is America. It is demoralizing and humiliating for me to have to beg for the liberty for me to do what I know best and for that which I am well trained. You must defend us from government and free us to take care of our patients and please join me in my oath to first do no harm.

Respectfully, thank you.

Mr. LANKFORD. Thank you.

[Prepared statement of Dr. Willey follows:]

Charles J. Willey M.D.

Physician and CEO
Innovare Health Advocates

Oversight of IRS's Legal Basis for Expanding Obamacares's Taxes and Subsidies

House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

July 31, 2013

Mr. Chairman and members of the Committee, good morning and thank you for your service in defense of the great American taxpayer, the forgotten man. Thank you for allowing me to assist you this morning in that noble mission.

I am Charles Willey, a physician in my 29th year in the practice of Internal Medicine in St. Louis, Missouri. My care of patients has me aggressively leading them to long term health. I am indeed their advocate in a manner one would expect of a family member. My healthcare team is responsible and accountable for both the clinical and the economic outcome of our care of patients. You see, we have forged a rather unique business model for our health services. Since 1992, we have been prepaid for population health management, one person at a time.

Given that, in effect, we are paid to keep Medicare beneficiaries happy, healthy, active and energetic for life, we intervene early and often spending whatever time and expending whatever resource is necessary to achieve long term health. Our result is 5-star quality and satisfaction with a medical cost ratio of 60%. This is now happening at a scale of 40,000 members in the Medicare Advantage health plan that I founded in 2003 in St. Louis.

Witness that being healthy costs much less than being sick. Ladies and gentlemen, please understand the implication; if all Medicare beneficiaries were cared for in this method, you could freeze revenue to the Medicare program, cut nothing, and solve the greatest financial crisis of our very troubled time, the $70 trillion obligation to our honorable customers, the citizens and taxpayers of these United States.

You may wonder how we achieve such fine results. Well, we have aligned the incentives of the health plan and the physicians, with the long term health of the patient. It is also crucial that Medicare Advantage liberates us from much of the destructive regulation found in regular Medicare, Stark law and the S.E.C.

Now, I have set about to replicate these methods for my employees and those of other medical practices and small businesses in my town. Unfortunately, Obamacare throws a wrench into our gears because, it doubles down on all that is wrong with healthcare in America as we know it. It increases destructive regulation, it does nothing about the legions of ambulance chasing lawyers and creates a new entitlement to become and remain sick. It is treating these problems caused by government... with more government.

As an employer of 56 healthcare workers, it is doubly important that they have a health plan that gives them economic responsibility for their health decision and short term reward for becoming and remaining healthy not only for their own benefit but so they can model and teach it to our customers, the patients.

In our company health plan, we have been gradually increasing our deductible while expanding our health savings account. Now Obamacare would limit our deductible to $2,000 while we would have it be as high as the HSA maximum contribution and help our employees fund their HSA. This option would give the staff an ownership stake in the HSA and high motivation to avoid unnecessary costs by shopping wisely for necessary healthcare service and by becoming healthy so service is not necessary.

Our benefit design would also have a substantially higher premium and copayments for smoking, somewhat higher for being obese, and significantly higher for not complying with diabetes recommendations and keeping the diabetes under control. All of these policies are good for our employee's health upon changing their behavior and good for their savings accounts as well. Obamacare calls these policies discriminatory and prohibits them. This is a clear example of government promoting and maintaining illness that could be cured with a behavior change.

Discrimination against illness someone has through no fault of his or her own, like ovarian cancer, is unacceptable. But it is good to be candid about unhealthy behavior because that will motivate the behavior to stop. This is especially true when the method is to give the person the liberty to continue unhealthy behavior if they so choose but they are simply held accountable and must pay for the extra costs of their behavior.

To do otherwise is enabling much like the spouse or parent of an alcoholic. The lack of courage to oppose the self-destructive behavior actually promotes and maintains the illness, increasing the probability of greater illness, disability and even premature death, as well as all the costs attendent to these. This is how Obamacare is making entitlement of becoming and remaining sick. It codifies obesity, cigarettes smoking, ongoing substance abuse and other behavior choices not to be "discriminated against" in benefit design.

The health benefit plan for my employees would do the opposite of what Obamacare wants it to do – My plan would lead my employees to health, but I can't offer it under the employer mandate.

Now contrary to the clear legislative language in Obamacare, the IRS is blatantly ignoring the law and rewriting it to include the subsidy which triggers the tax penalty against me, the employer, in the federal exchanges, while they were specifically designed for state based exchanges only.

My Missouri legislature opted out of putting up a state based exchange, therefore, protecting my employees from the unhealthy benefit design and higher costs, and protecting my company from the onerous fines. I am not a criminal. I don't need to be fined for helping my employees achieve health and save for their future.

Remember, it costs much more to be sick than to be healthy. Fischer and Wennberg have long established that 50% of American healthcare costs are due to adverse behavior. 'The' problem with access to health care is predominantly a function of cost. Government increases cost in healthcare which decreases access, no doubt about it.

The federal government's mandates discourage the personal responsibility necessary for good health and enables self inflicted illness. The Oregon Medicaid expansion enabled beneficiaries to resume smoking since they could again afford cigarettes and there were no disincentives. Government-generated cost is a major problem with Medicaid and Medicare, and now in Obamacare too; which doubles down on the wrong policies, discouraging healthy behavior, and criminalize the correct incentives.

These are the reasons my company, Innovare Health Advocates has joined Halbig v Sebelius to overturn the usurpation of your Congressional authority by the IRS in rewriting law.

By inventing, several medical groups, an electronic prescription writer, a Medicare Advantage health plan and population health software, all the while caring for patients, I have spent a career reforming healthcare from the market place, fending off or working around destructive government policy whenever possible. With relief from this illegal aspect of the law, we at Innovare Health Advocates could continue with our plan for a very high quality, very low cost health care plan for non-Medicare people.

Please indulge me one final point.

Physicians are among the most highly educated and thoroughly trained professionals on the planet. We treat patients 24-7 in any context necessary, dropping whatever else we may be doing. Daily we hold life and death in our hands. It is a high calling. It is a duty and a privilege. It is a never-ending quest for knowledge and is continuous problem solving. We are delighted to serve.

Our collective experience in patient care, including understanding the economics of that care, cannot be managed or replaced by nameless faceless far away bureaucrats. Indeed that is the problem.

This is America. It is demoralizing and humiliating for me to have to beg on behalf of all physicians for the liberty to do what we know best and that for which are very well trained.

You must defend us from government and free us to take care of our patients, and free me from the IRS and Obamacare overreach to take care of my employees with an insurance plan that incentivizes them to health.

And please, ... Join me in my oath to, "first do no harm", then allow me to use my education, knowledge, and experience to fulfill the humble words of the Hippocratic Oath I took 32 years ago:

... to "prevent disease whenever I can, for prevention is preferable to cure."

Mr. LANKFORD. Mr. Lazarus.

Mr. LAZARUS. Thank you very much.

Mr. LANKFORD. Want you to click your microphone on right there in front you, the top button.

Mr. LAZARUS. Thank you.

Mr. LANKFORD. Thank you.

STATEMENT OF SIMON LAZARUS

Mr. LAZARUS. Thank you very much, Mr. Chairman, and members of the committee for inviting me today. I look forward to trying to help evaluate whether the Affordable Care Act premium assistance tax credits and subsidies should be fully available to all eligible individuals on ACA proscribed exchanges, whether they are facilitated by State governments or by the Federal Government.

I believe that they should be. I believe that the Treasury Department's interpretation is correct, that reviewing courts must defer to it, and that they should not and will not overturn it.

Now, my copanelists have a contrary claim. And they do so, I believe, because they adopt what I would respectfully call the quarantine approach to a statutory interpretation. They zero in selectively on certain provisions of the act, and one in particular, lift that provision out of context, and then impose on it an interpretation which, in the context of the entire statute and certainly its purposes, its purpose, highly implausible interpretation.

When you look at the statute in the context that it should be examined, and which I think courts will certainly do, other relevant provisions confirm that the text of the ACA is not at war with its central purpose. It does not sabotage that purpose; it rather effectuates it.

So let's just take a quick look at what we all know the purpose is. When Congress passed the ACA its fiercest critics concurred with its supporters that it had a simply-stated purpose, and that was to achieve near universal health insurance coverage, which is a quote from my copanelist, Professor Adler's lengthy article on this subject.

In addition, all sides recognized that the exchanges were a central mechanism for achieving that goal. It was not until November 2011, one and a half years after President Obama signed the ACA into law, that Professor Adler and his co-author, Michael Cannon of Cato, surfaced their discovery that there was an apparent glitch, as they called it, in the act, and that this glitch supported a 180-degree contradictory interpretation of the law's critical exchange mechanism. And as Michael Cannon has proclaimed, that result could drive a stake through the heart of Obamacare.

But the truth is we were all right the first time. The text and purpose of the ACA are in harmony. The Congress that adopted this law did not intend and the statute its authors drafted does not put this supposed stake in the hands of health reform opponents in State capitals, who are very sincere, I don't doubt that for a minute, but opponents such as Attorney General Pruitt, and in effect stiffing the core constituency that the law was enacted to benefit.

Now, statutory interpretation is not for the faint of heart, and I'm going to try to spare us all—try just to summarize very briefly,

if I can, what the gist of my argument is and leave details to my written statement for those who have the heart to try to plow through that. So I'm going to focus on the textual argument that the opponents, the ACA opponents make.

To begin with, as your opening statement I think very succinctly and clearly put it, Mr. Chairman, that—the opponents' argument zeros in on section 1401, which enacts a new section 36B of the Internal Revenue Code. And it targets a provision that is in there to define how to calculate the amount of premium assistance. And that provision pegs the premium assistance amount to monthly premiums for insurance policies which cover the taxpayer and which were enrolled in through an exchange established by the State under section 1311 of the ACA. It's no wonder that it took a year and a half to find this particular provision, I must say.

Now, the theory of my colleagues here is that because this subsection calculates premiums for policies that are issued through an exchange established by the State under section 1311, therefore, they say, Federally facilitated exchanges, which are directed in another section of the act to stand in where States fail to set up exchanges of their own, cannot be considered their equivalent and their policyholders and applicants who need premium assistance are left out in the cold.

If this seems like an implausible interpretation, it becomes much more so if one looks at the act as a whole, which I have done, but I'm not going to go through all of the things that I have learned by doing that. I'm going to focus on one provision which I feel particularly undermines the self-defeating spin that my colleagues here would put on section 36B and section 1311. And the section I would like to focus on of course is section 1321. And this is a section which says that if a State fails to establish an exchange, then the Secretary of Health and Human Services shall establish and operate such exchange and shall take such actions as are necessary to implement such other requirements.

Now, a key part of our position is simply that the use of the word "such exchange" and the use of "Exchange" with a capital E, showing that it's a defined term, that the logical, common sense interpretation of that language is that the exchange under HHS stewardship shall remain such exchange as it would have been under State stewardship and shall be its functional equivalent. It shall be subject to the same requirements. It shall have the authority necessary to take such actions as were necessary to implement its functions.

As the steward of such exchange, our position is, the Secretary stands in the shoes of or acts on behalf of a defaulting State Government. This type of surrogacy or stewardship is very commonplace in the law. And so that is what—that—that is what we feel 1321 and the statute as a whole contemplates.

There's really no reason to impose this cramped interpretation that, again, is—as Professor Adler's co-author, Michael Cannon, has said, would bring Obamacare's exchange engine to a screeching halt.

Mr. LANKFORD. Sorry to interrupt you. How much time do you have left? Because we want to receive all of your statement.

Mr. LAZARUS. I've overshot?

Mr. LANKFORD. 2 minutes over.

Mr. LAZARUS. I apologize.

Mr. LANKFORD. That's all right. Do you have a final statement there? Because we want to be able to receive questions from you as well.

Mr. LAZARUS. I just wanted to say that opponents recognize that they need more than this text-only argument. They've gone to a purpose argument. And they claim that Congress deliberately designed the exchange provisions so that they would essentially fail in Federal exchange States. And I just would like to suggest that it's rather implausible to think the ACA sponsors, and we're talking about people like Harry Reid, Senator Chuck Schumer, Max Baucus, Patty Murray, would have intentionally handed over to ACA opponents in State capitals, like Attorney General Pruitt, the power to sabotage the law in their States. But I think you have to—you have to think that's true in order to sustain the argument to the contrary.

Mr. LANKFORD. Thank you.

Mr. Adler.

Mr. LAZARUS. I apologize for going over so much.

Mr. LANKFORD. That's all right.

[Prepared statement of Mr. Lazarus follows:]

THE AFFORDABLE CARE ACT ENSURES PREMIUM ASSISTANCE FOR ELIGIBLE NEEDY INDIVIDUALS ON BOTH FEDERAL AND STATE-FACILITATED EXCHANGES.

Testimony of Simon Lazarus
Subcommittee on Energy Policy, Health Care, & Entitlements
Committee on Government Oversight & Reform
U.S. House of Representatives

Wednesday, July 31, 2013, 10:15 AM
2154 Rayburn House Office Building

I thank the Subcommittee for inviting me to assist its members and their colleagues in evaluating the lawfulness of the Obama administration's decision to ensure that Affordable Care Act (ACA) premium assistance tax credits and subsidies are fully available to all individuals eligible for such assistance, whether they seek insurance through ACA-prescribed exchanges facilitated by state governments or by the federal government.

I have written and spoken extensively about this and other legal issues relating to the ACA since the legislation was under consideration by Congress in 2009. I have also studied and published on the general subject of statutory interpretation. I am currently Senior Counsel to the Constitutional Accountability Center. CAC is a public interest law firm, think tank, and action center, dedicated to realizing the progressive promise of our Constitution, and of laws which, like the ACA, are designed to realize that promise. I hope to contribute to the Subcommittee's understanding of the question whether providing premium assistance to needy Americans in federal as well as state-facilitated exchange states is faithful to the text, structure, purpose, and history of the ACA.

Introduction and Summary

I believe that the interpretation of the ACA adopted by the administration is correct, that reviewing courts must defer to it, and that they should not and will not overturn it. The critics' contrary claim focuses selectively on certain provisions, then lifts them out of context and imposes on them a nonsensical interpretation. The critics' misread ignores other relevant provisions, that confirm that the text of the ACA does not sabotage, but rather effectuates its stated purpose of ensuring near-universal coverage for the millions of Americans nationwide who have previously lacked access to affordable quality health insurance and health care.

When Congress enacted the Affordable Care Act, three years ago, there was substantial partisan debate about whether the law was a good idea. But there was bipartisan agreement about what the ACA's purpose was. The health reform law's fiercest critics concurred with its supporters that it had, and has, a clear and simply

stated goal – "to achieve near-universal health insurance coverage."[1] In addition, all sides recognized that a principal mechanism for achieving that goal is the "exchanges" prescribed by the ACA. These exchanges, organized state-by-state, are market-places where individuals not covered by employer-sponsored group health plans or government insurance programs can obtain affordable coverage and, hence, care. Although Congress expected that competition -- along with statutory insurance reforms -- would discipline the cost and quality of insurance offerings on the exchanges, it also recognized that many millions of uninsured individuals would require additional financial support to afford premiums. Hence, the universal, bipartisan expectation was that such premium assistance support would be available in states that chose to establish and run their own exchanges, and also in states that failed to do so, and instead left that responsibility to the federal government. Not until November 2011 – one and one half years after President Obama signed the ACA into law – did my co-panelist Professor Adler and his co-author, Michael Cannon of the CATO Institute, surface their claim to the contrary. They said at the time that they "were first made aware of this aspect of the ACA" in December 2010, nine months after enactment. To ACA opponents probing for any opportunity, no matter how far-fetched, to impede the law's implementation, the discovery of this apparent "glitch" must have been invigorating. As Michael Cannon has often repeated since, if their contention were to prevail in court, the result could "drive a stake through the heart of Obamacare."

However, the truth is, we were all right the first time. The text and purpose of the ACA are in harmony. The Congress that adopted this law did not intend, and the statute its authors drafted does not seek, to put this supposed "stake" in the hands of health reform opponents in state capitols, in effect stiffing the core constituency the law was enacted to benefit.

The ACA's text assures premium assistance to eligible individuals in all states, whether governed by state or federally facilitated exchanges.

To make their counter-intuitive, not to mention counterfactual, claim that the ACA's text subverts its fundamental purpose, ACA opponents focus on one subsection of one section of the law, Section 1401, which enacts a new Section 36B of the Internal Revenue Code. IRC §36B(a) provides that "In the case of an applicable taxpayer, there shall be allowed as a credit . . . . an amount equal to the premium assistance credit amount of the taxpayer for the taxable year." That says an applicable taxpayer -- someone who is under 400% of the federal poverty level -- gets the credit. Subsection 36B(b), which contains the language on which the opponents found their argument, details how this "premium assistance amount" is to be calculated, in other words, how much the applicable taxpayer gets. Subsection 36B(b)(2) specifies that this figure is the "amount equal to the lesser of" two options. The first option, spelled out in the immediately following Subsection 36B(b)(2)(A), pegs the premium *assistance amount to "monthly premiums" for insurance policies which "cover the taxpayer and which were enrolled in through an Exchange established by the state under [Section] 1311 of [the*

[1] Jonathan H. Adler and Michael F. Cannon, *Taxation Without Representation: The illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX 119, 126 (2013)

ACA]." (Emphasis added) This italicized passage, from the ACA's instructions on how to calculate the amount of an individual taxpayer's premium assistance tax credit, is what Professor Adler and his fellow ACA opponents have seized upon to ground their claim that the ACA bars participants in federal-facilitated exchanges from access to affordable health coverage via receipt of premium assistance credits and subsidies. As they read the statute, the statute says that taxpayers in federal-facilitated exchanges get the subsidy, but the amount of the subsidy is zero.

Initially, the opponents made this language essentially their whole case. They claimed that the passage meant that the text of the ACA – the entire ACA – *unambiguously* required that the Act be construed to defeat its acknowledged purpose of promoting near-universal health coverage. But this phrase, buried so deep in a provision devoted to measuring how much eligible individuals receive in premium assistance credits that it wasn't discovered for close to a year after the President signed the bill into law, is a fragile reed on which to hang so counter-intuitive and consequential an asserted interpretation. The opponents soon realized that this isolated and internally contradictory "glitch" could not, by itself, support their characterization of the ACA's text – i.e., the text of the whole statute.

So they came up with a new argument. In the summer of 2012, Professor Adler and Michael Cannon, in the first published version of their article, asserted that "our further research" proved that this self-destructive provision (as they interpreted it) was not a mere glitch, after all, but rather "intentional and purposeful . . . ." As will be explained below, this amended claim is not merely weak, but literally lacking any basis in the statute, its massive legislative history, contemporaneous claims about the provision by legislators, governors, administrators, academics, columnists, or reporters, or common-sense recognition of what the authors of the ACA actually intended. But, before turning to the "intentional and purposeful" issue, I will briefly address what I believe are the key weaknesses that prompted the opponents to abandon their notion that they could prevail with their initial, purely textual argument.

1. ACA opponents' misguided – and misleading – text-out-of-context "quarantine" approach to construing the text of the ACA.

As noted above, opponents claim that the "stake" they have found to drive through the ACA's heart consists of a phrase in a subsection measuring the amount of individual premium assistance credits, referencing policies "enrolled in through an Exchange established by the State under [Section] 1311." The basic problem with this claim is the approach itself. In a June 17, 2013 debate at the CATO Institute about the issue being considered in this hearing, my debate partner, Rob Weiner of Arnold & Porter and formerly of the U.S. Department of Justice, characterized this as the "quarantine" approach to statutory interpretation – quarantine a few words, and rip them from their context.[2] Here, as elsewhere, this is a path to an absurd result, not to plain

[2] The points made in this testimony are largely drawn from the presentation that I jointly made with Mr. Weiner at the above-noted June 17 debate. Mr. Weiner made significant contributions to these points, though I of course bear full responsibility for the final version of this testimony. (On the other side of the

meaning. This interpretive path requires, first, that anyone seeking the meaning of the Act ignore the most elemental aspects of context. For starters, they disregard Title I of the Act, where the provisions we are debating appear, and which expressly states what it's trying to achieve -- quality affordable care for all Americans. Not just Americans in some states. The subtitle that contains the relevant provisions reiterates the goal -- Affordable Coverage Choices for All Americans. The section that creates the tax credits also expressly says what it's about - tax credits for premium assistance - to help people afford insurance.

Several specific provisions of this title and subtitle, briefly discussed below, detail how the exchange mechanism is to contribute to achieving the statute's purpose – and make clear that IRC Section 36B(b)(2), alone or in combination with any other provisions, cannot bear the weight opponents would impute to it, of defeating that purpose.

2. Section 1321(c)(1) provides that, where a state fails to establish the type of exchange that Section 1311 provides that it "shall" establish, the Secretary of HHS "shall establish and operate such Exchange."

The single provision of the Act that most straightforwardly undermines opponents' self-defeating spin on Section 36B and Section 1311 is Section 1321, which prescribes the federal alternative to state-established exchanges. Subsection 1321(c)(1) provides that, if a state fails to establish an exchange, as prescribed by the Act, the Secretary of Health & Human Services "shall establish and operate *such* Exchange and shall take such actions as are necessary to implement such other requirements [required of state-facilitated exchanges]." The logical, common-sense interpretation of that simple language is that, the exchange under HHS stewardship shall remain "such Exchange" as it would have been under state stewardship, shall be its functional equivalent, shall be subject to the same "requirements," and have the authority and responsibility to "take such actions as are necessary to implement" its functions. As the steward of "such Exchange," the Secretary, as numerous commentators have noted, stands in the shoes of, or acts on behalf of, or substitutes for, or stands in for the defaulting state government. This type of surrogacy or stewardship is commonplace in the law. There is no textual indication – nor any logical reason – why this language should be read to mean that, instead of establishing and operating an equivalent "such" Exchange, the Secretary shall operate a second-class exchange – indeed, one which, to quote Professor Adler's co-author Cannon would be unable to serve a majority of eligible uninsured or under-insured individuals, a circumstance that "would bring Obamacare's Exchange engine to a screeching halt."

3. The ACA's definition of "Exchange" applies equally to federal and state-established and operated exchanges.

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debate were Michael Cannon, CATO's Director of Health Studies, and Michael Carvin, partner at Jones Day and counsel to the plaintiffs in one of the lawsuits challenging the Obama administration's interpretation of the ACA at issue in this hearing.) A video of the debate is accessible on CATO's website, CATO.org.

The common-sense interpretation of "such Exchange," noted above, in Section 1321 is confirmed by the statute's definition of "Exchange," and the appearance of that defined term in Section 1321 and elsewhere in the Act. The definition and function of an Exchange are laid out in Section 1311. That section creates American Health Benefit Exchanges. And it says the statute will refer to them as an "Exchange*," with a capital E*. It has defined the term. And Section 1311(d), labeled "requirements," fills out the definition:

> An Exchange *shall be* a governmental agency or nonprofit *entity that is established by a State.* (Emphasis added)

That is a mandatory definition ("shall" is mandatory). Hence, whenever the term "Exchange" appears in the statute with a capital "E," it means an exchange established by the State under Section 1311. (The definition is repeated in Section 1563(b).) So, turning to Subsection 1321(c)(1): It says that if the State does not establish an Exchange:

> 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.

An "Exchange," with a capital E, as we have seen, is defined as an entity established by the State. So, if, as this provision directs, the federal government establishes an Exchange with a capital "E," it can *only* be an Exchange with capital E, as understood by the Act, if it fits the definition set forth in Section 1311 for capital "E" exchanges – i.e., if it is an entity covered by the law's definitional term of art, as an "Exchange established by the state under section 1311." The opponents' contrary, anti-common-sense interpretation would mean that the Secretary is commanded by Section 1321 to do what it cannot possibly do -- establish and operate a Capital "E" Exchange, which is in fact not, and cannot be a Capital "E" exchange. That, obviously, makes no sense. It also flouts the "plain meaning" conclusion that, once defined, that term must have the same meaning wherever it appears throughout the statute. The only exception to this rule is in circumstances where an alternative interpretation is made indisputably clear in a given provision, and/or the definitional meaning would produce absurd results, or contradict a manifest statutory purpose. None of those exceptions are applicable here.

There is in fact only one way to make sense of this provision. It says the secretary shall establish "such Exchange" and do what is necessary to make it work. It doesn't say "an exchange," with a small "e," or "a federal exchange." It says "such Exchange," with a capital E. Which exchange is provision referring to? There's only one such Exchange created and defined in the statute -- the one established by the State under 1311. And the only way the federal government could establish such an Exchange, as the statute defines it, is to act on behalf of, or substitute for, or stand in for, or step into the shoes of the State. That's very common in the law – under the

common law, in statutory civil law settings, and in federal statutes which, like the ACA, create federal-state "cooperative federalism" partnerships with state governments.

4. Excluding federally-facilitated exchanges from the statutory definition of "Exchange" produces pervasive absurd results throughout the ACA.

The consequences of the opponents' approach go beyond rendering 1321 nonsensical. If section 1321 does not permit the federal government to stand in for the state, then the states can never, ever reduce their Medicaid benefits or eligibility requirements. Why? Because the statute says unequivocally that the benefits and eligibility requirements have to stay the same "*until* the Secretary determines that an Exchange established by the State under section 1331 is fully operational."

Here are some other examples:

No CHIP back-up coverage: If a State doesn't have the money to ensure coverage for low-income children under the Children's Health Insurance Program, known as CHIP, the State has to make sure the children are enrolled in a qualified health plan "offered through an Exchange established by the State under section 1311." Under the opponents' definition, states with a federally facilitated exchange can't do this. So the opponents' cramped definition makes the statute impose another impossible requirement.

No qualified health plans on federally-facilitated exchanges. Because an Exchange is an only an exchange with a capital E when it's established by the State, if 1321 does not allow the federal government to step in for the State, then the states with federally facilitated exchanges can have no qualified health plans, because those are only ones sold through an exchange. With no qualified health plans, nothing works. The ACA become a health insurance statute without health insurance.

No accounting controls or screening for lawful U.S. residents. If an exchange, as § 1311 says, must be established by a state, and if §1321 doesn't change that, then under section 1313(a) (1), a federally-facilitated Exchange doesn't have to keep an accurate accounting of activities and expenditures, and under section 1411, a federally facilitated exchange doesn't have to make sure that people covered through an Exchange are not illegal aliens.

The only way to give meaning to the above-noted provisions, and avoid absurd results in these and other similar situations covered and referenced by the ACA, is to adopt the intended, common-sense definition of the statutory term "Exchange." That is, in federally-facilitated exchange states, the Federal government is acting on behalf of the State. Then, citizens in those states can get tax credits, because an exchange established by the state includes one where the federal government is standing in for the state.

5. Opponents' misreading of the defined term "Exchange" in ACA §1401 and its creature, IRC §36B, produces an absurd interpretation of §36B itself.

On its own terms -- within the four corners of that provision -- viewing the federal government as the stand-in for the state is the only way that the plain language of Section 36B itself makes sense and is internally consistent.

Subsection (a) provides:

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

An applicable taxpayer is defined as someone whose income is between 100% and 400% of the poverty level. So under this provision, if you meet the income test, *there shall be allowed* a premium assistance credit. The plain language of this provision says that low income taxpayer gets a credit.

The exchanges come into play in the next subsection, 36B(a)(2). The caption tells you what the subsection is about – the *calculation* of the premium assistance *amount* -- the amount of the credit to *assist* the taxpayer in affording insurance:

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

In other words, if you accept the opponents' reading, Congress is saying, "If your income is between 100% and 400% of the poverty level, you get a tax credit to assist you in buying insurance – except if you happen to live in a federally facilitated exchange state. In that event, Catch-22: the amount of premium assistance you get from this provision designed to help you afford insurance is zero. Is Catch-22 a more plausible reading of a statute designed to help lower income people afford insurance, than the common-sense understanding that the federal government stands in for and steps into the shoes of a state that fails to establish and manage an Exchange itself?

Opponents' "Purpose and Intent" Argument – that the 111th Congress *Deliberately* Barred Premium Assistance from Participants on Federally Facilitated Exchanges – Is Preposterous and Has Literally Zero Support in the ACA's Legislative Record.

As noted above, the first time ACA opponents surfaced their argument, they said their "gotcha" spin on two isolated provisions of text was all they needed to win their case. They soon recognized that this is not true. The individual provisions on which they rely are not self-explanatory. Moreover, they are contradicted by other textual provisions of the Act. So the opponents have moved off their original text-only argument. They have moved to a claim about the ACA's legislative history and its purpose. This is truly a remarkable claim.

They say that the legislative history of the statute reveals that the 111th Congress *deliberately designed* the exchange provisions to block premium assistance for residents of federal exchange states. If true, what the Act really means, and what its sponsors really intended, is a result that would not only cancel the core benefit the law sought to confer, for the core constituency it aimed to benefit. Further, under the opponents' misread, the ACA's sponsors would have intentionally handed over to ACA opponents in state capitols the power to subvert the law in their states, enabling them to "drive a stake through the heart of Obamacare" in the colorful language of Professor Adler's collaborator, Michael Cannon.

How do the opponents explain why the ACA's sponsors would come up with this self-defeating, indeed self-destructive strategy? Because, they explain, in structuring the premium assistance provisions of the Act, the sponsors' overriding purpose was to pressure states into establishing exchanges, and to do so by stiffing millions of their low-and moderate income constituents. If this seems like a rather odd pressure tactic for Democratic leaders to have adopted, closer examination makes clear that it is, quite simply, pure fiction.

In the first place, in the massive record of Congress' debate, drafting, and deliberation over the ACA, there is literally not one reference to this implausible purpose. Not one. It's the dog that didn't bark. Not at all. Not ever. The Senate Finance Committee's markup of the provisions at issue took from September 22 to October 13, and take up 2,823 pages of transcript. Senate floor debate went from November 21 to very late, as I recall, on Christmas eve, December 24, comprising 393 pages in the Congressional Record. Not once in this entire record did anyone in either party, member or staff, ever suggest that if states declined to set up exchanges, not only would they cede control to the feds, but they would deny benefits to their constituents.

It bears emphasis that ACA opponents impute this supposed design as a threat to pressure state political leaders. Now, to be effective, a threat can't be kept secret. But this supposed threat was never communicated by those to whom our opponents impute it. As I noted earlier, Professor Adler and his co-author Michael Cannon, a full-time opponent of the ACA, didn't even notice this issue until a year-and-a-half after the statute was adopted.

Nor was this supposed threat received or noticed by those for whom it was supposedly intended – state governments. Not that those state governments were asleep at the switch. On the contrary, state governments and their representatives were a vigilant, vigorous, and potent omnipresence in the process of drafting the ACA. They pushed demands and were responsible for many changes – including, securing for themselves the option of operating exchanges, rather than the House bill's version of a national Federal exchange.

But state representatives never spotted this supposed threat. On May 5, 2009, the National Governors Association presented testimony to the Senate Finance Committee on what the states considered "the important issues involving health care coverage proposals." Right after the bill passed, on March 26, 2010, the NGA circulated an 8 page single-space document laying out a timeline and spotting key implementation issues for their members. On September 16, 2011, the NGA published an Issue Brief on "State Perspectives on Insurance Exchanges," again, laying out state concerns regarding implementation of the exchange provisions. Not once is there the slightest suggestion that the NGA or its members saw the possibility that federally facilitated exchanges could not offer premium assistance, let alone that they viewed – or would have viewed -- this as an unwanted coercive threat.

In sum, the opponents' confection is a threat that was never made and never received. By itself, this fact demonstrates that such a threat or incentive was not *and could not* have been the purpose of the Congress that drafted and enacted the ACA. Without that purpose, the opponents' self-defeating interpretation of the law's definition of "Exchange" is insupportable.

Of course, Congress did include a mechanism designed to encourage states to set up exchanges themselves. It was precisely that if they did not the federal government would do it for them, and in effect deprive them of an opportunity to provide a valuable, visible, ongoing service to hundreds of thousands or in some cases millions of voters.

Significantly, Congress did provide precisely the sort of financial carrot-and-stick incentive that ACA opponents falsely read into the exchange provisions, when structuring the ACA's expansion of Medicaid. Hence, when Congress wished to go

down this road, they knew how to do it, and how to say they were doing it. They didn't do it with respect to the establishment and operation of the exchanges.

Courts Must and Will Defer to the Administration's Reasonable and Permissible Interpretation of "Exchange" to Cover Federally and State-facilitated exchanges.

Opponents know they cannot prevail without their claim that the legislative history reveals a purpose of threatening denial of premium assistance to pressure states into setting up exchanges. They know that, without that argument, their claim that the meaning of the text is "unambiguous" is unambiguously wrong. Otherwise, of course, the IRS' rule is at worst, a "permissible" interpretation, even if not the only permissible interpretation. As Justice Antonin Scalia reaffirmed and explained, barely two months ago, if a statute is "silent or ambiguous with respect to [a] specific issue," then the courts must defer to "a permissible construction of the statute" by the agency to which Congress has assigned responsibility for administering it.[3] At a minimum, Treasury's interpretation – by which the statutory term "Exchange" (with a capital "E") means both state and federally-facilitated exchanges – is reasonable and permissible. In a word, that ices the case for upholding the rule as construed by the Administration, and ensuring that eligible residents in all states will have access to affordable, quality health insurance, as Congress intended they should. As Justice Scalia observed, *Chevron* (the landmark Supreme Court case establishing the principle of judicial deference to reasonable agency statutory interpretations)[4] "provides a stable background rule against which Congress can legislate: Statutory ambiguities will be resolved, within the bounds of reasonable interpretation, not by the courts but by the administering agency."[5] There can be little real-world doubt that courts will find the Administration's interpretation "reasonable" and "permissible," and uphold it.

Conclusion: ACA Opponents Overreach, with a Last-Ditch Bail-out Bid for the Supreme Court to Drive a "StakeThrough the Heart of Obamacare."

Challenging the legality of premium assistance on federally facilitated exchanges is just one of many last-ditch strategems ACA opponents are promoting to ensure a still birth for the ACA in states that refuse to cooperate with its implementation. ACA opponents have fought hard to vindicate their passionate belief that government-facilitated universal health care is bad public policy and bad public morality. They have largely lost that fight, in the political arenas where in a democracy it should be fought – in Congress and in two national elections. Now they are asking judges and justices

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[3] City of Arlington, Texas v. Federal Communications Commission, No. 11-1545, Slip. Op.at pages 4-5 (May 20, 2013)
[4] Chevron v. Natural Resources Defense Council, 467 U.S. 837 (1984)
[5] Id. At 5

who, one guesses they believe, may share their ideological and political aversion to Obamacare and its namesake, for a last-ditch, 11th hour bailout.

What help are ACA opponents providing to these potentially sympathetic judges and justices?

- A theory that the Congress that enacted the ACA deliberately engineered it to fail in states governed by hostile governors and legislators;

- An alleged purpose never endorsed anywhere by anyone at any point in the legislative record, and antithetical to what everyone knows was Congress' actual intent in enacting the ACA.

How likely is it that a majority of the Supreme Court, or any court, will endorse that perverse premise, and bar access to affordable quality health care for millions of people whom Congress specifically intended to benefit? Such a decision, especially if rendered by an ideologically divided court, will likely appear to the public as a radical ratcheting up of the regrettable tradition of *Bush v. Gore* – though less principled and more transparently political. I doubt that the judiciary will take the bait these lawsuits tender, and venture out on that limb.

STATEMENT OF JONATHAN ADLER

Mr. ADLER. Thank you, Mr. Chairman and members of the subcommittee. Thank you for the opportunity to testify today. This subcommittee has asked for my views on the legal basis for the IRS and Treasury Department rule purporting to extend the availability of tax credits and cost-sharing subsidies to Federal exchanges.

I'll be brief. There is none. The IRS rule is directly contrary to the plain language of the PPACA and is not otherwise authorized by law. The plain text of not only Section 1401 but the entire act as a whole authorizes tax credits for the chase of qualifying health coverage and exchanges established by the State, under section 1311 of the act. This language is repeated not in a single provision but in multiple provisions of the act. Nowhere does the act authorize tax credits for the purchase of coverage in exchanges established by the Federal Government. The text of the statute does not support the IRS rule.

When the IRS finalized its tax credit rule, it offered no substantive defense of its decision to extend tax credits to Federal exchanges. In a cursory statement, it identified no statutory provisions authorizing a provision of tax credits, nor did it identify any relevant legislative history to support its position. It us hard to see how this rulemaking satisfied the APA requirements of recent decisionmaking.

And to this day, neither the IRS nor its supporters have been able to come up with a single statement prior to or contemporaneous to the passage of the act asserting that tax credits would be available in Federal exchanges. There are many statements that tax credits would be available in all 50 States, just as there are many statements that all 50 States would willingly and eagerly, even, create and implement exchanges. There are even statements that States would be required to create exchanges, something that we know the Federal Government could not compel. What there is not is a single statement saying that tax credits would be available in Federal exchanges because no one assumed that Federal exchanges would be necessary, which also explains why the act did not provide any funding for Federal exchanges.

Months after the rule was issued, after prodding from members of this committee, the administration and others began to advance arguments in support of the IRS rule. These arguments strained to find hints of authorization or spots of ambiguity that could be used to sustain the rule and ignore relevant statutory provisions. Some of these arguments were even mutually contradictory. None of these arguments can overcome the statute's plain text.

My copanelist in his testimony misrepresents both the timing and the substance of the argument I had made with Mr. Cannon and its relevant facts and statutory provisions that undermine his claims. Our argument is not based on a single provision but a careful reading of every provision in the statute. Indeed, the only way to read the statute without generating surplusage, that is, without generating language that must be rendered nugatory or irrelevant, is to recognize that when the statute says "established by the State," it means established by the State.

Some claim it would be absurd to condition access to healthcare on State cooperation— certain condition access to healthcare on State cooperation with Federal policy. This is called sabotage. But that is precisely what multiple provisions of the act do. The best example of this are the Medicaid provisions. As originally written, the Medicaid provisions threatened to withhold not only the Medicaid expansion but all Medicaid funding in State if a State refused the expansion. That would clearly have significant consequences on the most vulnerable populations.

Even with the expansion, the statute denies tax credits to the poorest of the working poor because there is a minimum income requirement for tax subsidies. My copanelist may think this is absurd policy, but it is indisputable that this is, in fact, what the text of the statute does.

Some say it would be—absurd to impose community rating requirements without also subsidizing the purchase of healthcare, but that is also what multiple provisions of this act clearly, indisputably do, such as the CLASS act provisions, such as the child-only coverage provisions. Some may think that the way the act was designed was absurd or bad policy, but that does not make it any less the law.

The relevant statutory language was not an accident or an error. It was a deliberate choice of those in the Senate who wanted State-based exchanges to play a key role in healthcare reform. Others preferred a Federal model, as I know many here in the House did. And had a House-Senate conference bill ever been enacted, a model based on Federal exchanges with unconditional tax credits might have been the law of the land. But that never came to pass.

After the loss of a filibuster-proof majority in the Senate, PPACA supporters opted to rely on the Senate bill and its provisions, clearly and expressly conditioning tax credits on State cooperation. If there was an error, it was in believing that a majority of States would cooperate and create their own exchanges at their own expense. Such a miscalculation cannot justify rewriting statute by administrative fiat the after the fact. Yet that is what the IRS has done.

This rule, if allowed to stand, will have substantial fiscal and economic consequences. Whether or not extended tax credits and cost-sharing subsidies is sound policy is not an issue here; whether the IRS can unilaterally rewrite a law it is entrusted to implement and enforce is. The majority in Congress believe such tax credits are worthwhile in Federal exchanges, then Congress may so provide in a statute. Unless and until it has done so, neither the IRS nor any other Federal agency has the legal authority to do so. Thank you for your time, and I am willing to answer any questions you might have.

Mr. LANKFORD. Thank you.

[Prepared statement of Mr. Adler follows:]

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Testimony of Jonathan H. Adler
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Oversight of IRS's Legal Basis
for Expanding ObamaCare's Taxes and Subsidies

Subcommittee on Energy Policy, Health Care and Entitlements
Committee on Oversight and Government Reform
U.S. House of Representatives

July 31, 2013

Mr. Chairman and members of this subcommittee, thank you for the opportunity to present testimony on the Internal Revenue Service rule purporting to extend the availability of tax credits and subsidies for the purchase of health insurance in federal exchanges under the Patient Protection and Affordable Care Act (PPACA), aka "ObamaCare."

By way of background, I am the inaugural Johan Verheij Memorial Professor of Law and Director of the Center for Business Law and Regulation at the Case Western Reserve University School of Law, where I teach courses on administrative and constitutional law, among other subjects. I particularly appreciate the opportunity to appear before this subcommittee given my extensive work on this issue, including the law review article I co-authored with Michael Cannon.[1] I will draw upon this article in my testimony today.

This subcommittee has asked for my views on the legal basis for the IRS and Treasury Department rule purporting to extend the availability of tax credits and cost-sharing subsidies to federal exchanges. My conclusion is simple: There is none. The IRS rule is directly contrary to the plain language of the PPACA and is not otherwise authorized by this or any other statute. With this rule, the IRS has usurped the legislature's role and assumed for itself the power to authorize tax credits and federal spending, as well as to trigger the imposition of penalties on employers and shift the incidence of the individual mandate tax penalty. Even worse, it appears that the IRS promulgated this rule without adequately considering the relevant statutory language or otherwise engaging in reasoned decision-making.

The PPACA

One of the central features of the PPACA is the creation of state-based health insurance exchanges, government-managed marketplaces in which consumers can shop for health insurance plans. Specifically, Section 1311 of the Act calls for each state to create its own "American Health Benefit Exchange" that will facilitate the purchase and regulation of qualified health insurance plans.[2] Section 1311's requirement that states create exchanges is not enforceable, however, as the federal government may not commandeer state governments to implement a federal regulatory scheme.[3] Rather, the federal government must give states a choice whether to cooperate. The federal government may offer various inducements for state cooperation, such as financial support or regulatory consequences, but states must be left with a meaningful choice.[4]

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[1] *See* Jonathan H. Adler and Michael F. Cannon, *Taxation without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA*, 23 HEALTH MATRIX 119 (2013).

[2] 42 U.S.C. § 18031(b)(1).

[3] *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"). For a brief discussion of this principle in the context of health care reform, see Jonathan H. Adler, *Cooperation, Commandeering, or Crowding Out: Federal Intervention and State Choices in Health Care Policy*, 20 KANSAS JOURNAL OF LAW & PUBLIC POLICY 199, 208-09 (2011).

[4] *See* National Federation of Independent Business v. Sebelius, 132 S.Ct. 2566, 2602 (2012) ("Congress may use its spending power to create incentives for States to act in accordance with federal policies. But when 'pressure turns into compulsion,' the legislation runs contrary to our system of federalism." (citation omitted)).

Despite the obligatory language of Section 1311, the PPACA gives states a choice of whether to take responsibility for (and bear the cost of) operating an Exchange. States that agree to set up an exchange are eligible for start up funds from the federal government. In addition, other provisions of the PPACA provide tax credits and cost-sharing subsidies to assist low-income residents of such states in purchasing qualified health insurance plans. Specifically, the Act offers refundable "premium assistance" tax credits to households with incomes between 100 and 400 percent of the federal poverty level (FPL).[5] These tax credits are refundable, which means that if the credit is larger than a taxpayer's tax obligations, the taxpayer is eligible for a payment from the Treasury. The Act further offers "cost-sharing" subsidies to help low-income individuals and families obtain more than the minimum level of coverage at no additional cost. Should a state refuse to create its own exchange, Section 1321 provides that the federal government is to create an Exchange in the state's stead.[6] In this respect, the PPACA embodies the sort of "cooperative federalism" common in many federal programs, from environmental regulation to Medicaid.[7]

As written, the PPACA only provides for the issuance of tax credits for the purchase of qualifying health insurance plans in Exchanges established by states under Section 1311 of the Act. The PPACA is quite clear on this point. The tax credits for the purchase of qualifying health insurance plans are provided for under Section 1401 of the PPACA, which creates a new section of the Internal Revenue Code – Section 36B.[8] This provision authorizes tax credits for each month in a given year in which a taxpayer has obtained qualifying health insurance through a state-run exchange. As defined by Section 1401, a "coverage month" is any month in which the taxpayer is "covered by a qualified health plan . . . that was enrolled in through an Exchange *established by the State under section 1311*."[9] The amount of the tax credit is also calculated with reference to a qualifying health insurance plan "enrolled in through an Exchange established by the State under [Section] 1311 of the Patient Protection and Affordable Care Act."[10] Section 1311 further establishes the "requirement" that an "Exchange" be "a government agency or nonprofit entity that is established by a State."[11] To further erase any doubt, Section 1304 of the PPACA also defines "State" as "each of the 50 states and the District of Columbia."[12] The cost-sharing subsidies provided under Section 1402 are similarly limited as this section expressly provides that cost-sharing reductions are only allowed for "coverage months" for which the aforementioned tax credits are allowed.[13]

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[5] *See* 26 U.S.C. § 36B.

[6] *See* 42 U.S.C. §18041(c)(I).

[7] *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.").

[8] *See* 26 U.S.C. § 36B.

[9] 26 U.S.C. § 36B(c)(2).

[10] 26 U.S.C. § 36B(b)(2)(A).

[11] 42 U.S.C. § 18031(d)(1)

[12] 42 U.S.C. § 18024(d).

[13] 42 U.S.C. § 18071(f)(2).

The textual limitation of tax credits to state-established exchanges has implications beyond the affordability of health insurance. Under Section 1513 of the PPACA employers with more than 50 full-time employees are required to offer "minimum essential coverage" to their employees.[14] Failure to offer such insurance can subject employers to a $2,000 fine for every full-time employee beyond the first 30 employees.[15] This penalty is triggered when an employee becomes eligible for tax credits by obtaining a qualifying health insurance plan through a state-run exchange. In addition, because individual exposure to the individual mandate tax penalty is dependent upon the out-of-pocket cost of obtaining qualifying health coverage, the availability of tax credits alters the incidence of the individual mandate's tax penalty.

Portions of the PPACA may not be models of clear legislative drafting, but the provisions authorizing tax credits for the purchase of qualified health insurance plans are abundantly clear. Tax credits are only authorized for qualifying coverage, and such coverage must be obtained through an Exchange "established by the State under section 1311." This language identifies two conditions for the issuance of tax credits – that the Exchange is established "by the State" and that it is established "under section 1311" – each of which requires purchase of the qualifying health coverage in a state Exchange. Indeed, these requirements are part of the definition of what qualifies as eligible health insurance coverage. Coverage obtained anywhere else simply does not qualify.

The IRS Rule

In May 2012, the IRS adopted regulations concerning the availability of health insurance premium tax credits under the PPACA.[16] Under the IRS rule, taxpayers would be eligible for tax credits (and, as a consequence, cost-sharing subsidies) upon purchase of a qualifying health insurance plan without regard to whether the plan was obtained through a state-based exchange under Section 1311 or a federal exchange under Section 1321. Neither the final regulation, nor the proposed rule issued by the IRS in August 2011, identified any specific statutory authority for redefining eligibility for premium assistance tax credits. Indeed, the IRS did not even address the fact that the PPACA expressly defines qualifying health insurance coverage as coverage purchased in an Exchange "established by the State under Section 1311."

In response to concerns that such a rule would extend eligibility for tax credits beyond what was authorized by the PPACA, the IRS offered an extremely cursory response. The justification for the rule offered by the IRS, in its entirety, reads as follows:

> 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

[14] 26 U.S.C. §4980H.

[15] The PPACA provides, in the alternative, that if an employer provides "minimum value" insurance coverage that is not "affordable," the employer is fined $3,000 per employee that receives tax credits or cost-sharing subsidies or $2,000 per employee after the first 30 employees, whichever is less.

[16] Department of the Treasury, Internal Revenue Service, *Health Insurance Premium Tax Credit*, 77 FEDERAL REGISTER 30377 (May 23, 2012), *available at*: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf.

> 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.[17]

Although commentators had pointed out that the express language of the PPACA limits the availability of the premium tax credits to state-established Exchanges under Section 1311, no additional explanation was offered in the *Federal Register*.

The IRS did not identify any statutory language to justify its interpretation when it finalized the rule. There is a simple explanation for this: There isn't any. This is key because in the absence of such language, the IRS lacks the authority to extend tax credits where Congress has failed to do so. As the Supreme Court has noted repeatedly, it is "axiomatic" that federal agencies only have that authority which has been delegated to them by Congress.[18]

While the IRS claimed that "relevant" legislative history supports its interpretation, it has failed to identify a single statement prior to or contemporaneous with the passage of the PPACA indicating that tax credits were to be available in federal exchanges. Contrary to the IRS's suggestion, the burden is not on opponents of its rule to identify legislative history or statutory language prohibiting the issuance of tax credits in federal exchanges. As the U.S. Court of Appeals for the D.C. Circuit has instructed federal agencies on numerous occasions, Congressional failure to withhold power does indicate such power was delegated, nor does it constitute a statutory ambiguity of the sort that would trigger *Chevron* deference to the Agency's interpretation of the statute.[19] A failure to delegate authority to an agency is just that: A failure to delegate authority.

The language of Section 1401 is crystal clear. Tax credits are available for the purchase of qualifying health coverage in Exchanges "established by the State under section 1311." The failure of Congress to authorize tax credits in federal exchanges means that such tax credits are not authorized.

Post-Hoc Defenses of the IRS Rule

Although the IRS failed to provide any statutory or other legal justification for its decision to extend the availability of tax credits to federal exchanges when it finalized the rule, federal officials and other defenders of the IRS rule have come up with several post-hoc justifications for the IRS decision. None of these arguments can overcome the plain tax of the PPACA.

Several defenders of the IRS rule argue that the language of Section 1321 effectively authorizes the provision of tax credits for the purchase of qualifying health insurance plans. So, for example, in October 2012 a Treasury Department official made the following argument:

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[17] *Id.* at 30378.

[18] See, e.g., Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208 (1988).

[19] *See, e.g.*, American Bar Association v. Federal Trade Commission, 430 F.3d 457 (D.C. Cir 2005); Railway Labor Executives Association v. National Mediation Board, 29 F.3d 655 (D.C. Cir. 1994).

> 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.[20]

Others have made similar arguments.[21]

Under this interpretation, when Section 1321 directs the federal government to create "such Exchange," it is authorizing the federal Section 1321 exchange to operate as a Section 1311 exchange. This is a clever argument, but it's incomplete in that it ignores inconvenient portions of the statutory text. Just because a federal exchange created under Section 1321 is subject to all the same requirements as a state exchange created under Section 1311 does not mean that tax credits available in a state exchange must be available in a federal exchange as well, particularly when the plain text of the statute provides otherwise.

As noted above, Section 1311 expressly requires that an authorized Exchange must be "established by a State" and Section 1304(d) also expressly defines "state" as "each of the 50 States and the District of Columbia." Later amendments to the PPACA also provide that Exchanges created by territories are to be treated as the equivalent of state-run Exchanges, but there is no such language concerning federally run Exchanges.[22] If, as argued, this language of Section 1321 made federal exchanges the equivalent of Section 1311 exchanges, this additional language enacted during the reconciliation process would have been unnecessary.

Even if one were to concede, for the sake of argument, that a Section 1321 Exchange is the equivalent (or "stands in the shoes") of a Section 1311 Exchange, this is still not enough to justify the extension of tax credits in federal exchanges. This is because, as noted above, when Section 1401 defines the coverage for which tax credits may be provided it identifies two relevant conditions: 1) that the insurance is purchased in a Section 1311 exchange, and 2) that the insurance is purchased in an Exchange "established by the State." So one can read Section 1311 to incorporate Section 1321, but a federal Exchange is still not an Exchange "established by the State" as expressly and repeatedly required by Section 1401. To accept this argument in

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[20] *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) (emphasis in original).

[21] *See, e.g.*, 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, http://www.healthaffairs.org/blog/2012/07/18/tax-credits-in-federally-facilitated-exchanges-are-consistent-with-the-affordable-care-acts-language-and-history/; 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.

[22] *See* 26 U.S.C. § 36B(f). This language was added by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, § 1004, 124 Stat. 1029, 1035 (2010).

defense of the IRS rule is to render this repeated language both redundant and surplusage and violate a fairly fundamental canon of statutory construction.[23]

A second post hoc argument in defense of the IRS rule is that Congress indicated its intention to provide tax credits in federal exchanges by imposing reporting requirements on both state and federal exchanges that include a requirement to report information related to tax credit payment and eligibility. As a Treasury Department official argued in October 2012, the adoption of these requirements as part of the Health Care and Education Reconciliation Act "strongly suggests 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."[24] This argument also fails.

First, the fact that the authors of the HCERA felt the need to expressly identify both Section 1311 and Section 1321 exchanges shows that the two are not equivalent. If the "such exchange" language noted above were sufficient to make a Section 1321 exchange equivalent to a Section 1311 exchange in all respects, it would have been unnecessary to mention both. Second, the relevant HCERA provisions require the reporting of lots of information that will be of use to federal authorities even apart from the provision of tax credits, including the level of coverage obtained and premiums charged. Insofar as the PPACA is designed to encourage states to create their own exchanges, the collection of information in federal exchanges indicating the level of tax credits or subsidies for which individuals would be eligible under a state exchange would be useful. Third, even were this not the case, enacting a single list of reporting requirements for all exchanges is easier and more efficient than trying to separately delineate what information must be reported by what sort of exchange. Indeed, these reporting requirements apply to types of Exchanges, such as SHOP exchanges, in which the relevant tax credits and cost-sharing subsidies are not available, so the adoption of these reporting requirements *cannot* establish that tax credits and cost-sharing subsidies are available in all exchanges subject to these requirements.

Lacking any statutory language with which to justify the extension of tax credits to federal exchanges, defenders of the IRS rule have argued that the agency's interpretation should be upheld under principles of *Chevron* deference. So, for example, Professor Timothy Jost argued that the IRS rule is valid because an agency's "official construction of an ambiguous statute should be accorded deference by any reviewing court."[25] Simon Lazarus has likewise argued that the IRS rule represents a "permissible interpretation" of the statute and that "courts must defer to an agency's interpretation of a law it is charged with administering, whenever its decision 'is

[23] *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.).

[24] *See* Mazur letter *supra*.

[25] 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/.

based on a permissible construction of the statute.'"[26] Here again, arguments in defense of the IRS rule falter.

Under the *Chevron* doctrine, the first question is whether the relevant statutory text is clear. If so, there is no basis for according deference to an agency interpretation for the agency "must give effect to the unambiguously expressed intent of Congress."[27] It is only when a statute is ambiguous that there is any cause to consider an agency's interpretation of that statute, and even then the agency's interpretation must represent a permissible construction of the relevant statutory text. Further, the question of whether a statute is ambiguous in the first place is one for which the agency receives "no deference" whatsoever.[28] And even a reasonable agency interpretation is only to be accorded deference "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."[29]

The biggest problem with the *Chevron* defense of the IRS rule is that there is nothing ambiguous about the relevant statutory text. Section 1401 is abundantly clear in basing the definition of an eligible coverage month on the purchase of a qualifying health insurance plan in an Exchange "established by the State under Section 1311." The provision's reference to the relevant statutory provision combined with the narrative description of the state-exchange requirement could not be any more clear. Thus there is no reason to even consider applying *Chevron* deference here. 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 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.[30]

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

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[26] Simon Lazarus, *The Supreme Court Is About to Get Another Change to Gut Obamacare*, THE NEW REPUBLIC, May 13, 2013, http://www.newrepublic.com/article/113194/affordable-care-act-another-supreme-court-challenge.

[27] Chevron USA v. Natural Resources Defense Council, 437 U.S. 837, 842-43 (1984).

[28] *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).

[29] United States v. Mead Corp., 533 U.S. 218, 226–27 (2001).

[30] 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. *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.").

limit the premium tax credit to State Exchanges."[31] 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.[32] Agencies, including the 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."[33] 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.

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 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. Such an argument is tremendously difficult because no matter how much the IRS and its defenders try, there is no way to turn a federal exchange created under Section 1321 into an Exchange "established by the State," let alone "established by the State under section 1311."

A final argument made by defenders of the IRS rule is that there is no plausible reason why Congress would have limited the availability of tax credits to state exchanges. Professor Jost, for example, has argued that 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."[34] But of course there is. The PPACA, as enacted, is based upon the Senate health care reform bill. The authors of the Senate bill wanted states to create exchanges. As noted above, the statute even purports to require states to do it. But Congress cannot tell states what to do. Thus it needed to provide them with an incentive to play along, and committing to create a federal exchange as a fallback is not much of a threat, and the promise of startup funding, by itself, is not much of an inducement. So the Senate bill also threatened to withhold benefits – tax credits and subsidies – to citizens of states that did not cooperate by creating their own exchanges. And where did the Senate get this idea? Potentially from Professor Jost, who wrote in 2009 that Congress could try to induce states to create exchanges by, among other things, "offering tax subsidies for insurance

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[31] 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.

[32] *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.").

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

[34] 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/.

only in states that complied with federal requirements."[35] While less common than threatening to withhold funds (as was done with Medicaid) this approach is not unprecedented, and multiple pre-enactment Senate health care reform bills contained similar provisions explicitly designed to encourage state cooperation.

Contrary to the claims of some IRS rule supporters, there is nothing "absurd" or unusual with conditioning benefits on state compliance with federal objectives. Congress regularly conditions funding or other federal benefits on state cooperation, and regularly threatens to cut off support to valued constituencies in response to state intransigence. The most obvious example of Congress using this supposedly "absurd" tactic is the Medicaid expansion. Under the PPACA as written, states that refused to participate in the Medicaid expansion would forfeit federal funding for the expansion as well as all federal support for the pre-existing Medicaid program. So not only did Congress threaten to withhold new benefits in unconsenting states, it also threatened to further undermine the PPACA's goals by withdrawing all existing Medicaid funding. In other words, if a state sought to undermine the PPACA by refusing to cooperate with the Medicaid expansion, this would trigger a sanction that would reduce health care coverage for needy populations — a result directly contrary to the stated goal of the PPACA. The Supreme Court ultimately concluded this deal was unconstitutional, but there is no question of what the statute sought to do. The PPACA also limits tax credits and subsidies to those making at least 100 percent of the poverty level, denying such benefits to those most in need. That some might find such a policy "absurd" does not make it any less the law of the land.

Defenders of the IRS rule would like this committee (and the courts) to believe that the language limiting tax credits and subsidies to state-run exchanges is a mistake, perhaps a drafting error. Yet the mistake, if there was one, was not in the drafting of the PPACA, but in the failure to anticipate the widespread resistance the law would face in the states. As the *Washington Post* reported earlier this month, PPACA proponents never even contemplated the possibility that numerous states would refuse to implement their own exchanges.[36] According to the *Post*'s report, when President Obama signed the PPACA into law "there was widespread expectation [states] would want to operate the new insurance exchanges."[37]

Supporters of the IRS rule have identified numerous statements indicating that PPACA supporters expected tax credits to be available in all fifty states. This is because it was universally expected that all states would create exchanges. Administration officials and members of Congress repeatedly said as much. The Congressional Budget Office scored the bill without considering whether tax credits would be limited to state-run exchanges, but it also scored the bill as if the federal government would not have to spend any money paying to implement federal exchanges. Indeed, the PPACA never authorized money for the creation of

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[35] 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. (emphasis added). 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).

[36] Ezra Klein and Sarah Kliff, *Obama's Last Campaign: Inside the White House Plan to Sell Obamacare*, WASHINGTON POST, July 17, 2013 (noting an "internal White House memo" detailing obstacles to PPACA implementation did not even identify "political opposition or widespread state resistance" as potential hurdles).

[37] *Id.*

federal exchanges, likely because bill supporters did not expect that such funds would be necessary.

Substantial Consequences

The IRS rule at issue is not authorized by law and is thus illegal. By all appearances the IRS also failed to even consider whether there was an adequate legal basis for this rule until *after* the rule was issued. This sort of agency behavior should be enough to concern this subcommittee. The fiscal and other consequences of this rule provide even more reasons for concern.

This rule requires the provision of tax credits in over thirty states that opted not to create their own exchanges. Because these are "refundable" tax credits, this means that the credits do more than provide tax relief to eligible individuals. They result in payments from the U.S. Treasury. Because the Administration has announced that it will not require exchanges to verify eligibility for tax credits, the cost could be significantly greater than many have anticipated. Issuance of the tax credits triggers cost-sharing subsidies that are paid to insurance companies – another draw on the U.S. Treasury. Tax credit eligibility also triggers substantial penalties on employers who fail to provide qualifying health insurance. The availability of tax credits will also expose many individuals to the individual mandate tax penalty who would not otherwise have been so exposed.

In sum, the decision to extend tax credits to federal exchanges will have substantial fiscal and economic consequences. Whether or not extending tax credits and cost-sharing subsidies is a sound policy decision is beyond the scope of this testimony. What should be clear, however, is that this is the sort of policy decision that must be made by Congress, not an individual federal agency. If a majority in Congress believes such tax credits are worthwhile, then Congress may so provide in a statute. Unless and until it has done so, neither the IRS nor any other federal agency has the legal authority to do so.

Conclusion

There are many PPACA supporters who would like tax credits and cost-sharing subsidies to be available in all fifty states, whether or not states create their own exchanges. A bill providing for credits and subsidies nationwide may even have had sufficient support to pass Congress at one time. That is not the law that Congress enacted, however. The law Congress enacted only provides for tax credits and subsidies for the purchase of health insurance in Exchanges established by states. Insofar as the IRS rule purports to provide tax credits and subsidies in federal exchanges, it exceeds the IRS's statutory authority and is contrary to law. The IRS rule is illegal, and should be withdrawn.

* * *

Mister Chairman and members of this committee, I recognize the importance of this issue to you, your constituents, and this nation. I hope that my perspective has been helpful to you today, and I will seek to answer any additional questions you might have. Thank you.

Mr. LANKFORD. And as I mentioned before, when Ms. Speier arrives, she will obviously have first priority an opening statement as well.

Let me press on with questioning on this.

Attorney General Pruitt, you had mentioned the effect on the State of Oklahoma, as well as on businesses in Oklahoma and individuals on the act. Can you highlight that a little bit more? What is effect of this if this rule, as is being proposed and final rule that's out there if it is implemented, what is the impact on the State of Oklahoma?

Mr. PRUITT. Well, particularly with Oklahoma, and it's been referenced on the panel today, Mr. Chairman, the law provided a sovereign choice to the State of Oklahoma with respect to the establishment of State healthcare exchanges. The law did not initially provide that choice under Medicaid. And the U.S. Supreme Court, by a 7 to 2 vote said that the Congress and the ACA could not, through the spending power of Congress, coerce or intimidate or threaten the States to expand Medicaid at the risk of losing the entirety of the Medicaid.

And so there are now two sovereign decisions that the States can make, one is whether to expand Medicaid and, two, whether to adopt a State healthcare exchange. So, Mr. Chairman, in our arguments before the court in Oklahoma, we are arguing that that decision that Oklahoma has made, the Governor and the legislature of the State of Oklahoma has balanced the competing interest, the penalties that would issue in the State of Oklahoma, the cost to the State of Oklahoma, the regulatory burden that exists, they balanced those factors and made a sovereign, informed decision not to adopt a State healthcare exchange.

The IRS action, Mr. Chairman, effectively takes that decision away. As you know, the IRS by rule of May of last year simply says, whether it's a State or Federal exchange, we're going to issue the subsidies and assess the employer mandate penalty. We think that's clearly against the clear reading of the statute and takes away the decision that Oklahoma as made. But as far as the businesses in our State, Oklahoma is also a large employer; therefore, we are subject to the tax provisions. We are in the process of evaluating and have already evaluated the cost of compliance and implementation and have made a decision as a State that we seek not to establish an exchange and avoid those costs and burdens. And we have made that argument as well before the court in Oklahoma.

Mr. LANKFORD. Mr. Adler, you made comments before about the commandeering principle between the States and the Federal Government. Can you elaborate on that?

Mr. ADLER. Certainly. Under several Supreme Court precedents, it is—Supreme Court has held that the Federal Government may not coerce a State to implement a Federal program. And cases such as *New York* v. *United States* and *Prince* v. *United States* established this principle, and it was reaffirmed in *NFIB* v. *Sebelius.* What this means is that if the Federal Government wants the State to participate in or cooperate with a Federal program, it must offer some inducement. And what the Federal Government regularly does is offer spending or threaten certain consequences for States that don't cooperate. And one approach that we've seen used

in multiple laws is for the Federal Government to threaten adverse economic treatment of private actors in a State if the State doesn't cooperate. This is—we see this in environmental laws, like the waste—Low-Level Radioactive Waste Act amendments that were issued in New York v. The United States, and it's what the text of the law does here by withholding certain benefits that—to individuals in exchanges and to insurance companies in States that don't cooperate.

Mr. LANKFORD. So you're saying this was not a compulsory thing to be able to put down on the States. This was a benefit that was put out in front of them and also a consequence to say there is a consequence if you don't; there's a benefit if do. And the assumption of the Federal Government was, based on prior laws, that if we lay this benefit and consequence in front of States, the States will then choose to do this on their own.

Mr. ADLER. Yes. That is something that is, again, commonly done throughout environmental law. It's done in other portions of this statute. It's how the Medicaid provisions, for example, operate. And certainly experts in healthcare reform, when the law was being written, actually proposed that this precise mechanism could be used as a way of inducing State cooperation and that this would be an alternative to trying to find an additional pot of money to try and induce State cooperation.

Mr. LANKFORD. Okay.

Mr. Lazarus, as I go through your testimony—thank you for being here as well and your preparation—it seems to be in your opening statement you try to look at the law as a whole and say Congress purpose to—or use the term it was the purpose of or it was the intent of versus the actual plain text reading of the statute, as Mr. Adler has said as well.

Can you identify—you mentioned this—this statement in there that the "such exchange" portion of it, but Section 1401 puts out the specific payments and specifically enumerates it has to be a State, from 1311, not the 13—it doesn't say from a State from 1311 or Federal from 1321.

Is there a section of the text that you look at that makes it plain that this should apply to Federal, or are you taking it based on what you assume is the intent or the purpose of the law as a whole?

Mr. LAZARUS. No. The text of the whole statute, and I focused in particular on 1321 and the "such exchange" language, shows and should be interpreted to mean that's a textual argument, it's not just some airy, some theoretical purpose point. That language should be interpreted to mean that a federally facilitated exchange stands in the shoes of and has all the same attributes and responsibilities as a State facilitated exchange.

Mr. LANKFORD. So when 1401 says a "State-based exchange" like 1311, it should have also said "State-based exchange like 1311 or 1321."

Mr. LAZARUS. No, it didn't need to say that. Because in 1321, where the Federal exchange is explained and its role is explained, it says, "The Secretary shall establish and operate such exchange." And the word "such" is a reference to the exchange in 1311 and, therefore, it's appropriate to interpret that to mean that it becomes

the same. And furthermore, Mr. Chairman, the fact that "Exchange" in 1321 here is capitalized, has an initial capital, is very important because that is a reference back to the definition of what a capital "E" Exchange, is which is made in 1311. And everywhere "Exchange" with a capital "E" appears throughout the statute, that means it is referring to that—to that defined concept. So that's a basic textual argument. There are some provisions, such as the provision of the reconciliation supplement to the ACA, which was enacted later in the year which——

Mr. LANKFORD. But that would have been later on. I do need to interrupt because we're running long in time again.

Mr. LAZARUS. May I make one comment on a little point that——

Mr. LANKFORD. I'm going to honor some of the other members. We'll come back. There will be other moments.

With that, I would recognize, let's see, who is up next here. I think Mr. Gosar.

Mr. GOSAR. Thank you, Mr. Chairman.

Can I get the slide up on the screen, please?

Mr. Adler, in the background of the 1401, Section 36B, is the most important part of the statutory interpretation in the law is text?

Mr. ADLER. Yes. Text is the most important part of statutory interpretation.

Mr. GOSAR. So is the text of the law clear that the tax credit should be linked to States that create their own exchanges, and can you explain that?

Mr. ADLER. It's very clear. In the relevant provisions it says "Exchange," and it's a capital "E" Exchange. But then it goes on to say "established by a State." So it is—even if one accepts that—that the word "exchange" in section 1401 incorporates by reference both section 1311 and section 1321, the statute then goes on to enumerate additional requirements. It repeats the section number, section 1311, and on top of that says "established by a State." And I would point out that "State" is also capitalized. And is also defined in the text of the statute. And the interpretation offered by my co-panelist requires us to forget or ignore the fact that "State" is defined in the statute and ignore the fact that the phrase "established by a State" is repeated, not merely in the definition of "exchange," but in the relevant provisions authorizing the tax credits.

And I would go on to say that in the reconciliation bill that amended the act, Congress recognized that it had to enumerate both Section 1311 and Section 1321 if that's what it meant. So when adopting reporting requirements in the HCERA, the Congress did not simply say "exchange," did not simply say "Section 1311 exchanges." It, rather, referenced both Section 1311 and Section 1321, showing that the authors of that recognized that these were separate and needed to be enumerated separately.

Mr. GOSAR. So when the administration and Mr. Lazarus, who is do doing their bidding here in regards to this, talk about "such exchanges" is equivalent to "State exchanges," your answer is?

Mr. ADLER. It is not. And even if I—even if I accepted that "such exchanges" meant that 1321 exchanges and 1311 exchanges were equivalent, even if we accept that premise—again, I don't—but even if we do, the fact that Section 1401 repeats the "established

by a State" requirement means that even if we accept Mr. Lazarus's argument, we have this additional language we have to account for. And the only way his argument can work is if we ignore that language and ignore an expressly defined term in the statute, which in his testimony he says we can't do.

Mr. GOSAR. Now, I'm a dentist, not an attorney. I think most people out in the real world want to hear it in plain terms. The administration's whole terminology was or program was to drive individual exchanges so that you had all these 50 different marketplaces. Is that true?

Mr. ADLER. That was the intent of the Senate bill. As we all know, there was a House-Senate conference that may have been intending to make changes to that. But that bill was never—was never brought out, never voted on. But certainly the Senate bill that became the law was designed to have every State create an exchange and then to use the State-based exchanges as the means for providing subsidies and tax credits.

Mr. GOSAR. Can you briefly summarize the findings of your research on Obamacare's legislative history?

Mr. ADLER. The history is entirely consistent with the intent that to have States, encourage States to create their own exchanges and to use State-run exchanges as the mechanism for providing subsidies and tax credits. And that no provision was made for providing these subsidies and tax credits through Federal exchanges, either in the text or in the funding. Because we must remember that while the statute did authorize subsidies to States to help them set up exchanges initially, it provided for no funding for the creation of Federal exchanges, which further reaffirms the plain understanding that no one thought the Federal Government would have to create exchanges. Secretary of Health and Human Services repeatedly said that every State would do it. That was what people expected.

What was—the mistake here was not in the drafting of the law; it was in not realizing that a majority of States had no interest in creating their own exchanges.

Mr. GOSAR. So what was the consequence of Scott Brown's election in Massachusetts?

Mr. ADLER. The consequence was that the Senate bill, which I know many Members of the House did not like, and many healthcare reform supporters——

Mr. GOSAR. Can you be more specific?

Mr. ADLER. Well, the Senate bill adopted the State-based exchange model. It had passed the Senate before Scott Brown's election. The plan at the time was to have that bill go to a House-Senate conference—a version of the House bill, which adopted a different approach. And there was certainly an account suggesting that at least when it came to exchanges, that the House approach was more likely to emerge from that conference. Scott Brown's election meant there were no longer the votes in the Senate to pass a conference bill. And so, in fact, the New York Times in a story about healthcare benefits for Congressional staff and Members of Congress this week pointed out that there are many provisions in the law that are a result of Congress being stuck with the Senate

bill as the basis for healthcare reform. And exchange provisions are among them.

And the choice was made to take a Senate bill that had many provisions that many people thought were inadequate if the only alternative was no bill. And that was the choice. Because there were not the votes to do anything else. And so the Senate bill may have provisions that some may think don't work very well. But that was the choice that was made.

Mr. GOSAR. Thank you.

Mr. Chairman.

Mr. LANKFORD. Thank you.

And Ranking Member Ms. Speier, recognize her for an opening statement, and then you may move directly to questions if you choose.

Ms. SPEIER. Thank you, Mr. Chairman.

Thank you, witnesses, for appearing. I apologize for not being present at your opening statements. As you know, the President of the United States came to speak to the Democratic Caucus. That happens maybe once or twice a year. And so it is obviously important for us to meet with him and be available to answer—ask questions as well. So I apologize for not being here. Hopefully, in the future, we can accommodate both sides of the aisle.

Congress passed the Affordable Care Act to make affordable health care available to all Americans. It is the law of the land, and I am pleased to say it is already working. More than 3 million young adults who would otherwise have been uninsured are now able to stay on their parents' health insurance. My son is one of them. More than 20 million children with preexisting conditions can no longer be denied health insurance. Seniors could save more than $7 billion on their prescription drug costs. Those are just a few of the benefits that have already kicked in. The full impact of the ACA will not be felt until next year.

Many States have embraced Obamacare and implemented their own exchanges and have already announced lower premiums, in some cases, dramatically lower than ever was expected. And that is despite offering better enhanced benefits, including free preventative care, no lifetime limits on coverage, and not being able to deny customers because they have a preexisting condition.

In California, average premiums in the exchange for 2014 are from 2 percent to 29 percent lower than average premiums this year. In New York, they will drop to as much as 50 percent lower. The law is working. And maybe that is what the opponents are afraid of.

What happens when Congress passes laws? Agencies implement them. That is why the Treasury Department issued regulations implementing provisions of the Affordable Care Act that relate to premium tax credits the act authorizes to make health insurance affordable to low-income earners. I know that when I voted to the law it never occurred to me that Americans could be treated differently simply because of where they live. No one ever debated using these subsidies as a carrot or a stick to get States to implement their own exchange. I expected as many Americans as possible to get affordable coverage and help if they needed it. Why would we give a tax credit to a taxpayer seeking health insurance

in one State and not a similarly situated taxpayer in another State?

Since the fall of 2012, this committee has been scrutinizing Treasury's implementation of the Affordable Care Act's tax provisions, including the provision of the tax credits to those who meet certain income criteria. Treasury has produced documents, given high-level briefings, and permitted committee staff to study sensitive documents without redactions. What we found was that Treasury followed the same transparent procedures in issuing this regulation that it has used in implementing other laws Congress has enacted. We have found no evidence to the contrary.

Chairman Issa also consulted CBO last year, which confirmed that its score of the Affordable Care Act at the time it was passed in March 2010 assumed that tax credit would be available to residents in all States, including States where exchange was established by the Federal Government.

I ask consent at this point, Mr. Chairman, to enter the CBO's response to Chairman Issa's question into the record.

Mr. LANKFORD. Without objection.

Ms. SPEIER. As we all know, there are detractors who have never liked the Affordable Care Act. That's part of politics. They have marshalled their best arguments and vigorously advocated to anyone who would listen. First, they tried to stop the Affordable Care Act in Congress. That failed. Then they took to the courts and pursued their case all the way to the United States Supreme Court. They lost there, too.

The continual effort to roll back time has become frustrating even to members of the majority's own party. Senators Coburn and McCain now categorize the House's efforts to defund ACA as dishonest and hype. Dr. Coburn stated: "The worst thing is being dishonest with your base about what you can accomplish, ginning everybody up, and then creating disappointment." Further: "It's a terribly dangerous and not successful strategy."

Those attempting to sabotage Obamacare aren't giving up. With all they are left with now are their second best legal arguments. Today's hearing was called by the majority to put the best light on one of these arguments. Indeed, two witnesses called by the majority on today's first panel are litigants in pending lawsuits on this very topic.

While I appreciate that these witnesses have traveled today to give us their interpretation of the legality of certain aspects of the healthcare law, I want to make this abundantly clear, this hearing is not the proper forum to litigate the merits of these cases. This subcommittee hearing room is not a courtroom.

I hope that no members intend to use this hearing or any of the documents obtained in the committee's investigation to try and influence the litigation. That would be really above and beyond the scope of our authority as Members of Congress.

Mr. Chairman, as you know, I am a strong believer in the importance of Congressional oversight, but I do not believe that we should insert this subcommittee into active litigation under the guise of oversight. I hope that you will exercise your discretion as chair of the committee and direct the members today to avoid ask-

ing questions which could jeopardize in any way a fair trial for all litigants.

Otherwise, I believe you may, intentionally or not, permit the legal process to be tainted by political interference. Simply does not serve any legitimate goal of this committee or of Congress.

That said, these arguments present real-world implications for millions of hardworking Americans who will be seeking access to affordable health insurance over the next several months and into the future. If Mr. Pruitt's lawsuit were to prevail, all he would achieve is making health care unaffordable to over 300,000 Oklahomans, who would no longer be able to receive premium tax credits to help them buy health insurance in Oklahoma. Contrary to any ideological victory some may think could be won by his lawsuit, the reality of legal victory is a terrible loss for the lower-income people of Oklahoma who pay the attorney general's salary and whose taxes are even underwriting the very lawsuit that would deny them benefits. We are all public servants, and we should be better than that. We should be looking to implement the law so that the reality attaches to the purpose—matches the purposes and that it be done in effective and efficient manner as possible.

Unfortunately, this Congress will be voting this week for the 40th time to repeal or defund the Affordable Care Act, in whole or in part. So while I may disagree with the attorney general's pursuit of this litigation that is so contrary to the general welfare of the people of his State, I have to concede that the current House of Representatives in its desperate attempt to gut this law is not setting much of an example.

I thank the witnesses today for their appearance, and that concludes my comments, Mr. Chairman.

Ms. SPEIER. And with that, would it be appropriate now for me to ask my opening set of questions?

Mr. LANKFORD. Absolutely. Without objection.

Ms. SPEIER. Thank you.

So, Mr. Adler, I understand that your reading of the Affordable Care Act is that it does not permit the IRS to provide premium tax credits to individuals who participate in health insurance exchanges administered by the Federal government. In fact, you believe the IRS has no authority to make such a rule. Is that correct?

Mr. ADLER. Correct.

Ms. SPEIER. The Congressional Research Service has also examined this issue, and it did not come up to the same conclusion. According to its report, which I would like to enter into the record, on page 8——

Mr. LANKFORD. Without objection.

Ms. SPEIER. The report states that the IRS rule, quote, "appears to be an exercise of the authority delegated to the agency to implement Section 36B, which includes the authority to provide refundable tax credits for taxpayers enrolled in health insurance exchange."

Have you seen the CRS Robert, Mr. Adler?

Mr. ADLER. I have. And I would note that earlier in that report, the CRS makes very clear that a plain reading of the statutory text would likely lead one to the conclusion that the IRS does not have the authority to do what it did, it does. The language that you just

quoted is language that the CRS then points to in case, a quote, were to include that the language sufficiently ambiguous to allow the IRS to make that interpretation.

But, again, prior to that, the CRS strongly suggests that the plain reading of the text, which is where one must start when looking at a statute, would foreclose the IRS rule. So I'm glad you cited the CRS report.

Ms. SPEIER. Actually, I think you are cherry-picking here. Because, in fact, what the CRS does in many cases is provide both sides of an issue, and then it comes up with conclusions. And what I read just now was the conclusion. "Thus, if reviewing the"—"Thus, if a reviewing court determines that there is ambiguity surrounding the issue of whether premium credits are available in Federal exchanges and reaches step two of the Chevron analysis, with respect to the regulations issued under 36B, the regulation will very likely be considered a reasonable agency interpretation of the statute and accorded deference by the court."

Mr. ADLER. Yes. And the first word of what you just quoted was the word "if." And the CRS, as I said, earlier in that report notes that it is unlikely that a court would reach that conclusion.

And I would add that it is important to remember in the context of Chevron deference, that the question of whether a statute is ambiguous is a question that courts owe no deference to agencies on. The D.C. Circuit has been explicit on that point. Time and time again it is a question of law purely for the courts.

And so the fact that the IRS believes it has found ambiguity in the statute is not relevant in asking the question. Whether or not the text is plain, I believe the text is plain——

Ms. SPEIER. Thank you, Mr. Adler.

Mr. Lazarus, I'd like to ask you a question. You believe Congress provided the IRS authority to provide premium tax credits to individuals who participate in Federal exchange. Is that right?

Mr. LAZARUS. I certainly do.

Mr. LAZARUS. Certainly do.

Ms. SPEIER. All right. So you obviously differ from Mr. Adler. Would you like to explain why?

Mr. LAZARUS. Well, in my statement, I——

Ms. SPEIER. And, again, I regret that I wasn't here to hear your statement.

Mr. LAZARUS. Well, I don't know what you missed. But basically we would make—I would make two points. First of all, the text of the statute, of the whole statute, not just the particular phrase that Professor Adler and his colleagues zero in on, the text of the whole statute supports strongly the sensible interpretation that tax credits and subsidies are to be available to all Americans whatever state they live in and whether they're in a Federal exchange State or a State with a State-facilitated exchange.

Secondly, Professor Adler has come up with an argument that Congress—it wasn't just a glitch that supports his interpretation, but that there was actually a deliberate design by the sponsors of the act. And he needs that, because the text doesn't really support his point. And this is a completely baseless and really—it's hard to say absurd, because it's much more than absurd. The notion that, as I said in my statement, that Senator Schumer or Senator Reid

or Senator Murray or Senator Bachus deliberately designed an exchange mechanism that would cause the statute to fail and deliberately put in the hands of their opponents, such as Attorney General Pruitt here, the power to sabotage the act entirely is so absurd that I can't imagine why any judge would spend 3 minutes paying attention to it.

So those are the two basic reasons that I feel that this interpretation, ingenious though it may be, will not be accepted.

Ms. SPEIER. Well. I would concur with you, Mr. Lazarus. And while I do represent a district in California, I also feel an obligation to represent all the people of the United States of America, and that's the way I looked at this legislation.

I yield back.

Mr. LANKFORD. Mr. McHenry.

Mr. MCHENRY. Thank you, Mr. Chairman.

I'd say to the ranking member's question, looking at page 8 of the Congressional Research Service: "The plain language of 36B suggests the premium tax credits are available only where a taxpayer is enrolled in an exchange established by the State. As noted previously, a strict textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS' authority to issue the premium tax credits is limited only to situations in which the taxpayer is enrolled in 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."

Ms. SPEIER. However.

Mr. MCHENRY. I would say that that—I appreciate the ranking member entering that into the record. I think it makes the case very clearly on why we're having this very important hearing.

Look, make no mistake about it, Obamacare is a mess, is an absolute mess. And what we're trying to do on my side of the aisle, and I think reasonable Americans have come to this conclusion, is that it's broken. For us to force this on the American people when they're having a hard time finding work is the wrong approach, absolutely the wrong approach.

And so whether it's Attorney General of Oklahoma or other elected officials around the country, when they see this being committed on their people and when they look at the clear letter of the law and you see their Federal Government going in a very different direction, they have an obligation to step forward. So I commend the Attorney General of Oklahoma for stepping forward today and for the work that he's done.

Look, the administration's argued that the information reporting requirements added to 36B that I reference here means that these subsidies are available both to Federal and State exchanges, and that's not what the letter of the law says. So, Mr. Adler, does the administration have the authority to simply decline to implement a provision of law, of the law, required?

Mr. ADLER. No. I mean, the executive branch is required to faithfully administer the laws that are passed by Congress, provided those laws are constitutional, and that is true of this administration and prior administrations. If Congress passes a law that in

hindsight seems to be unwise or perhaps even absurd, it is not the prerogative of individual agencies to try and rewrite the law through regulation.

Mr. MCHENRY. So the Congressional Research Service put together a 10-page memo on this legal question. The IRS put out—IRS or Treasury put out a one-paragraph explanation of their legality. Is the evidence provided by the administration, the IRS, and the Treasury, is that sufficient?

Mr. ADLER. No, it shouldn't. I mean, in addition to the limitations imposed by the clear text of the statute, the IRS, like all Federal agencies, is also under an obligation to engage in reasoned decision-making under the Administrative Procedure Act. That means when the IRS is involved in issuing a regulation, it has to make clear the reasoning it goes through—or that it went through in coming up with that regulation. And courts have applied that test to statutory interpretation engaged in by agencies, and——

Mr. MCHENRY. And that's your reference to Chevron?

Mr. ADLER. Right. Right. And so the scant paragraph that the IRS provided in finalizing the rule, even if it were a permissible interpretation of the act, and I don't believe it was, I believe it still failed the reasoned decision-making requirement that all agencies are under. And this requirement is a part of the Administrative Procedure Act because it's important that when agencies issue regulations or interpret Federal statutes that they make clear to the American people the reasons why they are interpreting a statute a particular way.

Mr. MCHENRY. So, you know, this administration, this is not something new for the administration, right?

Mr. ADLER. Well, I think it's fair to say that there are oftentimes when administrations of both parties have failed to engage in reasoned decision-making or failed to fully explain the reasons for their decisions. And I think that more often than not when an agency fails to provide an adequate explanation for its choice, it's because it realizes that there is no adequate explanation. And I think that's what explains the IRS——

Mr. MCHENRY. My time is limited. And Attorney General Pruitt, I'm not going to have time to ask you, but I'm deeply concerned about this case that you're pursuing, I'm very supportive of the case you're pursuing of folks that have strong moral convictions, that own businesses, being forced to buy healthcare policies counter to their moral principles and beliefs. And I encourage you to continue your good work on that. And there are a lot of folks that have been harmed by this, including in my district, and they're very, very closely watching your actions and the good work you're doing.

So thank you, Mr. Chairman. I yield back.

Mr. LANKFORD. Thank you.

Ms. Lujan Grisham.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman.

And I want to thank the panel for being here today and your time. But I have to say, I'm going to start my comments, I don't really have a question, I completely disagree, since we have matters of opinion here on the dais and we have matters of opinion there by the panel where we're picking a phrase out of a report in any context that we wish.

I think the Affordable Care Act is and continues to work effectively. And the businesses in my district in New Mexico finally have the support to protect the women and other employees to make sure that insurance companies don't, A, discriminate against them, and B, provide the bulk of their profits back into the direct delivery of care, which they should have been doing all along.

And so as you can see, I have my own opinions about the Affordable Care Act and the benefits, and I have my own opinion about the statutory language and its legislative history support for the IRS rule, which allows everyone, regardless if they're living in a State with a State-administered or federally administered exchange, to have access to the benefits of the Affordable Care Act.

And I'm not going to ask questions about that, because I agree with my colleague from San Francisco, this is not an appropriate forum. The courts now will decide this issue. Instead, I want to make these two points.

First, this week will mark the 40th time, as we've all said, the Republicans have attempted to repeal in whole or in part the Affordable Care Act. It's unprecedented for elected officials to devote this much time to impede, delay, and stop the implementation of Federal law and the benefits that the law will provide to millions of Americans. They are wasting precious time and government resources by impeding the effective and efficient implementation of Federal law. I see this hearing as part of that effort.

Second, the Affordable Care Act is the law of the land. Our job is to oversee in this committee the Affordable Care Act implementation and to make legislative recommendations and/or changes which make that process more efficient and more effective. Instead of holding a hearing on an issue that is subject to ongoing litigation, let's clarify this work and work on legislation that would ensure that everyone who lives in a State with a federally administered exchange can receive the same benefits as someone who lives in a State with a State-administered exchange.

I think we should be productive, not destructive, and I think we should remember the equal protection laws of this country, which indicate unequivocally that we should be treating everyone the same.

Thank you, Mr. Chairman.

Mr. LANKFORD. Thank you.

Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chair.

Mr. Adler, Mr. Lazarus in his 10-minute opening statement referred to the rest of you as ACA opponents. I don't know if you are. I mean, I assume these guys are. They're in a lawsuit. But I don't know, Mr. Adler, if you're an opponent. I certainly am an opponent. I think it's a bad law, it's going to harm families, and not help our healthcare system. But regardless of whether you're for or against the law, that doesn't change your interpretation of how the law was written, correct?

Mr. ADLER. Correct. In fact, I first wrote about these provisions of the law many months before the op-ed that Mr. Lazarus referenced, and at that time, when pointing out these provisions, the IRS had yet to propose its rule, and I at the time was not aware of the potential consequences of restricting tax credits and sub-

sidies in terms of the employer mandate. It was to me merely a question of statutory interpretation, and one that had been pointed out by others as well.

Mr. JORDAN. And that's as basic as it gets. I mean, I remember first year law students that you teach at that fine university in Ohio. Frankly, kids in grade school know that the legislative branch writes the law and the executive branch carries it out as written. Correct?

Mr. ADLER. Correct.

Mr. JORDAN. We all learn that in grade school, for goodness sake, and certainly any first year law school student would understand that.

Let me ask you this. Do you think that the employer mandate, which is part of the law scheduled to take effect starting January of next year, do you think the President has the ability to simply waive the employer mandate?

Mr. ADLER. I think that the justification for that that has been provided by the administration is inadequate. I don't believe it's subject to legal challenge, or I'm not sure that it could be subject to legal challenge, but I certainly have not seen an explanation that would justify that sort of blanket refusal to implement a clear statutory provision.

Mr. JORDAN. And it seems we've got two examples of where the language says one thing, the legislative branch wrote one thing, and the executive branch is doing something different.

Mr. ADLER. Yes. And I would just note, I mean, I have been critical of Republican administrations for doing similar things. To me, the executive branch should not——

Mr. JORDAN. That's my point. Whether you're for or against the law, it doesn't matter. We have the way things work in this wonderful system in America, legislative branch writes the laws, appropriates the dollars, executive branch carries out the laws and spends the dollars.

Mr. ADLER. Correct.

Mr. JORDAN. Pretty simple. And when the executive branch doesn't do what the legislative branch says, they're doing—they're behaving in an unconstitutional fashion. Correct?

Mr. ADLER. They're certainly not discharging their obligation.

Mr. JORDAN. Let me go back to—and, again, you've talked about this several times with other people, but I'd just like to hammer this point home: Interpreting a statute, the first thing you look at is the clear language of the statute. Mr. Lazarus says that you're taking it out of context, but tell how these five words are taken out of context: exchange established by the State.

Mr. ADLER. Yeah. I don't think—I don't think that when that phrase is used repeatedly——

Mr. JORDAN. Yeah.

Mr. ADLER. —not just once, in multiple places, that it can mean anything other than what it clearly says.

Mr. JORDAN. Yeah.

Mr. ADLER. And if the defining of terms is as important as Mr. Lazarus says it is, then the fact that "State" is a defined term in the statute should be just as important as his emphasis on the word exchange being defined in the statute.

Mr. JORDAN. Yeah. The other side has accused Republicans of sabotaging the law, working against the law. I mean, I am, but I would just like to ask a few questions of Mister—I am working against it, I'm trying to sabotage it, I'm trying to stop it because I think it's bad. But I just want to ask Mr. Willey if he would agree—and, frankly, I'd love to get my colleagues on the other side, their reaction—is Mister—is Democrat Senator Max Bachus trying to sabotage the law when he says, I just see a huge train wreck coming down the road? I would ask Mr. Willey if he thinks that union president Jimmy Hoffa is sabotaging the law when he says: "This will destroy the very health and well-being of our members, along with millions of other hardworking Americans." And, frankly, I'd ask, is Howard Dean trying to sabotage the law when he says the Independent Payment Advisory Board is essentially a healthcare rationing body.

So, I mean, the simple fact is this law is not working, even though the other side says it is, it's not working. And you don't have to take Republicans' word for it, you can take Democrats' word for it.

So, Mr. Willey, I'll ask you, do you agree with those statements from Democrats?

Mr. WILLEY. Completely. And as in my testimony, there's clear design in this law that will put the government in the—Federal Government in the business of promoting illness and maintaining it as an entitlement. It's bad all the way around. It's distorting what's happening in health care already. It's causing the least efficient, most expensive, most dangerous sector of the healthcare industry to be the winner. That's hospitals, hospital cartels.

Mr. JORDAN. I've got 10 seconds. I just want to get Mr. Lazarus. And you can have time past my 5 minutes if the chairman says so. But is Max Bachus, do you agree with Senator Bachus when he says this is a train wreck coming? Do you agree with Mr. Hoffa when he says it will destroy the well-being of our members, along with millions of other hardworking Americans? And do you agree with Howard Dean that the Independent Payment Advisory Board is a problem?

Mr. LAZARUS. Well, I——

Mr. LANKFORD. We need your microphone on again, Mr. Lazarus.

Mr. LAZARUS. I'm sorry. I consider myself a lawyer of sorts. And I'm not a health policy expert and——

Mr. JORDAN. Well, no, but in your opening statement, in that long opening statement you made, you accused the other three guys of being opponents. I assume that means you're a proponent. So I'm asking you, do you agree with those statements that I read? Or do you think Senator Bachus has lost it and he doesn't know what he's talking about, do you think Mr. Hoffa's wrong, and do you think Mr. Dean's wrong?

Mr. LAZARUS. I am a very strong supporter of the Affordable Care Act. I don't really know what Senator Bachus was referring to.

Mr. JORDAN. I just read it to you. He's talking to Kathleen Sebelius.

Mr. LAZARUS. I don't know what he had in mind. I am completely unfamiliar with the statements by Mr. Hoffa and Mr. Dean, so I really have no ability to comment on them.

Mr. JORDAN. Okay. All right.

Thank you, Mr. Chairman.

Mr. LANKFORD. To the chairman of the full committee, Chairman Issa.

Mr. ISSA. Thank you, Mr. Chairman.

I'll start off with—I guess I'll start off, Mr. Adler, do you live in Cleveland Heights?

Mr. ADLER. I used to. Not anymore.

Mr. ISSA. Okay. I grew up there.

Mr. ADLER. Oh, great.

Mr. ISSA. So my brother's a Case graduate and my sister-in-law is with the university, so I guess I'm a strong proponent of Case Western Reserve.

Mr. ADLER. Glad to hear it.

Mr. ISSA. But having said that, I'd really like to ask you constitutional questions. And one of them is not constitutional, but more a balance of opinions. The Congressional Budget Office when scoring the Affordable Care Act scored it assuming that all States were going to buy into this and participate. With a little checking, we asked the CBO how many lawyers they had on it, and they said they had basically one and a half lawyers' time, full-time equivalents, none of whom were constitutional lawyers. And those lawyers did not issue a decision or an opinion as to why they were scoring that everyone was going to participate.

From a standpoint of the law, is there any evidence, when people talk about CBO scoring, that CBO issued an opinion, and even if they did, if that opinion wasn't published to Members of Congress, would it really bear any credibility as to, for example, Attorney General Pruitt's point of it's not in the foursquare of the law?

Mr. ADLER. Yeah. I am not aware of any legal precedent for relying upon a CBO score in interpreting a statute. I would note that the CBO often scores statutes in ways that it is directed to by Congress even if that involves adopting implausible assumptions.

I would also note that the CBO scoring statute, as I understand it, did not account for any Federal spending necessary to create Federal exchanges. So if the CBO had considered the possibility that the Federal Government would be creating exchanges, I would think it would have had to account for all of the spending the Federal Government would have had to engage in to do that.

Mr. ISSA. I think you've made my point very well.

Now, in preparation for this hearing we asked for documents, and we found out through public disclosure that we received 500 documents. Just before coming here, I had a count done. We received 386 documents, and you'd be pleased to know that 70 of those pages were your work already publicly posted. So you've been presented as responsive to our inquiry as to the administration's decision. Clearly they didn't read what they sent us.

Let's get back to my Democratic friends on the other side are always saying the law is the law. Is there case law that you know of where a law very specifically does or doesn't do something and the executive branch creates a rule that is outside of the actual—

any actual text that they can cite in the law? And I'm not trying to make the Attorney General's case, but we've looked through the entire 2,400 pages or more that we had to pass before we could find out what was in it. We now know that there's nothing in there that says it.

Have you found anything? And I know your thesis on this goes to great lengths to say you didn't find it. But have you looked again? Is there, in fact, anything in there that would allow somebody in good faith, maybe Mr. Lazarus, who's a strong supporter and would like to find a scintilla of justification, did you find that?

Mr. ADLER. I don't. There is nothing in the statute. And we also looked, and to be honest, we expected to find in the legislative history statements that went against our thesis. We expected to find Members of Congress saying, oh, there will be subsidies in Federal exchanges, and then in that case the argument would have been do we go by congressional statements or do we go by the plain text of the statute. We couldn't find even that.

And those that have criticized our paper have not been able to find a single contemporaneous statement where any Member of Congress or supporter of the law said there will be credits in Federal exchanges. The closest they can find is statements saying there will be tax credits in all 50 states. But those same sources usually say that every State will willingly create an exchange, which would be the reason for tax credits in all 50 states.

So it is striking how little there is in either the statute itself, which is of course what we should focus on, or in the surrounding legislative history to support the——

Mr. ISSA. Let me just close with a quick series of questions. The Constitution exclusively gives the right of appropriation of funds to this branch. Is that correct?

Mr. ADLER. Correct.

Mr. ISSA. And if we choose not to appropriate funds, we make a statement, notwithstanding previous law. Is that correct?

Mr. ADLER. Correct.

Mr. ISSA. So our absolute right not to appropriate funds for portions of the Affordable Care Act that we believe do not mean today what the President has out of thin air caused them to mean is exclusively our jurisdiction under the Constitution?

Mr. ADLER. Yes. And I'll just add that Congress has for the past several decades regularly opted to defund portions of authorized laws that Congress did not want to see implemented, and this has been done under both Republican and Democratic majorities.

Mr. ISSA. So I'll leave the doctor out of it. The other two lawyers were correct that it's exclusive jurisdiction of the Congress, and that Congress has a right not to fund anything it doesn't want to fund, particularly if it's outside the four squares of existing legislation. Is that correct, Mr. Attorney General?

Mr. PRUITT. Yes, Mr. Chairman.

Mr. ISSA. Mr. Lazarus, I know you love the Affordable Care Act, but isn't it our right not to fund that which we believe should not be funded, and isn't it the right of every successive Congress to start anew as to appropriations since George Washington was leading a ragtag army and asking for money a very long time ago?

Mr. LAZARUS. Well, I think it's quite clear that Congress has the power——

Mr. ISSA. The right and responsibility. I was asking, and I know I need to yield back, but the power is a different question. The right and responsibility under the Constitution, wouldn't you say that is clearly within the four squares of our Constitution?

Mr. LAZARUS. Well, I think particularly the word "responsibility" is putting a spin on it that I don't think is necessary and I wouldn't necessarily want to add to. But certainly you have the power. That's what Congress is for and that's what politics is all about, so——

Mr. ISSA. Well, Mr. Chairman, I don't want to engage in politics, but the term "responsibility" to me means a lot. I know to my Democratic friends and to you, Mr. Chairman, right and responsibility under the Constitution means a lot to us. And I yield back.

Mr. LANKFORD. Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Mr. Chairman. Mr. Chairman, this hearing is nothing but another partisan attack on the Affordable Care Act, the gentleman's comments about not engaging in politics notwithstanding. Isn't it a coincidence that it corresponds with the 40th attempt to repeal the Affordable Care Act this month.

And, you know, I understand my colleague from Ohio has once again referred to the Senator Max Bachus statement about a train wreck, and I think, once again, it's important to put that statement into context. At the time, Senator Bachus was objecting to the cutting by HHS to the—of the PR budget for implementation of the Affordable Care Act, and what he said was: "A lot of people have no idea about all of this. People just don't know a lot about it, and the Kaiser poll pointed that out. I understand you've hired a contractor." He was addressing Kathleen Sebelius, Secretary Sebelius. "I'm just worried that that's going to be money down the drain, because contractors like to make money. I just tell you, I see a huge train wreck coming down," And what he was talking about is, if people don't know about the Affordable Care Act and sign up, it is going to be a problem, and I don't think anybody disputes that.

Opponents of Obamacare are trying to deny low-income people in certain States, like my State, Pennsylvania, the tax credits they need and deserve under the law to make health care affordable. If they succeed in the courts, all they will have achieved is creating a two-tier society with profound effects in my home State and throughout the Nation. What matters most is that it does nothing to address the real issues.

The real issue is that four out of five in the U.S. Will live in poverty or long-term unemployment at some point in their lives, and the majority has yet to pass a single jobs bill in the 113th Congress. The real issue is that in places like Scranton and Wilkes-Barre and Easton and Pottsville, my district, unemployment is 9.2 percent. The real issue is that over 70,000 people in my district don't have health insurance. About 6,500 of those people are children. In fact, 9.4 percent of families and one in five children in my district live below the poverty line. These are the exact people who need these tax credits.

Instead, we're sitting here wasting time and taxpayer dollars trying to find any possible reading of the law, a technicality, to take away health care from the people who need it most.

Many of my Republican colleagues believe that the ACA should be repealed or defunded and have voted nearly 40 times already to do so. The efforts to defund have become frustrating even to members of the Republican Party. Senators Coburn and McCain have expressed their distaste for the continual futile votes to eliminate funding for the ACA.

And, Mr. Lazarus, my question for you is, are you aware that despite the Supreme Court's ruling upholding the ACA, the House this week is going to vote for the 40th time to repeal the act? You aware of that?

Mr. LAZARUS. Well, I'm now aware of it, because you've just told me.

Mr. CARTWRIGHT. Thank you.

The ACA was clearly designed to provide all Americans with a path to affordable health care regardless of where they live. The ACA represents immeasurable progress and has already bettered the lives of millions of Americans.

Now, Mr. Lazarus, if the opponents of the ACA are successful, what will happen to the millions of Americans who are already benefiting from health reform?

Mr. LAZARUS. Well, in States like Attorney General Pruitt's, where the Federal Government is going to be operating the exchange, if the opponents such as he are successful, then the large majority of people who are supposed to be benefited by the law and supposed to be able to get access to affordable health insurance policies on the exchanges simply won't be able to do so. I mean, this is why you'd have to call this not only a poison pill theory of how to interpret the statute, but it's really a self-administered poison pill theory.

Mr. CARTWRIGHT. Thank you, sir.

And I'd say this: What a sad state we would be in if we regressed again to a time when children are denied coverage for preexisting conditions, where hard-working people are forced to bankruptcy because of one health emergency, and where the emergency room again in this country serves as the primary care facility.

With that, I yield back, Mr. Chairman.

Mr. LANKFORD. Thank you.

Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Today we've heard basically infomercials or commercials for Obamacare from the other side of the aisle, but the purpose of today's hearing is about the separation of powers in government, the checks and balances, and the authorities bestowed upon the Constitution the legislative branch to use those executive—the legislative and executive branches.

What we had here was a very unpopular law that was pushed through in a hurry with the election of Scott Brown. They know the law was flawed when it was passed. The House had different ideas about how this should go forward. And the perception by the people at that time—and I, like Mr. Willey, was a practicing physician

when this was passed for 18 years prior to coming to Congress, and so I look at it through that perspective.

But the people in the country did not like this concept. They didn't like it in the 1990s, they didn't like it about 4 or 5 years ago, because it represented in their mind a Federal or government takeover of health care.

The Senate knew, in fact they implied in letters that I'll introduce in just a minute, that it would be better if they had a Federal exchange or a national single payer, but this was widely rejected by the American people. And therefore, it is my contention that it was their intent to avoid using the term, opposed to what Mr. Lazarus was saying, to avoid using the term "Federal exchange" and focused on State exchanges, because "State" sounded less like government takeover of health care. So this was by intent.

I'd like to enter into the records a Law Review article from Professor Timothy Jost.

Mr. LANKFORD. Without objection.

Mr. DESJARLAIS. Okay. Mr. Adler, have you—can we put that up on the screen, please?

[Slide]

Mr. Adler, have you seen this Law Review article?

Mr. ADLER. Yes, I have.

Mr. DESJARLAIS. Okay. On page 7, Professor Jost writes that a way to get around the commandeering problem would be for Congress to exercise its constitutional authority to spend money for public welfare either by offering tax subsidies for insurance only in States that have complied with Federal requirements or by offering explicit payments to States that established exchanges for the Federal requirements.

Can you comment on whether or not what you found in your research would suggest that the Senate bill—did it do this?

Mr. ADLER. The Senate bill is certainly written to do precisely what Professor Jost suggested that it could, and that had been done in prior contexts, as he notes, as with health savings accounts.

Mr. DESJARLAIS. Okay. Who is Timothy Jost and why is he relevant?

Mr. ADLER. He is a law professor who is a very prominent expert on health law, and as far as I'm aware, was very involved in healthcare reform and in helping to develop ideas that were part of healthcare reform.

Mr. DESJARLAIS. Okay.

Mr. Chairman, I'd also like to enter into the—or ask unanimous consent to enter into the record a story from NPR that references Democratic House members from Texas who wrote President Obama urging that the House approach be preserved in the final bill.

Mr. LANKFORD. Without objection.

Mr. DESJARLAIS. And also would like to introduce into the record a letter from U.S. Rep. Doggett and six of his colleagues, Democratic colleagues.

Mr. LANKFORD. Without objection.

Mr. DESJARLAIS. Okay. Basically this letter is describing where in Texas they saw this problem coming as well, and suggested

that—they urged the President that the House approach should be preserved in the final bill. They worry that because leaders in their State oppose the health bill and they won't bother to create an exchange, leaving uninsured State residents with no way to benefit from the new law.

So it wasn't an accident that "Federal exchange" was left out, as Mr. Lazarus suggests. And for him to suggest that you, Mr. Adler, and the others on this panel are just engaging in self-defeating spin or are just looking to find a glitch to bring this healthcare law down, would you disagree with that, and what is your intent?

Mr. ADLER. Well, as I mentioned before, I first wrote about these provisions in the law before I was aware of the way these provisions interacted with, for example, the employer mandate and before it was clear that a majority of States would refuse to implement exchanges. To me, as a scholar of administrative law and federalism, it was interesting to see different ways in which Congress has tried to induce State cooperation in different Federal—in various Federal programs.

And I'm also someone that's very concerned about the nature of congressional delegations of authority to agencies. And here, as in other contexts, if an agency departs from clear statutory text, that's a problem. And it doesn't matter whether it's the healthcare law or the Clean Air Act or any other statute, and it doesn't matter whether it's a Democratic or Republican President. That's something that agencies should not do.

Mr. DESJARLAIS. Thank you.

Mr. Pruitt, could you quickly give us an update on where the lawsuit that you're engaged in is going and what do you expect to occur in the near future?

Mr. PRUITT. Well, thank you, Congressman. We have fully briefed a motion to dismiss filed by the Federal Government and that case was argued before the court back in June, and we're awaiting the decision by the court at this time.

If I could, Mr. Chairman, I think it's important to remember that this Congress and Congress routinely uses spending power to accomplish something called cooperative federalism. And it's not unfamiliar to this committee, it's not unfamiliar to Congress.

And I would say, Congressman Cartwright, with respect to the statement that's been made a couple of times that all citizens across the country were intended to be treated equally under the ACA, you know, in the Medicaid arena, routinely States engage in cooperative federalism with Congress. Citizens are treated differently quite often. As you know, eligibility determinations are given to the States, and there's incentives to the States to match the appropriations of this Congress to cover at times more individuals.

It might be surprising to the Congressman that in the State of Oklahoma we've had a program called Insure Oklahoma that's been around since 2003, and it covers 30,000 individuals that could not otherwise afford health insurance. But CMS has notified the State of Oklahoma, despite that program being very successful at providing access to health care, because the State of Oklahoma has not expanded Medicaid under the ACA, CMS has killed that program and told the State of Oklahoma to cease operations under the

1115 Medicaid waiver that exists in the State of Oklahoma since 2005.

So it is somewhat incongruent to say that a State, when it makes a decision that's been reserved to the State by Congress to decide whether a State healthcare exchange should issue in that State, we've made the decision we're a proponent of the rule of law. It's not an opponent of the policy decisions that you have made in this Congress. We are seeking to give life and meaning to what you have passed in this body. And when an agency makes a decision that's inconsistent with that, when it makes a decision that's clearly against the plain reading of the statute—Mr. Lazarus has said on more than one occasion that the context of the statute justifies his position.

It only justifies his position if you don't read the plain language under 1401, Section 1401. You have to count that as surplusage in 1401 to say that somehow these statutes are harmonious with one another as far as providing benefits under a Federal exchange.

So this is something that on a couple of occasions this morning the motives perhaps of the State of Oklahoma in bringing this lawsuit have been brought to bear. I want you to know that the motives of my office—I did not, the Attorney General's office did not make a decision about whether to expand Medicaid, it did not make a decision about whether to adopt a healthcare exchange. We are simply giving life and meaning to the plain reading of the statutes, honoring the decisions that have been made by our Governor and by our legislature and by this Congress.

And I believe that every member of this committee should take seriously the language that's been passed by Congress to make sure that agencies heed that, otherwise rule of law is degradated, and that's what we're a proponent of.

Mr. LANKFORD. Thank you.

Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman.

I'd say to the Attorney General, it's tough to take the statute seriously. You have Mr. Adler tell the tale again, as it has been sadly told so many times before, of how this law came into being. And it was not a serious work product on the day it passed this House and went to the President's desk. It could have been a serious work product. We could have sorted these things out. We could have solved a lot of these problems. But politics trumped good policy and we didn't. Candidly, Attorney General, it embarrasses me that you have to sort this out in the courts, that we're not able to sort this out here on Capitol Hill. It ought to be an Article I and Article II decision, not an Article III decision. And we have failed the citizens of Oklahoma in that respect.

I'd say to you, Dr. Willey, I too got the same word from the White House that if I had only been smarter, I would not have chosen a health savings account, I would have chosen a plan that had more first dollar coverage, that didn't expose me to so much risk, and didn't require me to be as responsible for my decisions. But thankfully the Federal Government has intervened, counseled me, and I'm going to do better starting January 1st, and I'm told I will be much happier as a result.

I so appreciate what Mr. Lazarus said about not impugning anyone's motives here at the table, that you have no doubt folks believe what they say when they're trying to do the best for their citizenry. That's not what I heard from my friends on the other side of the aisle this morning, and that's very frustrating to me. Because here you are, you are trained in ways that, with the exception of Dr. DesJarlais behind me, the rest of us only wish we had those skills and insights to the human condition, and yet folks say perhaps you're out to get your employees, that your desire to help them to be well is inferior to the government's desire to treat them after they get sick.

And it is incredibly frustrating to me that we second guess, again, folks who have spent not just years, but decades of their lives becoming experts in this field, and we supplant the judgment of our physicians with the judgment of our attorneys. Incredibly frustrating to me, speaking as an attorney.

Let me ask you, Mr. Lazarus, because, again, I appreciate the honesty with which you're approaching this. Obviously we're on different views—different sides of this issue. Let me ask you, I could probably stipulate that the capital "E" in Section 1401 makes a difference. I might not believe it, but I would stipulate it for the purposes of this conversation. Why, then, do we need to include "established by a State"? Why don't we just say "exchange" and be done with it? It seems that including that language almost by definition tells me we're trying to distinguish this capital "E" exchange from all of the other exchange conversations we're talking about in the statute. Do you not find that troubling?

Mr. LAZARUS. I don't find it troubling. I understand how you could see it that way. I think that my point and the point of those who read the statute the way I do is simply that when in 1321 it says that the Secretary shall establish "such Exchange" with a capital "E," it's referring back to the definition of a capital "E" exchange in 1311, which includes established by the State. And that would be the interpretation, which I think is a completely reasonable, not necessarily the only interpretation. But once you admit that it is a potential interpretation, then you have to look at the whole context and the purpose of the statute and what——

Mr. WOODALL. Well, you drive home the point about the dangers of sloppy legislating. Again, going back to Mr. Adler's tale of here we are, we're in a conference, we're trying to sort out two different congressional positions, we're trying to bring this language to perfection, and then we just jettison that effort altogether and say whatever those other guys passed, even though we didn't expect it to be ready for primetime, that's going to be good enough.

In fact, I was sitting in this very same chair earlier this year, I don't know if you're familiar with the navigator and assister language here, and by assister language I mean there's no assister language in here whatsoever, and yet HHS read that in. This isn't the first time we've had this conversation. If you feel the frustration of my colleagues, it's because this isn't the first time someone's read something into the statute that doesn't exist. We see it time and time and time again.

And folks wonder why Washington doesn't function. If the administration would have come here on any of those occasions and

said, we made a mistake, would you work with us to help us craft a solution, we would be in a different case today.

Let me ask you, Mr. Adler, I'm looking at 10 pages of CRS analysis of the legality surrounding Section 1401. I see one paragraph of Treasury analysis on that same topic. What's your assessment of the seriousness with which Treasury analyzed this issue?

Mr. ADLER. Well, based on what the Treasury Department published in the Federal Register, it does not appear that they engaged in the sort of reasoned decision-making that is required of agencies when they issue regulations and purport to provide authoritative interpretation of the statute. They were derelict in their responsibilities in providing that major justification.

Mr. WOODALL. With the chairman's indulgence, let me ask you why—because there are a lot of serious public servants over there implementing congressional mandates, it's not a new job for them—why in the world is it that you believe such a cavalier work ethic was applied to this topic when folks are so serious about others?

Mr. ADLER. You know, I don't know, to be honest. I mean, there are many instances, and we quote several in our article, where the IRS was quite forthright about not being able to implement the law in particular ways because the text prevented them from doing so and went on at length discussing the relevant statutory provisions.

The way this provision is treated is an anomaly. And I don't mean to impugn anyone's motives, I don't know why they did it this way, but as someone that's looked at the statute and the legislative history and on, I think a partial explanation may be that the evidence to support their theory wasn't there. And I think that's further confirmed by the fact that months later, when the Treasury Department first began providing explanations for the rule, it adopted mutually inconsistent explanations. The "such Exchange" justification and the reliance on the HCERA reporting requirements that apply to both Section 1311 and Section 1321 are mutually inconsistent. They can't both be correct. And yet in, I believe it was October 2012, Treasury Department offered them both simultaneously, and I believe that was because there really isn't anything there.

Mr. WOODALL. I thank you all for being here. Candidly, if the 435 of us and the 100 folks on the Senate side and the White House and the agencies approached this issue with the same seriousness and sincerity that the four of you do, I think we would have an entirely different conversation about this and the American people would be better served.

Thank you, Mr. Chairman.

Mr. LANKFORD. Thank you.

Gentlemen, thank you very much for being here for the morning. It's very important to be able to bring up and be able to walk through. This is a conversation that we can deal with on how is the law interpreted, how is the law written, and how will it be applied in the days ahead. This has billions and billions of dollars of impact on our Federal budget. And as Mr. Cartwright has rightly assessed as well, it also affects a tremendous number of lives of people around the Nation. And so this is very significant for us to

hear. And thank you for your contribution, both your written and your oral testimony.

We will take a short recess while the clerks set up for the second panel.

[Recess.]

Mr. LANKFORD. We'll now recognize our second panel.

Ms. Emily McMahon is the Deputy Assistant Secretary for Tax Policy of the U.S. Department of Treasury.

Thank you for being here. Pursuant to all committee rules, all witnesses are sworn in before they testify. If you'd please rise and raise your right hand, please.

Do you solemnly swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Thank you. You may be seated.

Let the record reflect the witness did answer in the affirmative.

To allow time for discussion, you've testified before hearings before, there will be a clock in front of you counting down to 5 minutes. We'd ask for you to be able to get as close as you can to 5 minutes, but obviously you're the sole witness on this panel. You're here for us to be able to hear from you and to be able to ask you questions. So your entire written statement obviously will be made a part of the permanent record as well. With that, I'd like to go ahead and recognize you for your opening statement.

STATEMENT OF EMILY S. MCMAHON, DEPUTY ASSISTANT SECRETARY FOR TAX POLICY, U.S. DEPARTMENT OF THE TREASURY

Ms. MCMAHON. Thank you, Chairman Lankford, Ranking Member Speier, and members of the committee. I appreciate the opportunity to testify regarding the premium tax credit created as part of the Affordable Care Act.

The ACA established affordable insurance exchanges, also known as health insurance marketplaces, where consumers can choose a private health insurance plan beginning in 2014. So that this insurance is affordable, Congress also included in the ACA a premium tax credit that it has been estimated will help approximately 20 million Americans to afford private health insurance. These premium tax credits may be worth over $4,000 per covered individual each year on average.

On August 17th, 2011, the Treasury Department and the IRS issued proposed regulations implementing the premium tax credit under Section 36B of the Internal Revenue Code. Final regulations were issued on May 23rd, 2012. These regulations provide that the premium tax credit is available to eligible individuals enrolling through all exchanges, whether directly operated by a State government or a federally facilitated exchange operated on behalf of a State.

The regulations were developed in accordance with our standard procedure for developing regulations under the Internal Revenue Code. Career IRS staff attorneys and attorneys from Treasury's Office of Tax Policy conducted a rigorous analysis of the statutory provisions, drawing on their extensive collective experience interpreting and implementing the code. Public comments were solicited

on the proposed regulations and were carefully considered during the development of the final regulations.

Treasury and IRS believe that the final regulations interpret the statutory language in a manner that is appropriate to its context and consistent with the purpose and structure of the statute as a whole, pursuant to longstanding and well-established principles of statutory construction. This interpretation takes into account the fact that Section 36B(f)(3), added by the ACA, requires federally facilitated exchanges to report to the IRS data related to eligibility for the premium tax credit and the receipt of advance payments, a requirement that would be pointless unless the enrolling individuals were eligible for the premium tax credit.

The regulations also reflect the fact that where a State chooses not to establish an exchange pursuant to Section 1311 of the ACA, Section 1321(c) of the ACA provides that the Secretary of Health and Human Services shall establish and operate such Exchange within the State. In other words, Congress made the federally facilitated exchange the equivalent of a State exchange in all functional respects, including making qualified individuals eligible for tax credits to purchase insurance through those exchanges.

I also note that the relevant legislative history does not indicate that Congress intended to limit the premium tax credit to State exchanges, or more specifically, to exclude the federally facilitated exchange.

And finally, the regulations are consistent with the explanation of the ACA released by the nonpartisan Congressional Joint Committee on Taxation and with the assumptions made by the Congressional Budget Office in estimating the effects of the ACA, a point that CBO Director Elmendorf recently confirmed in a December 6th, 2012, letter to Chairman Issa.

I understand that some members of this committee will have questions about our legal interpretation. While Treasury appreciates the committee's important oversight role, it is important to remember that our conclusions also are subject to ongoing active litigation. In fact, I understand that some of those plaintiffs were on the earlier panel.

As such, it is important to recognize that only the Justice Department speaks to the administration's official legal positions as to the merits of our conclusions. I will do what I can to answer the committee's questions today subject to the Treasury Department's legitimate confidentiality interests and sensitivities concerning active litigation.

As you know, the Affordable Care Act is projected to provide health coverage for nearly 30 million additional Americans. Agencies throughout the administration are implementing the ACA to build on the progress already made toward better and more affordable coverage. We welcome the opportunity to continue our work with this committee to achieve these objectives. Thank you.

Mr. LANKFORD. Thank you.

[Prepared statement of Ms. McMahon follows:]

EMBARGOED UNTIL 10:30 A.M. 7/31/13

Written Testimony of Emily S. McMahon
Deputy Assistant Secretary for Tax Policy
U.S. Department of the Treasury
Before the House Oversight and Government Reform Subcommittee on Energy, Health Policy and Entitlements

July 31, 2013

Chairman Lankford, Ranking Member Speier, and members of the committee, I appreciate the opportunity to testify regarding the premium tax credit created as part of the Affordable Care Act (ACA).

Background

The ACA established Affordable Insurance Exchanges, also known as Health Insurance Marketplaces, where consumers can choose a private health insurance plan that fits their needs beginning in 2014. To help ensure that this insurance is affordable, Congress also included in the ACA a premium tax credit. It is estimated that, when fully implemented, the ACA will provide premium tax credits to help approximately 20 million Americans afford private health insurance. These premium tax credits may be worth over $4,000 per covered individual each year on average.

On August 17, 2011, the Treasury Department and the IRS issued proposed regulations implementing the premium tax credit under section 36B of the Internal Revenue Code (the Code). Final regulations were issued on May 23, 2012. These regulations provide that the premium tax credit is available to eligible individuals enrolling through all Exchanges, whether directly operated by a state government or a federally-facilitated Exchange operated on behalf of a state.

36B Premium Tax Credit Overview

The premium tax credit is a refundable income tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through an Exchange. The credit is generally available to individuals and families with incomes between 100 percent and 400 percent of the federal poverty level (generally $23,550 to $94,200 for a family of four in 2013) who enroll in coverage purchased through an Exchange and who are not eligible for affordable, comprehensive coverage from another source. The credit may be paid in advance directly to the individual's insurance company, lowering the individual's monthly out-of-pocket premiums. If the credit is paid in advance, the individual will reconcile on his or her tax return the amount paid in advance with the actual credit computed on his or her tax return. The amount of the credit is generally set so as to make a benchmark plan affordable to the individual based on their household income. Individuals who are eligible for a premium tax credit may also be eligible for a cost-sharing reduction, which is designed to make affordable any cost-sharing – such as deductibles or co-payments – an individual may owe in conjunction with their insurance.

Treasury and IRS Regulations Process

It may be helpful to describe the process through which regulations are developed. It is the responsibility of the Treasury Department and the IRS to write regulations to implement the tax laws passed by Congress. In every case, we do so in a careful and thoughtful way, with the goal of implementing the law consistent with congressional intent and resolving any statutory ambiguities in a reasonable manner that gives effect to the purpose of the statute. We follow a standard procedure for drafting, approving, and publishing tax regulations, and our process in this case followed the normal course.

Under our standard procedure, the development of Treasury regulations implementing the Code begins with the IRS Office of Chief Counsel. IRS lawyers review the statute to identify any issues that regulations should address and to develop preliminary resolutions of those issues. The IRS lawyers apply well-established principles of statutory construction and draw on their long experience implementing the Code. The analysis is then shared with tax lawyers from the Treasury Department's Office of Tax Policy (OTP), and the two groups confer about the proper interpretation of the statute, discuss any differences of opinion, and develop a consensus approach.

Under this standard procedure, OTP and IRS lawyers work together to draft proposed regulations, which are published in the Federal Register. The Treasury Department and the IRS solicit public comments on the proposed regulations during an official comment period; and, in many cases, the IRS also holds a public hearing to allow stakeholders to provide feedback in person. IRS and OTP lawyers review any comments they receive and consider whether any of the suggested changes should be adopted. Finally, IRS and OTP lawyers draft a final regulation, which includes responses to any comments and makes modifications to the proposed regulations as necessary. All final tax regulations are signed by the Treasury Department's Assistant Secretary for Tax Policy and the IRS Deputy Commissioner.

The IRS and OTP followed this standard procedure in developing the proposed and final regulations under section 36B. In particular, first the IRS, and then the OTP lawyers, considered the express language of section 36B, as well as other relevant provisions of the ACA. They separately and together concluded that the ACA should be interpreted to provide tax credits to income-eligible individuals enrolling through all Exchanges, whether federally-facilitated or directly operated by a state government. This approach was reflected in the proposed regulations issued in August 2011. We received written and oral comments in response to the proposed regulations – some of which were supportive; others argued for a different interpretation. The IRS and OTP reviewed the issue again, taking the comments into account, and concluded the statute should be interpreted as in the proposed regulations on this point. The Treasury Department and the IRS published final regulations in May 2012 that adopted this view.

Eligibility for Premium Tax Credits

Treasury and IRS believe that the final regulations interpret the statutory language in a manner that is appropriate to its context and consistent with the purpose and structure of the statute as a whole, pursuant to longstanding and well-established principles of statutory construction. This interpretation takes into account the fact that section 36B(f)(3), added by the ACA, requires federally-facilitated Exchanges to report to the IRS data related to eligibility for the premium tax credit and the receipt of advance payments – a requirement that would be pointless unless the enrolling individuals were eligible for the premium tax credit. The regulations also reflect the fact that, where a state chooses not to establish an Exchange pursuant to section 1311 of the ACA, Congress provided in section 1321(c) of the ACA that the Secretary of Health and Human Services (HHS) "shall . . . establish and operate *such* Exchange within the State" to serve the residents of that state. In other words, Congress made the federally-facilitated Exchange the equivalent of a state Exchange in all functional respects, including making qualified individuals eligible for tax credits to purchase insurance through those Exchanges.

I also note that the relevant legislative history does not indicate that Congress intended to limit the premium tax credit to state Exchanges, or, more specifically, to exclude the federally-facilitated Exchange. And finally, the regulations are consistent with the explanation of the ACA released 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. In fact, CBO reaffirmed this point in a December 6, 2012 letter to Chairman Issa in which Director Elmendorf stated: "To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state."

Conclusion

I understand that some members of this committee will have questions about our legal interpretation. While Treasury appreciates the Committee's important oversight role, it is important to remember that our conclusions also are subject to ongoing, active litigation. In fact, I understand some of those plaintiffs were on the earlier panel. As such, it is important to recognize that only the Justice Department speaks to the Administration's official legal positions as to the merits of our conclusions. I will do what I can to answer the Committee's questions today, subject to the Treasury Department's legitimate confidentiality interests and sensitivities concerning active litigation.

As you know, the Affordable Care Act is projected to provide health coverage for nearly 30 million additional Americans. Together with the Departments of Health and Human Services, Labor, and other agencies throughout the Administration, we are implementing the ACA to build on the progress already made toward better and more affordable coverage. We welcome the opportunity to continue our work with this Committee to achieve these objectives. Thank you, and I look forward to answering your questions.

Mr. LANKFORD. Ms. McMahon, thank you for being here. And we will have obviously questions about how the rule came together. You're a part of that team that actually helped pull the rule together. Obviously there are other attorneys and other folks that were involved in that process. What was your role in the proposed rule and then the final rule when it was done?

Ms. MCMAHON. Mr. Chairman, at the time that both the proposed regulation and the final regulation were issued, I was the Acting Assistant Secretary for Tax Policy, and in that role, it was my responsibility to approve regulations implementing the Internal Revenue Code.

Mr. LANKFORD. Great. Well, part of the process that we're trying to go through today is not only the final decision of it, obviously, and there will be a legal conversation on that, but how that was pulled together. You used the term there was a rigorous analysis of IRS legal and folks at Treasury and such to be able to look through it and go through the law. Obviously, it's a long law. It's new in its format in a lot of ways.

We have asked Treasury for a tremendous number of documents just in trying to gather how was the decision made between the State exchange issue or whether this "such Exchanges," as you mentioned, also includes, where was that conversation?

What we have found so far is a half-page memo that included that one piece of justification of "such Exchanges." That's around, if I'm guessing correctly, around a $600 billion decision that was made to be able to include that in, and so we asked for the background of that.

Today we actually received a letter from Treasury saying they've given us 500 pages of documents so far to provide the background on that. We actually went and looked, and we've actually received 386 pages of documents, a little bit of a miscount there; 154 pages of that was the draft proposed rule itself.

So let me just walk through a little bit of what else we received. So 386 pages that we've received from Treasury and IRS about how this discussion came to be, 154 of that was the draft proposed rule, 70 pages of that were a draft of Cannon and Adler's Law Review article. Obviously, we had Mr. Adler here today, 70 pages of that was his. Five pages were Professor Jost's response to the Law Review article, so that was, again, after this was done. Fifty-nine pages were law cases found through Westlaw when a senior Treasury official asked Cameron Arterton, the Treasury employee tasked with defending the rule, to find good Chevron cases. Eleven pages were letters from House Republicans and Senator Hatch to the IRS raising questions about the rule. Forty-five pages were from public hearings on the 36B regulation. Eight pages were from the public comments that people made about the rule. Three pages of emails about setting up a meeting to discuss this issue with Energy and Commerce staff. Eight pages were an article from the Centers of Budget and Policy Priorities on the subject, written, again, after the final rule. Three pages were a Wall Street Journal op-ed from Cannon and Adler. Three page of the debates at a Senate Finance hearing between Senator Bachus and Ensign.

So, again, our request for documents were about the conversation when this was being discussed early on. What we received was 369

pages of public material or relevant—or material that was obviously after that. Two pages showed us that 6 months prior to the release of the final rule Treasury was considering Chevron's applicability of this case. The remaining 15 pages of documents were mostly emails from Treasury staff forwarding or commenting on articles from Cannon and Adler and Professor Jost.

What we need to know is, how was the conversation accomplished? What happened in that conversation? Was there active discussion? Were there notes taken from that? What we've asked for were the notes about that. What we've received is everything well after that and things that are not relevant. Or most of this is public information that we could download from the Internet, not based on those conversations.

How can we determine what that conversation was like leading up to this decision?

Ms. MCMAHON. Well, a couple of things, Mr. Chairman. First of all, we did provide additional materials for review by your staff.

Mr. LANKFORD. In camera.

Ms. MCMAHON. In camera. And those materials included two—at least two legal memoranda relating to both the proposed and final regulations, the memos that accompanied the clearance packages as the regulations—at the time the regulations were published.

I understand, as you mentioned, Treasury sent a letter this morning explaining our concerns with providing additional documentation——

Mr. LANKFORD. Not just additional, just documentation at all on it, because all this is not relevant actually to the question that we asked. We have a lot of pages, but just not—they're just not relevant to what we asked for.

Sorry. Go ahead.

Ms. MCMAHON. Well, Mr. Chairman, we did, I can assure you, we did have an extensive discussions of the Federal exchange question, both before the proposed regulations were issued and between the issuance of the proposed and final regulations. There was an IRS–Treasury working group that—comprised of career staff, IRS attorneys, and attorneys from Treasury's Office of Tax Policy, who analyzed very carefully a number of issues that were presented in the development of the 36B regulations. This was one of them. We considered the issue carefully before, as I said, the proposed regulations were issued. And we received a number of public comments on proposed regulations. And so the issue was reconsidered before issuance of the final regulations.

A lot of the discussion was oral in meetings and, you know, personal—the in-person discussions. But, you know, to the extent that there are additional documents that may relate to the—our internal deliberations, as I think as our letter of this morning explained, we have concerns about confidentiality and the chilling effect that release of those additional documents might raise—or might present if we—on the rulemaking process, if we were to provide them.

Mr. LANKFORD. So there is not any written evidence. There's oral on that, as far as the conversations between those. Can we get a

list of those individuals that were involved in that conversation specifically about this issue?

Ms. MCMAHON. Mr. Chairman, I can't provide you off the top of my head a list of all of those?

Mr. LANKFORD. I understand that.

Ms. MCMAHON. —individuals. There are a number of people involved and people came and went at different times. I can take that request——

Mr. LANKFORD. That would be great. Obviously, there are a lot of issues, I discussed it's a large law, and there's a lot of things that apply to it. This is the specific issue that we're trying to identify. How was that conversation, what was the diligence that was put to that? You've use words like "extensive" and "diligence." Terrific. We just want to get a chance to get in the feel of that and what actually happened with that.

With that, I'd like to recognize Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

And thank you for coming today, Ms.McMahon. I have some questions for you.

First, Ms. McMahon, the Treasury Department issued a final regulation allowing premium tax credits to be available to all people, regardless of the origin of their exchange participation. Am I correct in that?

Ms. MCMAHON. Yes, that's correct.

Mr. CARTWRIGHT. All right. Now, under the interpretation of the Affordable Care Act put forward by Professor Adler, residents of States with federally operated exchanges would not qualify for the premium assistance tax credits. Now, Ms. McMahon, has our government ever provided tax credits on a State-by-State basis or denied citizens tax credits based solely on their State of residence?

Ms. MCMAHON. I am not aware of any code provision that operates in that manner, no.

Mr. CARTWRIGHT. And now how about this, was the Treasury Department ever consulted on a carving out of premium tax credits?

Ms. MCMAHON. To the best of my knowledge, no.

Mr. CARTWRIGHT. I want to talk about regulation drafting a bit. The Departments of Treasury and HHS have both conducted stakeholder outreach to solicit comments and guidance on a broad range of the ACA's provisions. Ms. McMahon, Treasury invited comment and questions from the public, from scholars, from business owners, from individuals. Am I correct in that?

Ms. MCMAHON. Yes, that's correct.

Mr. CARTWRIGHT. Will you tell us, how were these comments and questions utilized in the formation of the ACA regulations?

Ms. MCMAHON. Congressman, we always take into consideration public comments that we received. In a number of cases, with respect to ACA provisions, we actually solicited public comment before the issuance of proposed guidance to make sure that our proposed guidance reflected public input, stakeholder input. When we've issued proposed guidance, including the 36B regulations in particular, we received over a hundred comments on various issues relating to the regulation. And we have taken all of those into account in accordance with our standard rulemaking procedure.

Mr. CARTWRIGHT. And you followed the standard rulemaking procedure, did you?

Ms. MCMAHON. Yes, we did.

Mr. CARTWRIGHT. So was the process—were the efforts by Treasury to design the regulations for the ACA similar to other Treasury regulations?

Ms. MCMAHON. Yes, Congressman. The process was essentially the same as the process that we always use in developing tax regulations.

Mr. CARTWRIGHT. Okay. Now, was the Department of the Treasury aware of the argument that premium tax credits should be available only in State-run exchanges? Was this alternative interpretation considered during the rulemaking process?

Ms. MCMAHON. Yes, Congressman. We became aware of that argument in the course of developing the proposed regulations. And we considered it very carefully at that point and, as I said, again, between the publication of the proposed and final regulations.

Mr. CARTWRIGHT. Okay. Good. Now, would you characterize the administration's efforts as transparent and fair in the rulemaking process?

Ms. MCMAHON. Yes, Congressman. I would. We published our proposed guidance for public comment. We received a number of public comments. We held a public hearing, at which a number of people testified. And we took into account all of the comments that we received.

Mr. CARTWRIGHT. Well, now, the—when you think about it, the fundamental purpose of the Affordable Care Act is to create an inclusive, accessible market for health insurance that makes affordable care available to all. The law achieves this aim in a variety of ways, including expansion of Medicaid, development of health insurance marketplaces, and providing incentives for participation in the health insurance market. All of these provisions support the goals of universal access and a strong, sustainable healthcare system. Ms. McMahon, do you consider the purpose and intent of the law when you go about drafting regulations?

Ms. MCMAHON. Yes. Yes, we do. And the purpose of the Affordable Care Act, as we understand it, was to achieve universal healthcare coverage, affordable healthcare coverage for citizens in every State.

Mr. CARTWRIGHT. Well, thank you for that. Again, thank you for coming today. And I yield back.

Mr. LANKFORD. Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Ms. McMahon, in the previous questions, you indicated that you knew about this constitutional concern when you were putting together the proposed rule and then the final rule. Correct?

Ms. MCMAHON. Congressman, we were aware of the question regarding Federal exchanges. I wouldn't characterize it as a constitutional question. It was a——

Mr. JORDAN. You knew there was a controversy about how this was going to be interpreted, exchanges established by the State. You knew there was a concern, a controversy.

Ms. MCMAHON. We knew that the issue had been raised. The first time——

Mr. JORDAN. I guess what I'm getting at, you were aware of it but you didn't think it rose to any level where it would require any different type of process to reach a conclusion. You just kept it within the same process that the IRS has when figuring out how we're going to establish rules to implement legislation. Nothing unique done.

Ms. MCMAHON. Well, we became aware of it by reading an article in a——

Mr. JORDAN. Did you do anything different than you would do for anything else is what I'm asking.

Ms. MCMAHON. No. We followed our standard process——

Mr. JORDAN. Your established process. And just refresh my—quickly, if you can—what is that established process? I mean, do you have the final say? Is there a group of people who look at, here's how we think—this is what we think the law says, here's how we think it should work. A group gives you a recommendation. You give it a thumbs up or thumbs down, and then I assume ultimately it winds up on Doug Schulman's desk, and he gives it the final okay. Is that sort of how it works?

Ms. MCMAHON. Well, the process begins with an IRS–Treasury working group of staff attorneys who consider relevant issues arising in connection with the implementation of a particular code provision. They do——

Mr. JORDAN. Is that working group a formal number, or is it sort of ad hoc? It can be five people one day? It can be 20 the next? How does that work?

Ms. MCMAHON. Well, usually, at the beginning of the rulemaking process, a group is identified, people who are subject matter experts. And that group comprises the working group for development of the regulation.

Mr. JORDAN. Do you know who those people are? I mean, Mr. Lankford was hinting at this. Do you know some names off the top of your head, or are you going to get that to us?

Ms. MCMAHON. As I said earlier, I can take that request back.

Mr. JORDAN. Did you personally—did you get some of these—we had a letter that was signed by 24 Members of Congress, several doctors, Dr. Roe, Dr. DesJarlais signed the letter, Dr. Burgess and others. Do you know if that group or did—if you personally reviewed that letter citing concerns about this very issue?

Ms. MCMAHON. Congressman, I'm not sure exactly which letter you're referring to. If you give me the number——

Mr. JORDAN. We can make it available——

Ms. MCMAHON. —comment letters from Members of Congress, which we did consider.

Mr. JORDAN. You did take a look at that.

Do you know if—the proposed rule was, I guess, August 17th or sometime in August of 2011. The final rule was this May—or, excuse me, May of 2012. Is that—that—that right?

Ms. MCMAHON. Yes.

Mr. JORDAN. And in this decisionmaking process, we know that the director of implementation for the Affordable Care Act, Sarah Hall Ingram, came on board in December 2010 to help implement the Affordable Care Act. Was Miss Hall Ingram involved in the process of making the determination about this issue?

Ms. MCMAHON. Yes, Sarah Hall Ingram was involved in discussions about—generally about the development of the Section 36B——

Mr. JORDAN. So there's one of the people who was involved. So you can give us one name. Any other names you can give? We got Ms. McMahon; we know you were involved. We got Sarah Hall Ingram. Anyone else? Was Doug Schulman directly involved in this as well? Was Steve Miller?

Ms. MCMAHON. Neither of those individuals was involved in the working group. But the——

Mr. JORDAN. But Sarah Hall Ingram was.

Ms. MCMAHON. She was not involved, to the best of my recollection, in the working group of lawyers that worked on development of the regulation. But in the course of that process, a number of people, both within the IRS and Treasury who had involvement with ACA implementation, were briefed——

Mr. JORDAN. Was she extensively involved in this?

Ms. MCMAHON. Unfortunately, I don't recall.

Mr. JORDAN. Thank you, Mr. Chairman.

Mr. LANKFORD. Dr. DesJarlais.

Mr. DESJARLAIS. Ms. McMahon, thank you for being here today.

Secretary Lew's chief of staff, Chris Weideman briefed the committee in November 2012 and stated that a thorough legal analysis was not conducted related to the availability of tax credits and Federal exchanges because it wasn't one of the most significant issues considered in the 36B regulation. Was this also your perspective?

Ms. MCMAHON. Congressman, I'm not familiar with Mr. Weideman's comments. I could say for—from my own perspective, we did consider this question a serious issue. We analyzed it in a serious manner.

Mr. DESJARLAIS. So you feel that you did do a thorough legal analysis.

Ms. MCMAHON. Yes.

Mr. DESJARLAIS. And can you give me examples of what that was? What was the thorough legal analysis?

Ms. MCMAHON. Well, members of the IRS and Treasury working group looked very carefully at the provisions of 36B itself, at other relevant provisions of the Affordable Care Act, including sections 1311 and 1321, which addressed the establishment of exchanges and, as I said earlier, make clear that the Federal exchange is intended to be the functional equivalent of State exchanges. There are other provisions of the ACA as well that relate to the advance payments, the premium tax credits.

Mr. DESJARLAIS. Excuse me. Did anyone raise the issue that IRS' and Treasury's interpretation of tax credit availability in Federal exchanges would have enormous tax and spending implications?

Ms. MCMAHON. Congressman, we believe that our interpretation of the statute is consistent with the way that the Affordable Care Act was scored by the Congressional Budget Office and the Joint Tax Committee.

Mr. DESJARLAIS. Okay. That's not the question I asked. Did the IRS or Treasury's analysis at any point factor—at any point factor or consider whether Congress made tax credits available only in

State-based exchanges as an incentive for States to create exchanges?

Ms. MCMAHON. When we became aware of the—this question, we also became aware that that was the rationale that was being suggested.

Mr. DESJARLAIS. Do you have any evidence that the IRS or Treasury ever considered that Congress made tax credits available in the State-based exchanges as an incentive for States to create exchanges?

Ms. MCMAHON. Congressman, in the course of our rulemaking process, we did look very carefully at all of the legislative history relating to the Affordable Care Act, and we found nothing to suggest that the incentive rationale that you're suggesting——

Mr. DESJARLAIS. Is there any evidence to support that you did this—you say you did this, you say there was a thorough investigation. Is there evidence to support a thorough investigation? And remember we got, like, a half-page brief. Is there anything to show this? You say this, but we're not seeing it.

Ms. MCMAHON. I—Congressman, I would simply refer you to the letter that we sent this morning regarding our concerns with release of additional documentation.

Mr. DESJARLAIS. Did Treasury factor into its analysis that Obamacare's author created large financial incentives, such as an exchange establishment grants, to cover the cost of States creating exchanges and that the author failed to create any specific funding for the creation of Federal exchanges?

Ms. MCMAHON. Congressman, I don't recall whether that point was explicitly considered during our rulemaking process.

Mr. DESJARLAIS. All right. On October 12, 2012, Mark Mazur, Assistant Secretary for Tax Policy, wrote a letter to Chairman Issa on the tax credit rule. Mazur wrote, 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 to limit the availability of the tax credit.

Did you review this letter?

Ms. MCMAHON. Yes, I'm familiar with the letter.

Mr. DESJARLAIS. Can you tell us how the IRS and Treasury searched for a pattern for references to "exchanges" in Obamacare?

Ms. MCMAHON. Well, Congressman, IRS and Treasury staff attorneys looked through the Affordable Care Act and examined all of the references to "exchanges," to try to determine whether there was any particular convention that Congress had used in describing State or Federal or exchanges or both. And as the letter indicates, we were not able to find it——

Mr. DESJARLAIS. When an agency looking on a complicated rule is searching for a pattern in the way Congress referred to certain terms, would you expect them to categorize or organize these results? I assume you would, but I don't mean to put words in your mouth.

Ms. MCMAHON. Well, Congressman, as I've said, our working group did a very thorough analysis——

Mr. DESJARLAIS. Did you categorize or organize the results?

Ms. MCMAHON. I am not familiar with——

Mr. DESJARLAIS. Okay. Do you know that the IRS and Treasury employees have admitted to committee staff that no one at either IRS or Treasury ever categorized or organized references to exchanges or exchanges established by a State and exchanges established under the ACA in any way?

Ms. MCMAHON. Congressman, I am not familiar with the comments that you are referring to.

Mr. DESJARLAIS. Do you think—do you think that it's a problem that no one in IRS or Treasury categorized or organized all the references to exchanges established by the State under section 1311 in order to determine whether a discernible pattern exists?

Mr. LANKFORD. You can answer the question. I think we're running close on time, but you can answer that.

Ms. MCMAHON. Congressman, I—the IRS and Treasury working group did a very thorough analysis. And I am satisfied that their work appropriately looked at all of the relevant ACA provisions and I am satisfied with their conclusion that no discernible pattern existed.

Mr. DESJARLAIS. But you can produce no evidence of such.

Ms. MCMAHON. Congressman, I would simply refer you again to the letter we sent this morning in which we described our concerns with producing additional documentation.

Mr. DESJARLAIS. Thank you, Ms. McMahon.

Mr. LANKFORD. Mr. Cardenas.

Mr. CARDENAS. Thank you very much, Mr. Chairman.

My first question is, when it comes to the issue of availability of premium tax credits, which have been of interest to the majority since last fall, I understand that Treasury has responded to the majority's request by providing documents, briefing, and in camera review of sensitive documents since last August, when the chairman made his first request for information. Ms. McMahon, would you recount for the committee the number of requests for information made by the majority on this issue?

Ms. MCMAHON. Congressman, we have received a number of requests for information, both formal and informal. We have provided hundreds of pages of documents, including legal memoranda, some of which we made available for review in camera. Our staff has also met three times, for a total of 8 hours, with staff of this committee to explain our process in developing these regulations and the legal research and analysis that we conducted.

Mr. CARDENAS. So when it comes to all of those requests between you and your staff and your team, how could your response be categorized? Is that you have been responsive to those requests or irresponsive?

Ms. MCMAHON. Congressman, we have done the best that we can to provide the committee with the information that it needs, including answering many, many questions presented by the staff and providing a number of documents, including memoranda that describe our legal analysis. We are happy to continue working with the committee to provide additional information that you may need. But I believe that today we have been very responsive.

Mr. CARDENAS. Thank you.

While I still have time, Mr. Chairman, I want to take the opportunity to ask that we enter into the record this letter, dated July

31, the heading of Department of the Treasury, addressed to the Honorable Darrell Issa, Chairman of the Committee on Oversight and Government Reform. And it's signed by Alastair M. Fitzpayne. If we can add that to the record.

Mr. LANKFORD. Without objection.

Mr. CARDENAS. Thank you. Thank you very much.

In addition to that, I have some more questions. I understand that you and your staff have also participated in a number of briefings with committee staff. How many of these briefings have been held, and what amount of time had these briefings totaled for you and your staff?

Ms. MCMAHON. Congressman, we participated in three separate briefings. I believe the total time that our staff spent was over 8 hours. We had——

Mr. CARDENAS. In meetings, not including preparation.

Ms. MCMAHON. No, in actual meetings with committee staff. That's correct.

Mr. CARDENAS. Isn't it also true that Treasury has made available to committee staff a viewing of sensitive documents without redactions?

Ms. MCMAHON. Yes, Congressman, that is correct. Some of the memoranda that we originally provided in physical copies were redacted. And when the committee staff requested to review the redacted material, we made unredacted versions of those memos available in camera for review.

Mr. CARDENAS. I appreciate your responsiveness to this committee and to the staff and the efforts you have made to detail your rulemaking process as it relates to health insurance premium tax credits.

Are the kinds of documents that Treasury has made available to the committee staff also potentially of interest to the plaintiffs in the two lawsuits in Oklahoma and the D.C. Federal Court?

Ms. MCMAHON. Congressman, my expectation is that they—yes, they would be of interest to the plaintiffs in the litigation.

Mr. CARDENAS. Because those documents are of the same issue; correct?

Ms. MCMAHON. Yes, the documents that we provided at least in part relate to this question.

Mr. CARDENAS. Okay. As my time is running short, one last question. Isn't it true that the plaintiffs in those lawsuits have not yet started the discovery process because there are legal questions about whether or not their lawsuits have standing?

Ms. MCMAHON. Congressman, the Department of Justice is handling the litigation for the administration. But I believe you're correct, the litigation is at the very early stages.

Mr. CARDENAS. Basically, it was a question, but I just stated a truth and a fact.

Thank you very much, Mr. Chairman.

Mr. LANKFORD. Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman.

Ms. McMahon, I very much appreciate you being here. Hope one day we'll have a Republican administration. But I hope never to be sitting in the chair where you're sitting. So I'm grateful to you for doing that, and your team that came with you; $600, $700 billion

question is a pretty heady material. I remember we had a former IRS Commissioner sitting in that chair who said he was absolutely satisfied that a very thorough examination had been done. It turned out he never even picked up the phone to call to find out if a thorough examination had been done.

I know that's not the case with you today. But you've said that several times. "The working group did a very thorough analysis," you've said several times. "I'm satisfied," you've said several times, "I assure you that we had extensive discussions." And yet we have so very little paperwork to support all of that. I reviewed the in camera materials that we've had a chance to see. But can you tell me, because this is—this is—is so important to my folks back home. They do read statutes that they get published as plain language. If it says "State exchange," they think it means State exchange.

Do you remember when these conversations were beginning, do you remember this being an important issue that this working group, this team was trying to sort out because the language of the statute was so plain?

Ms. MCMAHON. Congressman, I do remember when the issue was first identified, largely because I was the one who first became aware that some individuals were suggesting as a possible interpretation of the relevant provisions that the credit would not be available in a Federal exchange. I read an article——

Mr. WOODALL. So the working group was already going on, the analysis had already begun, this thing was already robustly established and producing. And then you heard that this might be an alternative interpretation. Is that kind of the timeline?

Ms. MCMAHON. Well, this was—at the time that we identified this issue, we were also at—in the early stages of the process, I would say. And were identifying a number of issues that would need to be resolved.

Mr. WOODALL. Do you remember any discussion that said, golly, if we don't resolve this in the affirmative, our entire vision of how these subsidies are going to be deployed across the country is going to come unraveled? I mean, again, this is a huge decision. If you decide the other direction, folks in my home State of Georgia aren't going to receive any subsidies whatsoever. So that the import is—cannot be overstated. Do you remember any discussion that if said if we don't get this right we are going to sweep out the foundation on which the President's healthcare plan is established?

Ms. MCMAHON. Congressman, I would say that we recognized that the interpretation that the credits would not be available on Federal exchanges was inconsistent with our understanding——

Mr. WOODALL. I'm asking a very different question.

Again, I know you have a staff of professionals that you work with, but this is not an ordinary issue. This isn't a—this isn't a 501(c)(4) issue, this isn't a, can I claim a homeowner tax credit issue. This is the President's landmark social agenda program going to be held to the statutory standard under which it was—was passed by Congress and signed by the President, I can't imagine that this discussion was held at—at IRS headquarters and throughout the Treasury Department, and there was not some discussion of we've got to get this done. Is it your recollection that

that was never a topic of conversation? No one ever felt that sense of urgency that we've got to get this right because otherwise the President's social agenda comes unraveled.

Ms. MCMAHON. I—Congressman, we analyzed this question——

Mr. WOODALL. I understand that. And you've said that several times. But I'm asking a question that no one else has asked, so I'm expecting the answer to be something different than what you've given to everyone else, and that is, do you recall that topic ever coming up in all of these extensive discussions that you've had, the thorough analysis that you had, all of those conversations that satisfied you that this was done properly? And if the answer is no, that's okay. I just wanted to know.

Ms. MCMAHON. Congressman, as I've said, we appreciated the fact that the interpretation that you are suggesting would be inconsistent——

Mr. WOODALL. I don't think you're going to answer my question, and that frustrates me.

Could I get the slide up here? Because I've just got four sentences that I'd like to put there on the board. This is the analysis that I saw in the pre-proposed regulatory language. Four sentences up here in this analysis. My friends at CRS, who are not burdened with the actual responsibility of implementing this, produced 10 pages for us of pros and cons helping us work through what the issues were, what the patterns were, what the legal adoption was. Four sentences is what I—is what I've gotten from you all from the very extensive discussion groups, the very thorough analysis. And it says in sentence 4, The phrase "established by a State" may be interpreted to refer to an exchange established to operate in a State.

Can I just ask you, what are the other exchanges? We're going to interpret the phrase "established by a State" to mean these can be the ones that are established to operate in a State. What are the other exchanges that this phrase doesn't refer to? "Established by a State" may be interpreted to refer to an exchange established to operate in a State. What are the other exchanges that we're concerned about. We're going to interpret this one to mean these exchanges. What are the other exchanges that it could be interpreted to mean?

Ms. MCMAHON. Well, Congressman, in addition to the exchanges established by a State, there are obviously Federally-facilitated exchanges.

Mr. WOODALL. The different exchanges. The ones that aren't these, the ones that are the other ones. Because I think that's exactly what my folks back home think, that you're exactly right. They're the ones that are established by a State, then there are all the other ones that aren't established by a State, which is why we had this language in here.

Mr. Chairman, there's no mention of this issue in the proposed reg clearance package. And I just find it unbelievable that as a freshman member on this committee, first-year member of this committee, I can't see the documentation that was produced for folks that say it was an extensive discussion, it was a very thorough analysis. I get four sentences and some in camera documents for something that is the largest single dollar value issue that this

Congress and this Nation are going to consider in 2013. I thank the chairman.

Mr. LANKFORD. Thank you.

With that, I recognize ranking member Mrs. Speier.

Ms. SPEIER. Mr. Chairman, I must say that I am deeply troubled by the attack approach that is taken by virtually every other member of the Republican side of the committee, with the exception of you. You, for the most part, have shown great deference to the witnesses, speak politely to them, ask questions in a manner that they can answer.

This is not a courtroom. I think bullying witnesses that come before us is inappropriate as colleagues that sit here in an effort to try and find out information.

Now, having said that, I find it particularly interesting that we will dice and splice the language and the law and regulation here in the Affordable Care Act, but in the IRS code that specifically says that a 501(c)(4) will be exclusively for the social welfare purposes in this country, and then the IRS comes in and by regulation changes "exclusively" to "primarily," we haven't had one iota of an interest in delving into that particular issue. Instead, we have spent months looking at the IRS and trying to find a link between the White House and the IRS with the establishment of 501(c)(4)s that were conservative in nature. And then, lo and behold, we find out that they were treating 501(c)(4) applications that were progressive and conservative the same. And they were looking at them. Well, the reason why they were looking at them is because it's really hard to understand where that line is drawn.

But the discussion that went on earlier today about how it would be absolutely outrageous for a regulatory entity to obscure a statute, which was what our first panelists were talking about, for the most part, it kind of like doesn't relate when it comes to the IRS. And I think that's just quite entertaining, at the very least.

Now, Ms. McMahon, I thank you for being here. I want you to know you're not being treated any differently than any other administrative person that comes to this committee and is raked over the coals by my colleagues on the other side of the aisle. And I regret that, and I apologize on their behalf, with the exception of the chairman, who has always shown great discretion.

Now, let's go on and discuss this issue.

Is it not true that this particular bill, the Affordable Care Act, was debated ad nauseam in the Congress of the United States? Maybe not ad nauseam, but deliberatively and extensively.

Ms. MCMAHON. Yes.

Ms. SPEIER. All right. So we had a robust legislative debate on this issue. The Senate Finance Committee alone marked up the bill for more than 3 weeks, producing a transcript of nearly 3,000 pages. The subsequent floor debate lasted more than 1 month. Now, I recognize many of my colleagues weren't here at the time. I was. And it reflected more than 400 pages in the Congressional record.

If, in fact, the intention was to create a carrot-and-stick relationship with the States, don't we think that at some point in time that would have been raised by someone?

Ms. MCMAHON. Yes, Congresswoman Speier, we—we reviewed the transcripts of the floor debates to try to find out if there was any discussion of the carrot/stick approach that you mentioned. And we did not find any discussion of that approach or any evidence that that was the approach that was intended.

Ms. SPEIER. And wouldn't it be something that would reflect poorly on Members of Congress that we would only want to give the value of affordable health insurance to some people in the country and not all people in the country?

Ms. MCMAHON. Congresswoman, we believe that the Affordable Care Act was intended to provide affordable health insurance for individuals across the country. We agree with that objective, and we are doing our best to implement the ACA in a manner consistent with that objective.

Ms. SPEIER. So copious documents were reviewed, the references to a premium tax credit that would be offered to exchanges in the State was not ever set forth as one that was going to be a benefit only to those States that offered exchanges. Correct?

Ms. MCMAHON. That's correct. We did not find any evidence in our review of legislative history that there was any intent to exclude the Federal exchanges from the scope of the premium tax credit.

Ms. SPEIER. We had a request of the chairman of this committee to the Congressional Budget Office, and the CBO wrote back, "To the best of our recollection, the possibility that those subsidies would only be available in States that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered."

Is that consistent with your experience in having researched this issue as well?

Ms. MCMAHON. Yes, Congresswoman, that is consistent, that letter is consistent with our understanding.

Ms. SPEIER. All right. So, based on the transcript from the Senate Finance Committee, the floor debates, and the full Congressional record, do you believe that Treasury's interpretation of exchanges was reasonable?

Ms. MCMAHON. Yes. I believe it was reasonable and indeed the better interpretation of the statute.

Ms. SPEIER. Thank you, Mr. Chairman.

You've been very generous. I yield back.

Mr. LANKFORD. Dr. Gosar.

Mr. GOSAR. Well, presentation of facts.

Ms. McMahon, are you—are you aware that the IRS and Treasury's analysis of relevant legislative history considered the House bill and House floor statements prior to December 24th of 2009? You actually reviewed prior bills before——

Ms. MCMAHON. I believe that the prior bills were taken into account——

Mr. GOSAR. Isn't it true that the House passed the exact same version of Obamacare as the Senate passed? Let me rephrase it again. Isn't it true the House passed the exact same version of Obamacare as the Senate passed? I mean, Scott Brown may—have I think it's an easy answer.

Ms. MCMAHON. I believe that's correct.

Mr. GOSAR. It is a yes.

Isn't it also true that the House debate prior to the passage of Obamacare in the Senate on December 24, 2009 cannot be considered relevant legislative history? So prior to taking this up, so prior to December 24th, that history prior to that cannot be brought up. It's not relevant.

Ms. MCMAHON. I'm not sure that we can make—I can make an equivocal statement——

Mr. GOSAR. How long have you been in your post?

Ms. MCMAHON. I have been in my particular job at the Treasury Department for 4 years, approximately.

Mr. GOSAR. Okay. Do you recognize that a search of the House debate prior to December 24, 2009 was inappropriate and could not be considered relevant legislative history?

Ms. MCMAHON. Congressman, I'm afraid I——

Mr. GOSAR. The answer is yes. The answer is yes.

Ms. MCMAHON. Well, Congressman, I'm afraid I don't really understand the question——

Mr. GOSAR. Well, you're taking prior information, you're taking that what was actually debated on the House that had nothing to do with the Senate version. Because what I asked you is, the House passed the exact version of the Senate, did it not? It did. So the relevant aspect does not apply. It is not inappropriate to consider that discussion prior to December 24th, 2009 in discussions of what the law means.

Ms. MCMAHON. Congressman, with all due respect——

Mr. GOSAR. See, I'm really having problems here because, see, I'm a dentist. And details are a lot to me. The beauty is in the detail. And I'm having some real problems here that we pick and choose whatever information we want to and the facts that we want to. So let's continue. In the briefings, Treasury and IRS employees told committee staff that the review of the legislative history did not review—include a review of PPACA's two antecedent bills. To the best of your knowledge, is it true that the review of the legislative history did not include a review of PPACA's antecedent bills?

Ms. MCMAHON. Congressman, I would have to go back and ask that question of the Treasury staff. I can't recall at this point the answer to that question.

Mr. GOSAR. This is—I mean, here we're talking about something that I know a little bit about, about healthcare, about something so personable to people that we ought to get this right.

I'm going to ask you again. Are you aware that the antecedent Senate bills condition premium tax credits on State compliance?

Ms. MCMAHON. Congressman, I am unfortunately not prepared to discuss the antecedent bills. I'm happy to take the question back and provide you with an answer later.

Mr. GOSAR. Do you think the questions I'm asking are relevant? These antecedent bills, are they not relevant?

Ms. SPEIER. Mr. Chairman.

Mr. GOSAR. I do not yield.

Ms. MCMAHON. Congressman, I am not suggesting that your question is irrelevant. You are obviously entitled to ask any question that you like. And we will do our best to answer your question.

Mr. GOSAR. This is very important, don't you think? I mean, you know, in constructing this legislative agenda and looking at this, the beauty is in the details. And this is very, very pertinent information very, very pertinent information. Because what I see here is we have this Senate bill, and it came over to the House, and they passed it verbatim. No changes. Because they couldn't afford the changes. Because, I mean, that's where I want to go to next, is this letter from the House.

At the April briefing you had with committee staff, you were shown a letter that Texas Democrats in the House sent to President Obama, then Speaker Nancy Pelosi, and then Majority Leader Steny Hoyer. During that briefing, you stated that that was the first time you had seen the letter. Is that correct?

Ms. MCMAHON. That is correct.

Mr. GOSAR. Did anyone at IRS and Treasury consider that unusual circumstances of the passage of PPACA, more specifically, the election of Scott Brown in January of 2010, meant House Democrats needed to pass a Senate bill that they knew was flawed or not pass a bill at all? You are aware of the numbers in the Senate, right? So it wasn't going to move unless it was exactly the same bill.

Ms. MCMAHON. I am aware of generally of the process that led up to enactment of the Affordable Care Act. I cannot tell you in detail whether the particular—the political aspects of that that were considered in a manner you are suggesting.

Mr. GOSAR. I think this is very important, ma'am. Because it is very pertinent to the law. Because the Senate bill is very poignant to State-run exchanges. It doesn't talk about Federal exchanges or those States that opt out. It only talks about State exchanges. And that's what's so interesting about this context, is the beauty is in the details. We're not entitled to pick and choose if it doesn't exist in statute. And that's why this is meaningful. And that's why we want answers to all these questions. So I would expect the answers back.

I yield back, Mr. Chairman.

Mr. LANKFORD. Thank you.

Ms. McMahon, let me ask a separate question. And it deals with the advance subsidy of the tax credit. Those tax credits are going to be sent to those who qualify monthly. Doesn't get sent to them; it gets sent to their insurer, correct, their qualified health plan?

Ms. MCMAHON. That's right, to the insurance.

Mr. LANKFORD. So I'm going to give you a hypothetical situation, just trying to process through this. We've got a person that qualifies for it. They sign up. They go through the process. Payments start getting sent. Four months into it, the individual stops paying their portion; the government still continuing to pay theirs. The individual stops paying their portion. Is there a system in place for the insureds to notify the IRS to let them know, hey, this person stopped paying? And do we know yet how that is going to function? I know that is separate—somewhat connected to I think where

you're at. But do we know yet how it's going to work? That's a recent question that's come up.

Ms. MCMAHON. Congressman, that is an aspect of the implementation of the Affordable Care Act that I am not personally involved with; the IRS is handling, I believe, those sorts of questions.

Mr. LANKFORD. Okay. It's an interesting thing that we're just processing. I didn't know if you were connected in that group at all, what it may be. We don't know yet how, if someone stops paying at some point, how everybody is going to be notified or what the consequences for that are or how it's going to work.

The reference that we've talked about a couple times about the "such exchanges" piece, Treasury has argued that the "such exchange" in 1321 refers back to 1311, really puts them as equivalent. Is that correct?

Ms. MCMAHON. Yes, that's correct.

Mr. LANKFORD. In the memo, that seems to be the crux of the argument to say that they connect it to. In the reconciliation report, though, it lists them separately. It lists a 1311 and a 1321 and keeps them separate. And I think part of the struggle that we have is trying to figure out the reconciliation language seems to keep the Federal and the State exchanges different. They don't just refer to the—if they are equivalent, why refer to both and keep them separate? So there is some ambiguity in the law. And I know the earlier panel, you weren't privy to be able to hear some of the earlier conversation. But this ongoing conversation about what does the statute say and what does the statute mean or what is the purpose of it? A couple times you've referenced that you felt like it was the purpose of the law to be able to provide this coverage. We're struggling with what the text of the law says. And that's a part of the challenge of it.

You also mentioned you went back through legislative history and couldn't find anything that had the carrot and the stick approach. Did you also find anything through the legislative history that you can recall about suggesting there would be tax credits for those that are in Federal exchanges?

Ms. MCMAHON. In our review of the legislative history, we did not find any specific references to the premium tax credit being available in either State exchanges or Federal exchanges, is my recollection. They are—our review of the legislative history was consistent with our understanding of the purpose of the Affordable Care Act, which was that the credits would be available in all exchanges, whether State or federally facilitated.

Mr. LANKFORD. Okay. During the briefing, you mentioned the three different briefings and the request for documents that came up. That there were about 50 emails that Treasury considers privileged emails that are related to this topic. Would there be a day at some point we could see those things even in camera, evaluate these 50 emails? Do you know why they would be considered privileged information?

Ms. MCMAHON. Mr. Chairman, the letter that we sent this morning explains our concerns with the release of additional documents. That being said, I mean, we are still in ongoing discussions with your staff about providing you with any additional information that you may need, and we're happy to continue those conversations.

Mr. LANKFORD. Okay. I just note that I've dealt with counsel before. And attorneys, they take copious notes, as your staff behind you is currently taking copious notes as well, rightfully so, the right thing to do. And that's part of our challenge of this, is that we know that those notes would have occurred because it's important when you deal with issues this large. And obviously $600 billion-plus decision is going to have some sort of note taking through the conversation, how that actually occurred and then track with it. We'd just like to have to opportunity to be able to know did that function in the days ahead.

With that, I recognize ranking member Ms. Speier.

Ms. SPEIER. Mr. Chairman, I'm going to forgo asking any additional questions but reserve my right, depending on how the rest of the questioning goes.

Mr. LANKFORD. Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman.

The—I think that Ms. Speier is absolutely right, that for everybody who works in the executive branch—you do deserve an apology. You deserve an apology from Democrats, who refuse to do good oversight on Democratic administrations, and Republicans, who refuse to do good oversight on Republican administrations. That—that issue that Ms. Speier cites is spot on. It's outrageous that the Congress passed a statute that said "exclusively," and we've been operating under an IRS regulation that says "primarily," and absolutely no one is doing anything about it. And for the life of me, I don't understand how we advantage those of you in public service when we pass statutes and then refuse to follow up and make sure those statutes are implemented.

I want to ask my question again because I think you're very proud of your team and I think you're very proud of the work your team has done. And I'm thinking only one of two things are true of all the discussions you've been involved in on this issue: Either folks have talked about how important this is to the President's agenda, and that we need to come down on that side of the issue in order to make that domestic social policy a reality, or those conversations have never occurred at all. It would be shocking to me that folks—we all like to work on a team. I've sat on the same row that your staffers have sat on behind you. We all want to see our—our ideas succeed, and we want to see the American people served.

Do you recall, in all of these extensive conversations, all of this aggressive review of the $600 to $700 billion question, do you recall any conversation about how important it was to get to this interpretation because without this interpretation, the President's chief domestic policy agenda would crumble?

Ms. MCMAHON. Congressman, I do not recall conversations of the specific type that you describe. We did, as I've said, a very careful and thorough analysis of the statute. We recognized that the interpretation that was being put forward that the credit would not be available in Federal exchanges would have been a very different approach than we believe was contemplated by the Affordable Care Act. We appreciated that it would have been a very significant difference. However, we analyzed this question, applying longstanding principles of statutory construction——

Mr. WOODALL. I appreciate your answer earlier, where you said no reasonableness. This wasn't a reasonable interpretation, this was a proper interpretation. Right? We don't want folks to try to get to the reasonable interpretation; we want them to get to the proper interpretation. I appreciate your emphasis on that.

Let me go pack to something Mr. Cartwright asked earlier, and Ms. Speier may have touched on it as well, talking about how Tax Code treats people in different States differently. I remember when we passed the sales tax deduction. And up until then, we only gave a deduction for State taxes to those citizens in States that had State income taxes. If you didn't have a State income tax, you didn't benefit from this proposal. In the statute that we're talking about today, we said, if you do what we want you to do, you'll get your full Medicaid allotment of dollars. But if you don't do what we want you to do, you're not going to get any Medicaid dollars at all. Quite contrary to that larger purpose of trying to provide care for everyone in America, this statute said explicitly not only are you not going to get care tomorrow, we're going to take away the dollars that you're using to get care today. And the Supreme Court rightfully said that's an outrageous use of Federal power.

So it seems like there are lots of examples in our history, in our present, of using the Tax Code to treat some people in some States differently than we do people in other States. And to use the Affordable Care Act as a hammer, not a carrot approach, but the stick.

Did you consider those things—and do you agree with my analysis of those two circumstances as they exist today? And did you consider those in the analysis that you performed?

Ms. MCMAHON. Congressman, I mean, yes. We are aware of the provisions that you describe relating to Medicaid and the State——

Mr. WOODALL. The stick approach as opposed to the carrot approach.

Ms. MCMAHON. However, as I've said, in our review of the legislative history, including the floor debates, we found no evidence that there was any discussion of the carrot/stick approach in connection with the premium tax credits.

Mr. WOODALL. But it is consistent with past IRS practice to treat folks in some States differently than we treat folks in other States based on statute. Only those with income taxes get to deduct income taxes; only those with State exchanges get to deduct insurance premiums. That's consistent with past practice.

Ms. MCMAHON. Congressman, you are correct that taxpayers in States that have no income tax are entitled to deduct their sales taxes. That is not an IRS practice. It is a provision of the Internal Revenue Code.

Mr. WOODALL. Because the statute chose to treat people in some States differently than it chose to treat people in other States.

Again, I thank you very much for being here. Thank you, Mr. Chairman.

Mr. GOSAR. [Presiding.] I think the gentleman.

Ms. Speier.

Ms. SPEIER. I'm going to thank Ms. McMahon for being here. You did yeoman's work under taxing circumstances. And we thank you for your service to our country.

Ms. MCMAHON. Thank you, Congresswoman.

Mr. GOSAR. Thank the gentlelady.

I thought for a second I saw a smile. Warm a dentist's heart. I'm going to ask a few more questions, and you're holding up well. So continue that smile.

Prior to the release of the proposed rule in August of 2011, Treasury produced a proposed regulation clearance package, August of 2011. In this clearance package, the issue of whether subsidies would be available in Federal exchanges is not even mentioned. Why not?

Ms. MCMAHON. Congressman, I don't recall. I did not prepare the memo that you are referring to. I don't recall why the issue was not included in the memo. However, I do know that the issue was discussed and considered actively before the issuance of the proposed regulations.

Mr. GOSAR. Who at Treasury produced this clearance package?

Ms. MCMAHON. I don't have it in front of me, but it is usually the staff attorney within the office of tax policy who is the principal liaison to the IRS Treasury working group that works on the regulations. I think the memo that you were referring to was produced by David Gamage, who was that attorney at the time.

Mr. GOSAR. Make sure we have that access, please. That answer. Make sure it's specific. I know you gave us the answer but you were kind of unsure.

Ms. MCMAHON. I can certainly provide that.

Mr. GOSAR. Thank you. You were part of a team that briefed committee staff in April on IRS and Treasury's decision to extend tax credits in Federal exchanges. Do you recall Rebecca Ewing or your staff telling committee staff that in the early stages, there were no real discussions of whether tax credits would be available in Federal exchanges, and that a conclusion was quickly made that tax credits would be available in all States?

Ms. MCMAHON. Congressman, to the best of my recollection, what our staff said at that briefing was that originally the working group had assumed that the premium tax credits would be available in both State and federally facilitated exchanges, because that was consistent with their understanding of the Affordable Care Act. However, when we identified this interpretive question after reading a press article, at that point there was discussion of that question and analysis performed.

Mr. GOSAR. And as a follow-up, if 1311 and 1321 exchanges are equivalent, as the administration argues, why was it necessary to mention both Sections 1311 and 1321 in the reporting requirement added by reconciliation?

Ms. MCMAHON. Congressman, I really don't know why there was a difference in the language used in the reporting—information reporting provision that you cite and other portions of Section 36B. As I've said, we did look at not only 36B, but other provisions of the ACA, and we were not able to find a clear pattern for when references to "exchange" or "exchange established by a State" or "Federal and State exchanges" were used.

Mr. GOSAR. I just guess my point is, if they were the same, wouldn't mentioning 1311 be sufficient? I mean, I'm also one of those clear path of least resistance, two points of reference. If

they're all the same, 1311, that's all you'd have to do. So it shows us a moniker that there's some kind of problems here statutorily.

Ms. MCMAHON. Well, Congressman, there are other relevant provisions of the ACA that refer simply to an exchange, including provisions relating to advance payments of the premium tax credit and determinations of eligibility for the premium tax credit. And the term "exchange" is defined broadly to include both State and Federal exchanges.

Mr. GOSAR. But the Senate bill is about State exchanges, not about Federal exchanges.

Now, did anyone at IRS or Treasury consider that Congress referenced both 1311 and 1321 exchanges because they intended those exchanges to be treated differently?

Ms. MCMAHON. Congressman, our interpretation of Sections 1311 and 1321 was that, in fact, Congress intended them to be functional equivalents, that the Federal exchange would be a functional equivalent of——

Mr. GOSAR. So I guess my point, not to interrupt you here, but I have to, is, is that the Federal bill or the Senate bill talks only about State exchanges for these subsidies. I mean, this is a sticking point.

See, we have this balance. There's the judicial branch, the executive branch, and the legislative branch. And what we have to start doing is, is when we write poor legislation, we have to acknowledge we have got poor legislation. And we can't have the judicial branch stepping in or the executive branch messing into that. It has to go back and redefined. There are consequences for writing bad language. Do you understand that? We can't go in here with judicial branch going and intercepting the legislative branch. It doesn't work. And that's why we're in a sticking point right here. Do you understand that?

Because it seems like we're missing—we've got a bunch of eggs here, and we're mixing eggs right and left, lemons, oranges, everything in that basket. We looked at details on House legislation prior to December 24th, 2009, and yet the House passed the exact same version of the Senate bill. This is where our problem is and this is kind of the sticking point.

Prior to your April 2013 briefing with committee staff, did you ever raise a point that the law referenced exchanges established by the Senate under Section 1311 only when Congress was making requests for States for actions?

Ms. MCMAHON. I'm sorry, Congressman. I'm not sure what you're asking. Did I raise this question when?

Mr. GOSAR. In April of 2013, this year in April, did you ever raise the point that the law referenced exchanges established by the State under Section 1311 only when Congress was making requests for States for actions?

Ms. MCMAHON. Congressman, we considered the language of 1311 and 1321 in conjunction with our development of the proposed regulations, which occurred in 2010 and 2011.

Mr. GOSAR. Can you do follow-up for any evidence that you may be able to provide along those lines?

Ms. MCMAHON. Congressman, I can take your request for additional information back and we will see if we can provide you with additional information.

Mr. GOSAR. I would hope so.

Mr. GOSAR. Before it was ruled unconstitutional by the Supreme Court, the PPACA withdrew all Medicaid funds to States that did not expand Medicaid. Withdrawing all Medicaid funds in noncompliant States also appears inconsistent with the purpose to make health insurance affordable for all Americans who cannot otherwise afford it.

Was the decision to withdraw all Medicaid funds consistent with the purpose to expand health insurance?

Ms. MCMAHON. Congressman, I am not an expert on Medicaid, but I believe that the particular provisions relating to Medicaid and the situation you describe were well known at the time of the enactment of the Affordable Care Act, and the consequences to the States of expanding or not expanding Medicaid were discussed at the time.

Mr. GOSAR. So did you see any parallels, did you personally see any parallels with how we restricted or looked at the restriction of Medicaid funds to States with parallels for exchanges in the State—in States?

Ms. MCMAHON. Congressman——

Mr. GOSAR. Was that part of an analysis of it?

Ms. MCMAHON. As I've said, we did not find any evidence in the legislative history that Congress intended a carrot-and-stick approach with respect to the premium tax credit. In contrast to that, the provisions you describe relating to Medicaid were discussed and debated at the time of the passage of the Affordable Care Act.

Mr. GOSAR. So do you recognize that, looking at this law, that there are applications that would actually expand insurance under this law, health insurance under this law? Do you recognize that?

Ms. MCMAHON. Congressman, the purpose of the Affordable Care Act overall——

Mr. GOSAR. I don't want that purpose, I want your personal evaluation. There's inadequacies here that are actually going to stymie health insurance for individuals. Do you agree with that?

Ms. MCMAHON. Congressman, we are concerned, obviously, that States that choose not to expand Medicaid——

Mr. GOSAR. Well, even those States that take it, there's a problem here. Do you not see that there's a conflict in the way the application of the law, regardless of how we apply this, that there's going to be an inadequacy about how we actually get insurance to individuals? Isn't there individuals that are going to be hurt by this law in getting healthcare insurance?

Ms. MCMAHON. Congressman, unfortunately, I am not an expert in Medicaid, and the Medicaid program is not within the jurisdiction of the Treasury Department.

Mr. GOSAR. Okay. So let me go to this. Was the withdrawal of Medicaid funding ever discussed by the IRS or Treasury during their analysis?

Ms. MCMAHON. I'm afraid I don't recall whether that question was specifically discussed.

Mr. GOSAR. If we could ask staff to follow up on that.

Mr. GOSAR. I've got two more. Okay.

Prior to your April 2013 briefing with committee staff, did anyone at IRS or Treasury bring up that the reconciliation bill explicitly created equivalence between territorial exchanges and exchanges established by the Senate and State?

Ms. MCMAHON. Congressman, I'm afraid I don't know the answer to that question either off the top of my head.

Mr. GOSAR. So will you supply the answer?

Ms. MCMAHON. I can take that question.

Mr. GOSAR. Yeah. And last but not least. Did anyone at IRS or Treasury consider that Congress, as they did with U.S. territories, could have explicitly offered tax credits in Federal exchanges through reconciliation?

Ms. MCMAHON. Congressman, as I've said, we believe that our interpretation was consistent with the provisions of the statute as a whole, as it was finally enacted. I don't know personally whether the working group considered the language of the antecedent bills in their analysis.

Mr. GOSAR. Thank you.

I'm going to yield back to the chairman of the full committee.

Mr. ISSA. [Presiding] You're nearly done. This is almost administrative, but I'd like to go through a couple of things with you. You used a term just now, perhaps you could repeat it: You tried to work consistent with the final enactment of the bill. Could you repeat what you said? Or I can have it read back.

Ms. MCMAHON. I believe what I was trying to say was that in our rulemaking process we analyzed the Affordable Care Act in its final form in the manner in which it was finally enacted.

Mr. ISSA. Okay. Well, let's take that, because you're a political appointee. Your job is to do the bidding of the President. The people who did the analysis, I assume, are political appointees who did the bidding of the President. The President wanted the Affordable Care Act and clearly wanted it to be as broad as he could even when States pushed back and said no. Is that a fair statement, at least from this side of the dais?

Ms. MCMAHON. With all due respect, I do not believe that——

Mr. ISSA. Are you a political appointee?

Ms. MCMAHON. I am personally a——

Mr. ISSA. Were the other individuals involved in the analysis primarily political appointees?

Ms. MCMAHON. No. In fact, they were not. The working group of tax lawyers that did most of the work on development of these regulations included career IRS staff attorneys in the Office of Chief Counsel and nonpolitical staff attorneys in Treasury's Office of Tax——

Mr. ISSA. Well, great. Then where the hell's the paper on that? Quite frankly, you claim to have sent me 500 pages. We got 386 pages, and 154 of them are the proposed rule itself. Where is the analysis? Congress doesn't agree with you, at least the House of Representatives, that your rule is consistent with the law. We asked for the analysis. You've stonewalled us. Where is the analysis?

Or are we going to get into the deliberative process? Are we going to get in to how you decide to make a decision that's not sup-

ported in the law? You're not going to give us papers that effectively tell where that is. Are you prepared today to say you've given us full discovery when you say you have career lawyers who worked on this? Where are the notes, recommendations, analysis that we asked for?

Ms. MCMAHON. Mr. Chairman, Al Fitzpayne of the Treasury Department sent a letter to you and others this morning that explains our concerns relating to confidentiality and sensitivities relating to the active, ongoing litigation, concerns relating to our—your requests for additional documentation.

That being said, his letter did describe the documents that we—additional documents to the ones that you have seen that we discovered in our internal search, and——

Mr. ISSA. Well, let's go through your search. $600 billion this bill's going to cost, and you tell us there's 50 emails that are responsive to that. Is that really what you're saying? Did you not use email at Treasury?

Ms. MCMAHON. Mr. Chairman, I have not personally reviewed all of the documents that were discovered in the——

Mr. ISSA. Okay. So it's very possible that there are more documents.

Ms. MCMAHON. Mr. Chairman, I simply don't know. I did not perform the internal search. That was not done by——

Mr. ISSA. Okay. Well, let's go through it. The deliberative process behind—in this letter that arrives in anticipation of your being here, I suspect. Your letter also requests information concerning deliberative process behind 36B regulations. In addition, you describe a telephone conversation with Treasury staff from March 2013 regarding such information. We disagree with your description, but you've given us no information.

I'm going to send you back with a couple of things here today. One of them is this body has every right to the most sensitive information, period. Now, every day we have State Department deliver us classified information related to Benghazi. The keeper sits there, people who are cleared for classified information go through that.

If Treasury wants to make sure that information that is known to be such that you do not want it subject to release because of ongoing litigation, tag it, bring it in here, let us look at it.

If I do not get either in camera all discovery or hauling it back and forth as appropriate and full disclosure, not only will I issue a subpoena, but I'm going to have to do a lot more.

The American people are about to spend more money on this program perhaps than any other program launched in its infancy. This is very expensive.

And you mentioned Medicaid. Obamacare is effectively simply a Federal-pays-both-sides large Medicaid program. That's really what it's becoming. The Federal taxpayers are going to be on the hook for huge amounts of money.

All we're asking for is that you obey the law as written and you provide us information when we believe that you created a rule that the last panel couldn't find actual language that would allow you to have that interpretation.

You've said here today under oath that in fact you had a significant number of people, career professionals who did analysis. You've given this committee no such analysis.

I'm sending you back very simply. You were pretty close to a useless witness who came saying, I don't know. And if history is of any indication, the things you said you'll take back for the record, you won't come back with any answers. You didn't send 500 pages. You didn't send 386 responsive pages. You sent almost nothing.

The American people, if they're going to spend trillions of dollars and if they're going to have mandates that are not within the language of the legislation, they deserve that analysis, they deserve it to be nonpolitical, they deserve it to in fact have come out of something other than political appointees figuring out how to circumvent a change in the House of Representatives. It's that simple.

Thank you for being here. Do you have anything in closing?

Ms. MCMAHON. No, Mr. Chairman.

Mr. ISSA. Thank you. We're adjourned.

[Whereupon, at 1:59 p.m., the subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Opening Statement of Chairman James Lankford
Subcommittee on Energy Policy, Health Care and Entitlements

"Oversight of IRS's Legal Basis for Expanding Obamacare's Taxes and Subsidies"

July 31, 2013

Today's hearing continues this Subcommittee's oversight of the Administration's implementation of Obamacare.

While the substance discussed during today's hearing may be complicated, the principles involved are not. Congress makes laws, and the President and the executive branch are responsible for carrying these laws out. At issue today is an example of the Administration rewriting the law to meet its political objectives.

In 2010, Democrats with overwhelming majorities in both Chambers of Congress passed a law that expanded the scope of federal government control and involvement over American's health care choices through a complex scheme of mandates, rules, taxes, and subsidies.

To encourage states to set up state based exchanges, the Senate and House created subsidies for individuals only in states that operate their own health exchange. In Section 1311 of the Affordable Care Act, a health insurance exchange is defined specifically as a "governmental agency or nonprofit entity that is established by a state." In Section 1401 of the law, the subsidy is provided monthly when the taxpayer is "covered by a qualified health plan..... that was enrolled in through an Exchange established by the State under section 1311."

As a Congressional Research Service legal analysis has made clear, the language is straightforward.

According to the Congressional Research Service:

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

At the time that Congress passed Obamacare, the Administration confidently predicted that it would become more popular and states would willingly create their own exchanges. However, 34 states have refused to participate and left building the exchange to the federal government.

Therefore, the impact of the IRS and Treasury rule that extends tax credits to individuals in federal exchanges is substantial.

First, CBO has estimated that roughly 75% of the cost of the subsidies will be new federal spending. As a result, this rule will add hundreds of billions of dollars of federal spending, which was not authorized by Congress in the statute.

Second, the subsidies are tied to the law's employer mandate so that employers face large tax penalties if their workers receive subsidies. Therefore, IRS's and Treasury's rule directly harms many employers and workers in states that chose not to create an exchange.

My State of Oklahoma is one of these states. The leaders in my State decided to protect our employers and workers from the employer mandate tax penalties and protect future generations of Americans who will face increasing debt by not creating a State Exchange. That was their option within the law, but now the IRS and Treasury's rule has invalidated my State's decision, harmed many employers and workers in my State, and added to the federal deficit.

Because of the significance of this rule, this Committee, along with the Ways and Means Committee, has conducted oversight for over a year, focusing on the process and factors IRS and Treasury considered.

The evidence we have gathered is consistent:

The IRS was given an enormous role in implementing many Obamacare provisions but the issue of whether tax credits would be available in federal exchanges was not given substantial time or attention.

Prior to the proposed rule, the IRS only had a single, weak reason supporting their interpretation: that the designation that the Secretary create a federal exchange in

States that choose not to operate their own was enough to authorize subsidies in those States as well.

After several media commentators pointed out that the IRS rule was inconsistent with the statute, Treasury assigned one individual to gather additional information. Rather than doing an unbiased review of the statute and legislative history, it appears this individual only sought information to support the predetermined conclusion that the tax credits would also be available in federal exchanges.

At three briefings with Committee staff, IRS and Treasury officials could not remember details and could not provide evidence for factors they may have considered. There is virtually no evidence to support Treasury's assertion that they "carefully considered the language of the statute and the legislative history."

For example, in a letter to Chairman Issa on October 12, 2012, Assistant Secretary for Tax Policy Mark Mazur stated that there is no discernible pattern to how Congress used the term Exchange in Obamacare. But, during the course of these briefings, IRS and Treasury employees admitted that they didn't organize or categorize the usages of Exchanges *in any way* to look for a pattern.

Today, I hope to gain a bit more clarification from Emily McMahon, the Deputy Assistant Secretary for Tax Policy, about IRS and Treasury's careful consideration of the statue.

I also look forward to hearing from several witnesses in the first panel, including my good friend Scott Pruitt, the Attorney General of our State, for their perspective on the IRS rule.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

December 6, 2012

Honorable Darrell E. Issa
Chairman
Committee on Oversight
and Government Reform
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter responds to your request for information about CBO's March 20, 2010, cost estimate for H.R. 4872, the Health Care and Education Reconciliation Act of 2010, in combination with H.R. 3590, the Patient Protection and Affordable Care Act. Specifically, you asked for a description and explanation of CBO's assumption that the premium assistance tax credits established by that legislation would be available in every state, including states where the insurance exchanges would be established by the federal government.

To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state. CBO's analysts reviewed H.R. 4872 and H.R. 3590 to try to ensure that the agency's estimate accurately reflected the legislative language, as they do for all legislation that they analyze, but that question did not arise in the course of that review, and CBO did not perform a separate legal analysis of that issue.

I hope this information is helpful to the committee.

Sincerely,

Douglas W. Elmendorf

cc: Honorable Elijah E. Cummings
Ranking Member

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Opening Statement
Rep. Jackie Speier, Ranking Member

Subcommittee on Energy Policy, Health Care and Entitlements
Hearing on "Oversight of IRS's Legal Basis for Expanding Obamacare Taxes and Subsidies"

July 31, 2013

Thank you, Mr. Chairman.

Congress passed the Affordable Care Act to make affordable health care available to all Americans. It is the law of the land and it is already working. More than 3 million young adults who would otherwise have been uninsured are now able to stay on their parents' health insurance. More than 20 million children with pre-existing conditions can no longer be denied health insurance. Seniors have saved more than $7 billion on their prescription drug costs. Those are just a few of the benefits that have already kicked in.

The full impact of the ACA will not be felt until next year. Many states that have embraced Obamacare and implemented their own exchanges have already announced lower premiums—in some cases dramatically lower—than even we expected. And that is despite offering better benefits, including free preventative care, no lifetime limits on coverage, and not being able to deny customers because they have a pre-existing condition. In California, average premiums in the exchange for 2014 are from 2%-29% lower than average premiums this year. In New York they will drop as much as 50%.

The law is working, and maybe that is what its opponents are afraid of.

What happens when Congress passes laws? Agencies implement them.

That is why the Treasury Department issued regulations implementing provisions of the Affordable Care Act that relate to premium tax credits the Act authorizes to make health insurance affordable to low income earners. I know that when I voted for the law, it never occurred to me that Americans could be treated differently simply because of where they live. No one ever debated using these subsidies as a carrot or stick to get states to implement their own exchange. I expected as many Americans as possible to get affordable coverage, and help if they need it. Why would we give a tax credit to a taxpayer seeking health insurance in one state, and not a similarly situated taxpayer in another state?

Since the fall of 2012, this Committee has been scrutinizing Treasury's implementation of the Affordable Care Act's tax provisions, including the provision of tax credits to those who meet certain income criteria. Treasury has produced documents, given high level briefings, and permitted committee staff to study sensitive documents without redactions.

What we found was that Treasury followed the same transparent procedures in issuing this regulation that it has used in implementing other laws Congress has enacted. We have found no evidence to the contrary.

Chairman Issa also consulted CBO late last year, which confirmed that its score of the Affordable Care Act—at the time it was passed in March 2010—assumed that tax credits would be available to residents in all states, including states where the exchange was established by the federal government. I ask consent to enter the CBO's response to Chairman Issa into the record.

As we all know, there are detractors who have never liked the Affordable Care Act. They marshaled their best arguments and vigorously advocated to anyone who would listen. First, they tried to stop the Affordable Care Act in Congress. They failed. Then they took to the courts, and pursued their case all the way to the U.S. Supreme Court. They lost there too. The continual effort to roll back time has become frustrating even to members of the Majority's own party. Senators Coburn and McCain now categorize the House efforts to defund ACA as dishonest and hype. Dr. Coburn stated, and I quote "The worst thing is being dishonest with your base about what you can accomplish, ginning everybody up and then creating disappointment," "It's a terribly dangerous and not successful strategy." [End quote].

Those attempting to sabotage Obamacare aren't giving up, but all they are left with now are their second-best legal arguments. Today's hearing was called by the majority to put the best light on these one of these arguments.

Indeed, two witnesses called by the majority on today's first panel are litigants in pending lawsuits on this very topic. While I appreciate that these witnesses have traveled today to give us their interpretation of the legality of certain aspects of the health care law, I want to make this abundantly clear: this hearing is not the proper forum to litigate the merits of these cases. This subcommittee hearing room is not a courtroom.

I hope that no members intend to use this hearing or any documents obtained in the Committee's investigation to try and influence the litigation.

Mr. Chairman, as you know I am a strong believer in the importance of Congressional oversight. But I do not believe that we should insert this subcommittee into active litigation under the guise of oversight. I hope that you will exercise your discretion as Chair of the Committee and direct the Members today to avoid asking questions which could jeopardize, in any way, a fair trial for all litigants. Otherwise, I believe you may, intentionally or not, permit the legal process to be tainted by political interference. This simply does not serve any legitimate goal of this Committee or the Congress.

That said, these arguments present real world implications for millions of hard working Americans who will be seeking access to affordable health insurance over the next several months and in the future. If Mr. Pruitt's lawsuit were to prevail, all he would achieve is making health care unaffordable to over 300,000 Oklahomans, who would no longer be able to receive premium tax credits to help them buy health insurance in Oklahoma. Contrary to any ideological victory some may think could be won by his lawsuit, the reality of a legal victory is a terrible loss for the lower income people in Oklahoma who pay the Attorney General's salary and whose taxes are even underwriting the very lawsuit that would deny them benefits.

We are all public servants, and we should be better than that. We should be looking to implement the law so that the reality matches the purposes, and that it is done in as effective and efficient a manner as is possible.

Unfortunately, this Congress will be voting this week for at least the 40th time to repeal or defund the Affordable Care Act in whole or in part. So while I'm not happy that a State Attorney General would pursue litigation that is so contrary to the general welfare of the people of his state, I have to concede that the current House of Representatives, in its desperate attempt to gut this law, is not setting much of an example.

I thank the witnesses today for their appearance. I yield back the remainder of my time.

Contact: Jennifer Hoffman, Communications Director, (202) 226-5181.

CONGRESSIONAL DISTRIBTION MEMORANDUM

July 23, 2012

From: Jennifer Staman and Todd Garvey, Legislative Attorneys

Subject: **Legal Analysis of Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act**

This memorandum has been prepared for distribution to more than one congressional office.

This memorandum analyzes whether premium tax credits available to certain individuals under §36B of the Internal Revenue Code, as established under §1401 of the Patient Protection and Affordable Care Act (ACA),[1] would be available for individuals who participate in federally created health insurance exchanges. It has been argued that, under this section, premium tax credits would only be available in exchanges established by a state and not those established by the federal government. This memorandum provides a brief background on relevant provisions of ACA, addresses considerations that a court could take into account in interpreting the statutory language of §36B of the Act; and, finally, discusses how regulations implementing the premium tax credit could be evaluated.

Background

As part of ACA's intended goal of improving the private health insurance market and accessibility for health coverage, ACA specifies that by January 1, 2014, each state must establish an American Health Benefit Exchange ("exchange") that is either a state governmental agency or a nonprofit entity, in order to provide health coverage to qualified individuals and/or employers.[2] ACA generally provides that if a state does not elect to establish an exchange, or if the Secretary of Health and Human Services (HHS) determines that an electing state will not have an operational exchange by January 1, 2014, or has not taken certain specified actions, the Secretary must establish and operate an exchange within the state.[3]

In order to assist individuals in purchasing health insurance in an exchange, §36B of the Internal Revenue Code, created by §1401 of ACA, provides that, beginning in 2014, certain lower income taxpayers may receive a refundable tax credit that is paid directly to an insurer and applied toward the cost of the health insurance premium.[4] In general, there are two principal factors one must consider in determining whether

[1] P.L. 111-148 (2010). ACA was amended by the Health Care Education and Reconciliation Act of 2010, P.L. 111-152 (2010). (HCERA). These Acts will be collectively referred to in this memorandum as "ACA." It should be noted that section 1401 of ACA has been subsequently amended, but these amendments are not relevant to this analysis.

[2] P.L. 111-148, §§1311(b)(1), 1311(d)(1).

[3] P.L. 111-148, §1321(c).

[4] 26 U.S.C. § 36B.

a taxpayer will be eligible for a premium tax credit: (1) whether the taxpayer meets the income and other requirements for the credit;[5] and (2) whether any months during the taxable year qualify as "coverage months" for the taxpayer. With respect to this second requirement, in order for a taxpayer to receive a health insurance premium credit under ACA, at least one month in the year must qualify as a coverage month for the taxpayer.[6] The term "coverage month" in §36B means the following:

> [W]ith respect to an applicable taxpayer, any month if--
>
> (i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan ... *enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act ...*[7]

In addition, the amount of the premium tax credit is equal to the sum of the "premium assistance credit amount" for each coverage month the taxpayer experiences during the taxable year. The premium assistance credit amount is defined as the amount equal to the lesser of--

> (A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent ... of the taxpayer *and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act*, or
>
> (B) the excess (if any) of--
>
> (i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over
>
> (ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.[8]

It has been argued that, based on this language in §36B, i.e., "an Exchange established by the State under section 1311 of [ACA]," premium tax credits are not available to taxpayers in exchanges created by the federal government.[9] However, in May 2012, the Internal Revenue Service (IRS) rejected this interpretation in final regulations related to the premium tax credit, providing that premium tax credits are available to taxpayers who obtain coverage in both state and federally facilitated exchanges.[10] The preamble to the regulations explains the IRS's position that the statutory language of §36B supports this interpretation, and provides further that "... the relevant legislative history does not demonstrate that

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[5] In order to be eligible for a premium credit, a taxpayer's household income must be between 100% and 400%, inclusive, of the federal poverty line (FPL) for the taxpayer's family size. 26 U.S.C. § 36B(c)(1). Individuals with income below 100% of the FPL are ineligible for a premium credit, but may qualify for assistance under Medicaid. An exception is made for lawfully present aliens with income below 100% of the FPL, who are ineligible for Medicaid on account of their alien status. 26 U.S.C. § 36B(e). These taxpayers will be treated as though their income is exactly 100% of FPL for purposes of the credit.

[6] 26 U.S.C. § 36B(b)(1). It should also be noted that any month during which an individual is eligible for other minimum essential coverage would not be counted as a coverage month. Examples of other minimum essential coverage include, but are not limited to, affordable employer provided coverage, Medicare, and Medicaid.

[7] 26 U.S.C. § 36B(c)(2) (emphasis added).

[8] 26 U.S.C. § 36B(b)(2)(A)-(B) (emphasis added). It should be noted that the reference to the "silver plan" in subsection (B) refers to one that is offered in the "same Exchange" as plans described in subsection (A). 26 U.S.C. § 36B(b)(3)(B).

[9] *See, e.g.*, Wall Street Journal, Health Law Opponents Challenge Tax Credit, July 16, 2012, available at http://online.wsj.com/article/SB10001424052702303933704577531271643114572.html.

[10] Department of the Treasury, Internal Revenue Service, Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377 (May 23, 2012).

Congress intended to limit the premium tax credit to State Exchanges," and that this reading of the language of §36B "is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole."[11]

Potential Statutory Interpretation of Section 1401 of ACA

In general, the starting point for courts in interpreting the meaning of a statute is the language of the statute itself. The Supreme Court often recites the "plain meaning rule," that if the language of the statute is clear and unambiguous, it must be applied according to its terms. As the United States Supreme Court stated in *Connecticut National Bank v. Germain*:

> [I]n interpreting a statute a court should always turn first to one cardinal canon before all others. We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there .... When the words of a statute are unambiguous, then, this first canon is also the last: judicial inquiry is complete.[12]

Applying the plain meaning rule to §36B, it is possible that a court could read the phrase "an exchange established by the State under 1311 of ACA," as being clear to not include an exchange established by the federal government. Indeed, this language seems to be straightforward on its face, which has perhaps led some commentators to suggest that the lack of reference to a federally created exchange could have been a drafting error.[13] However, courts often assume that the language Congress employs, including additions and omissions to a particular statute, is intentional.[14] Therefore, a court may be inclined to find that §36B presents a clear statement regarding the types of exchanges in which taxpayers may receive a premium tax credit, and may not look to any additional factors in its analysis.[15]

On the other hand, it is possible that a court could find that it is unable to rely on a plain meaning interpretation of §36B, perhaps finding the language to be ambiguous.[16] In examining whether §36B is

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[11] *Id.* at 30378.

[12] 503 U.S. 249, 254 (1992)(citations omitted). *See also* 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, and if that is plain, and if the law is within the constitutional authority of the law-making body which passed it, the sole function of the courts is to enforce it according to its terms.").

[13] *See e.g.*, Brett Ferguson, *IRS Rule Related to Employer Mandate May Be Next Challenge in Courts, Critics Say*, BNA Health Care Policy Report, July 16, 2012 (statements of Judith Solomon).

[14] *See generally*, 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").

[15] It should be noted that there seems to be general consensus that the plain meaning rule aptly characterizes interpretational priorities (statutory language is primary, other considerations of intent and purpose secondary). However, agreement on the basic meaning of the plain meaning rule—if it occurs—does not guarantee agreement in the rule's application. For example, there have been cases in which Justices of the Supreme Court have agreed that the statutory provision at issue is plain, but have split 5-4 over what that plain meaning is. *See, e.g.*, Sedima, S.P.R.L. v. Imrex Co., 473 U.S. 479 (1985) (disagreement over the scope of civil RICO). *See also* Corley v. United States, 556 U.S. 303 (2009). There are other cases in which strict application is simply ignored; courts, after concluding that the statutory language is plain, nonetheless look to legislative history, either to confirm that plain meaning, or to refute arguments that a contrary interpretation was "intended." *See, e.g.*, Thunder Basin Coal Co. v. Reich, 510 U.S. 200, 209 (1994); *see also* Darby v. Cisneros, 509 U.S. 137, 147 (1993) ("Recourse to the legislative history of §10(c) is unnecessary in light of the plain meaning of the statutory text." The Court considered the legislative history, nevertheless, and found nothing inconsistent between it and the Court's reading of statutory language.). For general information on the plain meaning rule, *see* CRS Report 97-589, *Statutory Interpretation: General Principles and Recent Trends*, by Larry M. Eig.

[16] According to a leading statutory construction treatise, "[a] statute is ambiguous when it is capable of being understood by reasonably well-informed persons in two or more different senses." SINGER & SINGER, STATUTES AND STATUTORY

(continued...)

ambiguous, a court may look, for example, to the definition of "exchange" in ACA. ACA defines the term "exchange" as the following:

> EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.[17]

Section 1311 of ACA, as referenced in this definition, seems to only address the creation of state-established exchanges. The section does not explicitly speak to federally created exchanges -- those are addressed in §1321 of ACA. However, section 1321 of ACA also uses the term "exchange": it states that the Secretary of HHS must establish an "exchange" if a state should fail to take certain specified actions:

> (c) Failure to establish Exchange or implement requirements.
>
> (1) In general. If--
>
> (A) a State is not an electing State ; or
>
> (B) the Secretary determines, on or before January 1, 2013, that an electing State--
>
> (i) will not have any required Exchange operational by January 1, 2014; or
>
> (ii) has not taken the actions the Secretary determines necessary to implement [certain requirements]--
>
> the Secretary shall ... establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

Plugging in ACA's general definition of "exchange" into §1321 above arguably links a federally created exchange to one established by a state pursuant to the requirements of §1311. Thus, it may be questioned whether, based on the definition of "exchange," a federally created exchange should in some way be synonymous with one created by a state under §1311 and how this could affect the interpretation of §36B.

If a court considers the language in §36B to be ambiguous, it may look at legislative history and other extrinsic aids to determine congressional intent. While a survey of the legislative history of ACA with respect to §36B is beyond the scope of this memorandum, some have asserted that Congress intended to have premium tax credits only available in state-run exchanges in order to incentivize states to establish an exchange.[18] Conversely, others may claim that premium tax credits were part of ACA's goal of improving access to health care, which is arguably undermined if the availability of premium credits is limited to state-run exchanges. It has also been noted that reports by the Congressional Budget Office and the Joint Committee on Taxation assumed in their analyses of the legislation that premium tax credits

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(...continued)

CONSTRUCTION (Sutherland Stat. Const.) (7th ed.), vol. 2A, § 46.4 (2007).

[17] P.L. 111-148, § 1563(b). Section 1563(b) of ACA, entitled Conforming Amendments, amends section 2791 of the Public Health Service Act. Section 1551 of ACA states that unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act shall apply with respect to title I of ACA (which contains the provisions related to exchanges).

[18] *See* Julie Rovner, *Could the Health Law End Up Back in Court? Opponents Think So*, National Public Radio Health Blog, July 18, 2012, available at http://www.npr.org/blogs/health/2012/07/18/156936766/could-the-health-law-end-up-back-in-court-opponents-think-so.

would be available in both state and federally run exchanges.[19] Arguments such as these may be explored by a reviewing court.

Another important canon of statutory construction provides that parts or sections of statutes or Acts should be evaluated in connection with other parts and sections as one "harmonious whole" – requiring examination of not just one particular provision, but the broader legislative scheme in which the provision is included.[20] A court relying on this canon may look to §36B(f)(3), addressing certain reporting requirements with respect to the premium tax credit. This subsection states:

> "(3) INFORMATION REQUIREMENT.— Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange ...
>
> "(B) The total premium for the coverage without regard to the [premium tax] 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 ...
>
> "(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

Unlike the language in question, §36B(f)(3) addresses reporting requirements which seem to explicitly apply to both state and federally created exchanges (i.e., "Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act")). While one may argue that it is possible for this information requirement to be fulfilled without premium credits being provided to individuals participating in federally run exchanges (i.e., it could be reported to the Secretary that no taxpayer in a state with a federally run exchange received a credit), others may argue that if you look at this provision along with the other language in §36B, this demonstrates congressional intent to have premium tax credits available to taxpayers in both state and federally created exchanges, or, perhaps highlights a discrepancy that must be resolved by a court or the IRS in implementing the provision.

It is also possible that a reviewing court could examine how the language in §36B arises in other provisions of ACA and whether those other applications provide insight as to congressional intent.[21] The phrase "an Exchange established by the State under 1311 of [ACA]" arises numerous times throughout the Act. For example, §2001(b) of ACA, entitled "Maintenance of Medicaid Income Eligibility (MOE)," provides that states with Medicaid programs in effect on the date of enactment of ACA must maintain their programs with the same eligibility standards, methodologies, and procedures until the Secretary of

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[19] *See, e.g.*, Timothy Jost, *Implementing Reform: Funding And Flexibility For States On Exchanges*, Health Affairs Blog (Nov. 30th, 2011), available at http://healthaffairs.org/blog/2011/11/30/implementing-reform-funding-and-flexibility-for-states-on-exchanges/.

[20] *See* Sutherland, note 17 *supra*, at 201. Also, as the Supreme Court has noted, "[i]t is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme... A court must therefore interpret the statute 'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into an harmonious whole.'" FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000).

[21] However, it is important to note that it is possible for two statutory provisions with similar language to interpreted differently. *See, e.g.*, *General Dynamics Land Systems, Inc. v. Cline*, 540 U.S. 581 (2004), where the Court determining that the word "age" is used in different senses in different parts of the Age Discrimination in Employment Act, and that consequently the presumption of uniform usage throughout a statute should not be followed.

HHS determines that "an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational." Thus, as part of an analysis of the §36B language, a court might examine whether the MOE language applies solely to state-created exchanges, or, also to federal-run exchanges. If the MOE requirements end only when a state-created exchange is fully operational, then a question may be raised whether the MOE requirements would continue indefinitely in a state that chose not to establish its own exchange, and whether that would be a result intended by Congress. An assessment of Congress's intent regarding the application of the MOE requirements for state and federally-run exchanges might inform an analysis of the same language in the context of premium credits under §36B.

Administrative Authority to Interpret §36B to Include Federally Created Exchanges

As noted above, the Treasury Department, through the IRS, has issued final regulations that define an exchange, for purposes of §36B, to include both state and federally created exchanges. If these regulations were to be challenged as being outside the scope of the IRS's authority under the Administrative Procedure Act,[22] a determination of whether the Service exceeded its delegated authority in issuing the regulations under §36B may hinge on the degree of deference that a reviewing court accords the IRS's understanding of the scope of its authority under ACA. Courts have traditionally "recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer."[23] However, whether a court will defer to a specific agency interpretation or implementation requires an application of the "familiar standards of review" established in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*[24] In *Chevron*, the Supreme Court outlined what is largely considered a deferential test for reviewing an agency's formal interpretation of its own authorizing statute or a statute it administers. At step one, a reviewing court must determine "whether Congress has directly spoken to the precise question at issue."[25] If Congress has clearly addressed the issue, the court "must give effect to the unambiguously expressed intent of Congress."[26] An agency interpretation that is contrary to the clear intent of Congress must be rejected. If, however, the court determines that Congress's intent is unclear, or that the statutory language in question is ambiguous, the court proceeds to step two. At step two, a reviewing court will generally defer to any "permissible construction" of the pertinent statutory language.[27] This analysis is commonly referred to as the *Chevron* "two-step."

Although *Chevron* is generally associated with judicial review of agency statutory interpretation, the analysis is "principally concerned with whether an agency has authority to act under a statute" and is used

[22] The Administrative Procedure Act (APA) provides standards of judicial review that a court will use to determine whether an agency's action is valid. 5 U.S.C. §§ 702, 704. For example, the APA provides that a reviewing court must set aside agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The APA also states that a reviewing court must "hold unlawful and set aside agency actions, findings, and conclusions found to be … in excess of statutory jurisdiction, authority, or limitations, or short of statutory right. 5 U.S.C. § 706(2)(C).

[23] Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc. 467 U.S. 837, 844 (1984).

[24] *Id.*; Am. Library Ass'n v. FCC, 406 F.3d 689, 698; *id.*

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

[26] *Id.* 842-43. ("If the intent of Congress is clear, that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.").

[27] *Id.* at 843. *See also* Astrue v. Capato, 566 U.S. __, __ (2012)(deferring to the Social Security Administration's longstanding interpretation in regulations issued after a notice-and-comment rulemaking and finding that the regulations "warrant the Court's approbation" as they were "neither 'arbitrary or capricious in substance, [n]or manifestly contrary to statute'"(quoting Mayo Found. for Med. Ed. and Research v. United States, 562 U.S. __ (2011); 131 S. Ct. 704 (2011)).

to discern "the boundaries of Congress' delegation of authority."[28] In 2001, the Supreme Court revisited *Chevron* and reinforced this point. In *United States v. Mead Corporation*, the Court held that an agency's implementation of statutory authority "qualifies for *Chevron* deference 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."[29] *Mead* thus established a threshold requirement (what has been referred to as "step zero"[30]) restricting *Chevron* deference to only formal rules and other interpretations holding the "force of law" and promulgated pursuant to delegated authority. Policy statements, agency manuals, and interpretive letters, on the other hand, generally do not warrant such deference.

Given this framework, the question of whether a reviewing court will defer to the Treasury Department's interpretation of the scope of §36B will depend principally on whether that interpretation was made with the force of law pursuant to an exercise of delegated authority; whether the extent of that delegation was ambiguous; and whether the implemented interpretation was reasonable.

Action Taken Pursuant to Delegated Authority and with the Force of Law

The IRS has asserted that 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."[31] In effect, the agency has interpreted the term "exchange" to encompass all forms of health exchanges envisioned by ACA. As previously noted, §36B generally provides, among other things, that taxpayers may receive a premium tax credit during a "coverage month" where they were "enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act ...."[32] Notably, §36B also provides the Secretary of the Treasury with broad authority to "prescribe such regulations as may be necessary to carry out the provisions of this section...."[33]

Based on the reasoning of the *Mead* case, an agency's implementation of a statutory provision qualifies for *Chevron* deference 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."[34] Under this broad language, it would appear that the IRS Rule would meet *Mead's* preliminary threshold requirement. The IRS Rule was promulgated in the exercise of the broad authority delegated to the IRS to issue rules "necessary to carry out" §36B. Moreover, the Rule was adopted pursuant to notice and comment rulemaking and therefore clearly carries the "force of law." In *Mead*, the Court noted that "congressional authorization to engage in the process of rulemaking" is a "very good indicator of delegation meriting *Chevron* treatment."[35]

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[28] Arent v. Shalala, 70 F.3d 610, 615 (D.C. Cir. 1995).

[29] 533 U.S. 218, 226-27 (2001).

[30] *See, e.g.*, Cass Sunstein, *Step Zero*, 92 Va. L. Rev. 187, 207 (2006).

[31] Department of the Treasury, Internal Revenue Service, Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377, 30378 (May 23, 2012).

[32] 26 U.S.C. § 36B(c)(2).

[33] 26 U.S.C. § 36B(g).

[34] *Mead*, 533 U.S. at 226-27.

[35] *Id.* at 229. It should be noted that the *Mead* opinion has generated confusion among lower courts. The D.C. Circuit has issued a limited number of decisions that appear to more heavily scrutinize the threshold question of whether an agency was acting "pursuant to delegated authority." *See*, American Library Association et al. v. Federal Communications Commission, 406 F.3d 689, 699 (D.C. Cir. 2005) ("The agency's self-serving invocation of *Chevron* leaves out a crucial threshold consideration, i.e. (continued...)

The IRS Rule appears to be an exercise of the authority delegated to the agency to implement §36B, which includes the authority to provide refundable tax credits for taxpayers enrolled in a health insurance exchange. It may be argued that whether the scope of the IRS Rule was a proper interpretation of the statutory delegation, or specifically whether the agency misinterpreted the delegation by including tax credits for federally-facilitated exchanges in addition to state exchanges, is precisely the query the *Chevron* analysis was developed to address. This conclusion seems to be reaffirmed by the Supreme Court's recent decision in *Mayo Foundation for Medical Education & Research v. United States*,[36] where the Court evaluated the validity of regulations that prevented medical residents from being considered students for purposes of an exemption from Federal Insurance Contributions Act (FICA) taxes. The rules were issued pursuant to the Treasury Department's general authority to "prescribe all needful rules and regulations for the enforcement"[37] of the Internal Revenue Code. In finding it appropriate to evaluate the regulations under the *Chevron* analysis, the Court cited to *Mead* and noted that the Court indicated that its "inquiry in [this] regard does not turn on whether Congress's delegation of [rulemaking] authority was general or specific."[38]

Step One: Whether Congress has Spoken to the Precise Question at Issue

If a reviewing court proceeds to the first step of the *Chevron* analysis, it will ask whether "Congress has spoken to the precise question at issue."[39] Thus, a court will consider whether Congress has clearly articulated a position on the breadth of the IRS's authority to provide premium tax credits for taxpayers enrolled in health insurance exchanges. The plain language of §36B suggests that premium tax credits are available only where a taxpayer is enrolled in an "Exchange established by the State." As noted previously, a strictly textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS's authority to issue the premium tax credits is limited only to situations in which the taxpayer is enrolled in a state-established exchange. Therefore, 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. However, given the previously discussed 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.

As such, whether a court finds that there is sufficient ambiguity in §36B to proceed to *Chevron* step two may depend on the extent to which the court is willing to engage in a searching statutory interpretation involving text, context, legislative purpose, and legislative history, or whether the court would limit itself to a consideration of only the plain text of the provision.[40] In *Chevron* itself, the Supreme Court noted that a court should employ the "traditional tools of statutory construction" to "ascertain" whether

(...continued)

whether the agency acted pursuant to delegated authority."). However, in these cases the court has made clear that the rule in question would have failed under either *Chevron* "Step One" or "Step Two." *See*, Aid Association for Lutherans v. United States Postal Service, 321 F.3d 1166 (D.C. Cir. 2003) (holding that the Post Office had exceeded its delegated authority in broadly interpreting its authority under 39 U.S.C. 3626(j), but explaining that, "[o]ur judgment in this case is the same whether we analyze the agency's statutory interpretation under *Chevron* Step One or Step Two.").

[36] 131 S. Ct. 704 (2011).

[37] 26 U.S.C. § 7805(a).

[38] Mayo Found. for Med. Educ. & Research v. United States, 131 S. Ct. 704 at 713-14.

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

[40] This has been described as the "textualist-intentionalist divide." *See generally*, Linda Jellum, *Chevron's Demise: A Survey of Chevron from Infancy to Senescence*, 59 Admin. L. Rev. 725 (2007).

"congress had an intention on the precise question at issue."[41] The majority opinion then went on to consider text, purpose, and legislative history in concluding that the meaning of "stationary source" under the Clean Air Act was ambiguous.[42] Justice Scalia, on the other hand, has led the opposition to the use of legislative history and legislative purpose at "Step One", favoring a purely textualist approach to discerning whether a statute is ambiguous.[43]

In a 2007 case potentially relevant to the instant situation, *Zuni Public School District No. 89 v. Department of Education,* the Supreme Court considered a situation in which the legislative history behind the provision seemed to suggest a congressional understanding contrary to the plain language of the statute.[44] In *Zuni*, the majority, invoking *Chevron*, upheld an interpretation by the Secretary of Education of the Impact Aid Act's "equalization requirement" for aid expenditures to public school districts. Although the majority seemed to initially favor the textualist approach, noting that "normally neither the legislative history nor the reasonableness of the Secretary's method would be determinative if the plain language of the statute unambiguously indicated that Congress sought to foreclose the Secretary's interpretation," the court then turned to legislative history and purpose "because of the technical nature of the language in question."[45] Based on an evaluation of the statute's history, the majority determined that Congress's intent was unclear, and that the agency's interpretation was reasonable. While the regulations in the *Zuni* case involved complex calculations, something that is arguably not analogous to the applicability of the premium tax credits in §36B, the case still arguably indicates Court's willingness under certain circumstances to evaluate more than just the text of a statute in determining whether Congress has spoke on a particular issue.

Step Two: Whether the Agency Interpretation was Reasonable

As noted above, under "Step Two" of *Chevron*, if Congress has not directly spoken to the question at issue, the reviewing court's role is limited to determining whether the agency's interpretation was "based on a permissible construction of the statute."[46] Where Congress has not clearly expressed its intent, a court "may not substitute its own construction of a statutory provision for a reasonable interpretation" of the agency.[47] Therefore, if Congress's intent is unclear, the Court's role at *Chevron* "Step Two" is generally to defer to any reasonable agency interpretation of the pertinent statutory language.[48] The Supreme Court has indicated that deference to an agency's interpretation under step two is appropriate "whether or not it is the only possible interpretation or even one a court might think best."[49] Thus, if a reviewing court determines that there is ambiguity surrounding the issue of whether premium credits are available in federal exchanges and reaches step two of the *Chevron* analysis with respect to the

[41] *Chevron*, 467 U.S. at 843 n.9.

[42] *Id.* at 862-65.

[43] Under Justice Scalia's *Chevron* approach, the first step is simply to ask whether the enacted text is clear. Although initially following the intentionalist approach, some commentators have suggested that the majority of the Court now seems to generally support the textualist position. At least one commentator has asserted that "[t]oday, *Chevron*'s first step is routinely described and applied as a search for mere textual clarity." Jellum, *supra* note 41, at 761.

[44] 550 U.S. 81 (2007).

[45] *Id.* at 90.

[46] *Chevron*, at 842-43.

[47] *Id.* at 844.

[48] *Id.* at 843.

[49] *See, e.g.*, Holder v. Gutierrez, 566 U.S. __ (2012); 2012 U.S. LEXIS 3783, citing *Chevron*, 467 U.S. at 843-44.

regulations issued under §36B, the regulations will very likely be considered a reasonable agency interpretation of the statute and accorded deference by the court.[50]

[50] *See*, Thomas J. Miles and Cass R Sunstein, *Do Judges Make Regulatory Policy? An Empirical Investigation of Chevron*, 73 U. Chi. L. Rev. 823 (2006) (finding that more than 90 percent of invalidations under Chevron occurred at Step One).

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2009

Health Insurance Exchanges: Legal Issues

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O'Neill Institute
for National and Global Health Law

Legal Solutions in Health Reform

Health Insurance Exchanges: Legal Issues

Timothy Stolzfus Jost, JD

Legal Solutions in Health Reform is a project funded by
THE ROBERT WOOD JOHNSON FOUNDATION

Prepared for
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THE LINDA D. AND TIMOTHY J. O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN LAW

The O'Neill Institute for National and Global Health Law at Georgetown University is the premier center for health law, scholarship and policy. Housed at Georgetown University Law Center, in the heart of the nation's capital, the Institute has the mission to provide innovative solutions for the leading health problems in America and globally—from infectious and chronic diseases to health care financing and health systems. The Institute, a joint project of the Law Center and School of Nursing and Health Studies, also draws upon the University's considerable intellectual resources, including the School of Medicine, the Public Policy Institute, and the Kennedy Institute of Ethics.

The essential vision for the O'Neill Institute rests upon the proposition that the law has been, and will remain, a fundamental tool for solving critical health problems in our global, national, and local communities. By contributing to a more powerful and deeper understanding of the multiple ways in which law can be used to improve health, the O'Neill Institute hopes to advance scholarship, research, and teaching that will encourage key decision-makers in the public, private, and civil society sectors to employ the law as a positive tool for enabling more people in the United States and throughout the world to lead healthier lives.

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OVERVIEW
LEGAL SOLUTIONS IN HEALTH REFORM

The American public has increasingly identified health care as a key issue of concern. In order to address the multiple problems relating to the access and affordability of health care, President Obama and federal lawmakers across the political spectrum continue to call for major health reform. In any debate on health reform, a predictable set of complex policy, management, economic, and legal issues is likely to be raised. Due to the diverse interests involved, these issues could lead to a series of high-stakes policy debates. Therefore, **it is critical that advocates of reform strategies anticipate such issues in order to decrease the likelihood that legally resolvable questions become barriers to substantive health reform**. In an effort to frame and study legal challenges and solutions in advance of the heat of political debate, the O'Neill Institute for National and Global Health Law at Georgetown University and the Robert Wood Johnson Foundation have crafted the "Legal Solutions in Health Reform" project.

This project aims to identify practical, workable solutions to the kinds of *legal issues* that may arise in any upcoming federal health reform debate. While other academic and research organizations are exploring important policy, management, and economic questions relating to health reform, the O'Neill Institute has focused solely on the critical legal issues relating to federal health reform. The target audience includes elected officials and their staff, attorneys who work in key executive and legislative branch agencies, private industry lawyers, academic institutions, and other key players. This project attempts to pave the road towards improved health care for the nation by providing stakeholders a concise analysis of the complex legal issues relating to health reform, and a clear articulation of the range of solutions available.

LEGAL ISSUES V. POLICY ISSUES

Among the major issues in federal health reform, there are recurring questions that are policy-based and those that are legally-based. Many times questions of policy and of law overlap and cannot be considered in isolation. However, for the purpose of this project, we draw the distinction between law and policy based on the presence of clear legal permission or prohibition.

Under this distinction, policy issues include larger-scale questions such as what basic model of health reform to use, as well as more technical questions such as what threshold to use for poverty level subsidies and cost-sharing for preventive services. In contrast, legal issues are those involving constitutional, statutory, or regulatory questions such as whether the Constitution allows a certain congressional action or whether particular laws run parallel or conflict.

Based on this dividing line of clear permission or prohibition, policy questions can be framed as those beginning with, *"Should we...?"*, and legal questions can be framed as those beginning with, *"Can we...?"* The focus of this paper will be the latter, broken into three particular categories: 1) "Under the Constitution, *can we ever...?*"; 2) "Under current statutes and regulations, *can we now...?"*; 3) " Under the current regulatory scheme, *how do we...?"* This final set of questions tends to be mixed questions of policy, law, and good legislative drafting.

PURPOSE AND LAYOUT OF THE PROJECT

This project is an effort to frame and study legal challenges and solutions in advance of the heat of political debate. This effort is undertaken with the optimistic view that all legal problems addressed are either soluble or avoidable. Rather than setting up roadblocks, this project is a constructive activity, attempting to pave the road towards improved health care for the nation. Consequently, it does not attempt to create consensus solutions for the identified problems nor is it an attempt to provide a unified field theory of how to provide health insurance in America. Furthermore, this project does not attempt to choose among the currently competing proposals or make recommendations among them. Instead, it is a comprehensive project written to provide policy makers, attorneys, and other key stakeholders with a concise analysis of the complex legal issues relating to health reform and a clear articulation of the range of solutions available for resolving those questions.

LEGAL ISSUES

Based on surveys of current health policy meetings and agendas, popular and professional press, and current health reform proposals, our team formulated a list of legal issues relating to federal health reform. After much research, discussion, and expert advice and review, our initial list of over 50 legal issues was narrowed to ten. An initial framing paper was drafted which identified these ten legal issues and briefly outlined the main components of each. In May of 2008, a bipartisan consultation session was convened to provide concrete feedback on the choice and framing of the legal issues. The attendees of the consultation session included congressional staff, executive branch officials, advocates, attorneys, employers, and representatives of a wide range of interests affected by health reform. Feedback and analysis from this session further narrowed the ten issues to eight key legal issues which warranted in depth analysis of the current law.

These eight pertinent issues are truly legal in nature and must be addressed in any significant reform proposal to avoid needless debate or pitfalls as policy decisions are made. There are multiple other legal issues that will arise as the discussion evolves and, if a federal policy is adopted, the system changes. In this project, however, we have targeted the issues essential for an immediate discussion of federal health reform.

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Special thanks to the following individuals who contributed to the editing and production of the Legal Solutions in Health Reform Series, as well as the drafting of the Executive Summaries: Brian Bowen, Astrid Dorélien, Marissa Hornsby, Amy Killelea, Melanie MacLean, Anya Prince, and Luis Rodriguez. Also special thanks to John Kraemer for editing and production assistance.

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The author wishes to thank the following individuals who provided valuable feedback in reviewing earlier drafts of this paper. Note, they are not responsible for its contents and they do not necessarily hold the views expressed here: Michael Curtis, Judge Donald L. Smith Professor in Constitutional and Public Law, Wake Forest University; Michael Gerhardt, Samuel Ashe Distinguished Professor of Constitutional Law, University of North Carolina; John McGinnis, Stanford Clinton, Sr. Professor of Law, Northwestern University; Wilson Parker, Professor of Law, Wake Forest University.

EXECUTIVE SUMMARY

Prepared by the O'Neill Institute

INTRODUCTION:

Health insurance exchanges (HIE) are entities that organize the market for health insurance by connecting small businesses and individuals into larger pools that spread the risk for insurance companies, while facilitating the availability, choice and purchase of private health insurance for the uninsured. While there are legal issues that warrant consideration under a federal, state, or private exchange framework, those issues are not insurmountable barriers to implementation.

The section below outlines the legal issues and solutions for a health insurance exchange if administered through the federal or state government or through a private entity.

FEDERAL EXCHANGES: Congress has the power to implement an HIE at the federal level, but must consider certain laws and regulations during both design and implementation as outlined below:

- **Interstate Commerce:** The federal government has the authority to regulate matters that substantially affect interstate commerce. While the power to regulate interstate commerce is not unbounded, the power certainly extends to insurance regulation.
- **Tax and Spending:** The federal government can tax and spend for the general welfare of citizens, thus Congress could use tax incentives and its spending power to incentivize participation in a federal exchange or to develop a "play or pay" framework with the states.
- **McCarran Ferguson Act:** Congress specifically delegated the regulation of insurance to the states. Therefore, Congress must clearly and explicitly communicate its intention to preempt state regulation of insurance in any insurance regulation it legislates.
- **Anti-commandeering:** The federal government is prohibited from appropriating state officials to implement federal laws. Therefore, a federal HIE must not require implementation by state employees.
- **Due Process and Equal Protection:** When selecting insurers for inclusion in the exchange, the federal government must act rationally when making legislative classifications and distinctions. This analysis will also apply to state exchanges.
- **Takings Clause:** Severe regulation of insurance has in a few instances been found by the courts to constitute a taking. This must be considered when determining the limitations that will be placed on insurance providers to encourage participation in the HIE. This analysis will also apply to state exchanges.
- **Administrative Procedures Act:** A federal HIE must comply with the standards and procedures relating to the freedom of information, records privacy, and adjudication applicable to all federal agencies.
- **Other Considerations:** A comprehensive review of the tax code, as well as employee benefit and public health laws should be conducted once the federal HIE has been designed.

STATE EXCHANGES: There are no insurmountable legal barriers to implementation of HIEs at the state level. Certain Constitutional issues that apply equally to state exchanges have been analyzed under the federal exchange framework and stated above.

- **State Administrative Procedures Acts:** Most, if not all, states have adopted legislation that outlines procedures for rulemaking, records privacy, adjudication, tort claims and government contracting. A state HIE must comply with existing state law, but these laws must be analyzed on a state by state basis.
- **Employee Retirement Income Security Act (ERISA):** Federal law preempts any state law that relates to an employee benefit health plan. A state HIE would only be preempted if participation by employers is mandatory or if the state requires action on the part of an employer.
- **Health Insurance Portability and Accountability Act (HIPAA):** Existing federal legislation contains non-discrimination, guaranteed access and pre-existing condition requirements that may need to be met by a state exchange if it offers insurance to employment-related groups.

PRIVATE EXCHANGES: Implementation of a private HIE is not prevented by existing state or federal law.

- **Private Health Care Voluntary Purchasing Alliance Model Act:** A number of states have adopted laws or regulations authorizing the creation of private exchanges. Review of existing laws would be required to ensure they adequately support a multi-insurer framework.
- **Antitrust Laws:** Current federal antitrust laws prohibit unreasonable restraints of trade. States, however, are exempt from antitrust law and could extend this exemption to private exchanges. Private exchanges can also be structured to avoid antitrust violations.
- **Multiple Employer Welfare Arrangement Regulation (MEWAs):** Membership and organizational rules will determine whether the state or federal government, or both, regulates private HIEs.
- **HIPAA:** The consumer safeguards provided by existing federal legislation likely would not apply to HIEs unless a contractual relationship was established that identified the exchange as a business associate of insurers. Under this agreement, HIEs would be limited in their ability to disclose personal health data to employers.

CONCLUSION:
Health insurance purchasing exchanges have been proposed as a possible means of making insurance more accessible, increasing competition among health plans, and promoting choice of insurer. President Obama's campaign proposal and various congressional leaders have proposed establishing insurance exchanges through federal legislation. Although exchanges implicate many design and policy issues regardless of whether they are implemented at a federal, state, or private entity level, there are no absolute legal bars to the establishment of health insurance exchanges.

Legal Solutions in Health Reform:
Health Insurance Exchanges: Legal Issues
Timothy Stoltzfus Jost[1]

Introduction

This Legal Solutions in Health Reform paper identifies and analyzes the legal issues raised by health insurance exchanges. Like all Legal Solutions papers, it does not purport to provide a concrete proposal as to how health insurance exchanges should be organized or even whether they should play a role in health care reform. Rather, it attempts simply to describe the legal issues that health insurance exchanges raise, and to propose alternative solutions to legal problems where useful. More specifically, it analyzes and offers alternative solutions to the legal problems raised by proposals to establish insurance exchanges by the federal government, by state governments, and by private entities or associations. Because the focus of this project and paper is on legal issues, discussion of policy and design issues is attenuated. Nevertheless, some attention to policy issues is unavoidable, because law is the realization of policy.

Health insurance exchanges are entities that organize the market for health insurance, much like stock exchanges do for securities or farmers' markets for produce. They are intended to facilitate the availability, choice, and purchase of private health insurance plans for individuals and the employees of small groups. They are usually government or non-profit institutions, but can be operated by the state or federal government or by private business associations or even by businesses.[2]

Health insurance exchanges have been widely discussed as a solution to problems in the market for private health insurance. They figure prominently in the reform campaign plan proposed by President Obama, while a health insurance exchange, the "Connector," is at the heart of the much-discussed Massachusetts health reform program.[3] The bipartisan Wyden-Bennett health insurance plan also relies on health insurance exchanges to organize the health insurance market. Another bipartisan bill, the Small Business Health Options Program Act of 2008 (S. 2795), has been introduced specifically to "establish a nationwide health insurance purchasing pool."[4]

At a minimum, exchanges centralize individual health plan enrollment and premium payments. They also provide information about insurance plans to those who purchase insurance through them, thus permitting individuals to compare the products of a number of insurers and to choose the best product for their needs. Exchanges can be used to facilitate employer payment for insurance premiums, including direct payments by individuals and payments collected by employers from employees through tax-advantaged Section 125 cafeteria arrangements or non-tax-advantaged payroll deductions.[5] They could also be used to facilitate the use of tax credits to purchase insurance. Some authors would limit exchanges to these functions, and indeed define exchanges in these terms.[6]

Other advocates would, however, give exchanges additional, more regulatory, responsibilities. Exchanges can, for example, define the benefits that participating plans must cover or specify the rating practices that they must follow with respect to exchange purchasers. The Obama campaign health plan would, for example, establish a national exchange to, "act as a watchdog group and help reform the private insurance market by creating rules and standards for participating insurance plans to ensure fairness and to make individual coverage more affordable

and accessible."[7] The Obama exchange proposal would "require that all the plans offered are at least as generous as the new public plan and have the same standards for quality and efficiency."[8] It would also "evaluate plans and make the differences among the plans, including cost of services, transparent."[9] The State Health Help Agencies included in the proposed Wyden-Bennett Healthy Americans Act would be required to "develop standardized language for HAPI [Healthy American Private Insurance] plan terms and conditions and require participating health insurance issuers to use such language in plan information documents," as well as to ensure that plans follow the rating rules provided by the Act.[10] The Massachusetts Connector, the most prominent currently existing example of an insurance exchange, also has extensive regulatory responsibilities, as described below. An exchange with regulatory responsibilities would look very much like the health alliances proposed by the Clinton Health Security Act or like various proposed purchasing cooperatives or like those created by the states during the 1990s.

In this paper, I will use the term "exchange" broadly to cover a range of entities, public and private, that 1) facilitate the purchase of private insurance plans by individuals and employees, and 2) make available to these individuals and employees a choice of a range of insurance plans. I include exchanges that perform additional regulatory functions.[11]

The best known contemporary model of a health insurance exchange is the Massachusetts Connector, a model that is being considered by a number of other states.[12] The Massachusetts Connector is a quasi-public authority governed by a ten member board, with three members appointed by the governor, three members appointed by the attorney general, and four members who serve by virtue of their government positions.[13] The Connector's responsibilities include: 1) facilitating the purchase of insurance by individuals and small groups (of 50 or fewer members) by providing a centralized exchange for the purchase of approved health insurance products and by collecting premium payments from individuals and employers and remitting these to insurers; 2) defining the criteria that insurance products must meet to offer minimum creditable coverage for purposes of the state's legal mandate that individuals purchase such coverage; 3) administering the new Commonwealth Care Health Insurance Program for lower-income Massachusetts residents; 4) certifying if uninsured residents are unable to find insurance they can afford for purposes of being excused from the individual mandate; 5) establishing regulations for the § 125 cafeteria arrangements that employers must establish under the Massachusetts reform; and 6) offering insurance at reduced rates for uninsured young adults between the ages of 18 and 26.[14]

Although some market advocates have hailed insurance exchanges (including the Connector) as a private market solution to the problems of health care cost, access, and quality, the Connector is in fact a quasi-government agency and many of its functions are regulatory. Moreover, the Connector has fewer regulatory responsibilities than might have been necessary to ensure a functioning insurance exchange in other states because the health insurance market in Massachusetts was already heavily regulated before the Connector was established. Even before the recent reforms, the insurance market in Massachusetts was subject to guaranteed issue requirements, modified community rating with no medical underwriting, a lengthy list of mandates, and a history of regulators refusing to approve high cost-sharing, low-benefit products (for which, in any event, there seemed to be little consumer demand).[15]

The Massachusetts Division of Insurance, rather than the Connector, continues to enforce these requirements. The Massachusetts reform also instituted an individual mandate, which plays a key role in controlling adverse selection against the Connector.

The extent to which exchanges act as regulators is only one of the ways in which exchanges can vary. Another very important variable is whether they are established at the federal, state, or local level. The Obama campaign proposal contemplates a national exchange as does the Small Business Health Options Program Act of 2008 (S. 2795), while the Wyden-Bennett proposal and state initiatives like the Massachusetts Connector locate exchanges at the state level. Additionally, private exchanges have been established by employers or by business coalitions.[16] Although private exchanges lack regulatory authority, they have their own purported advantages - more flexibility in hiring and firing and the capacity to react more rapidly to changing conditions, for example.

With the election of President Obama, who campaigned on a platform of health reform, and strong Democratic majorities in both the House and Senate with leaders committed to health care financing reform - there is the real possibility of health reform legislation at the federal level. If we were assured that Congress would adopt legislation creating a national insurance exchange, this paper could be very short. The only legal limit on the ability of Congress to adopt legislation is the Constitution, and as will be discussed shortly, the Constitution imposes minimal constraints on the ability of Congress to act in this area. Congress would face serious policy and design problems in creating a national insurance exchange program, but those issues are not the focus of this paper.

It is important to remember, however, that we have been to the precipice of health insurance reform before, and Congress has not jumped.[17] It is possible that the current economic crisis or other pressing policy priorities will delay or even derail health care financing reform. Were that to happen, the states would have to take the initiative, as some of them are doing now. Congress could remove some of the legal impediments that now limit state reforms. Steps it could take to facilitate the creation of insurance exchanges by the states are described below. But Congress might not even do that, leaving the states to navigate around existing law. The states, moreover, are facing their own fiscal crises, and many may take no action on their own if Congress fails to act. This could leave the private sector to take the initiative, and to find its way through the constraints of both federal and state law.

This paper will proceed to explore the legal issues presented by the range of possible futures of health care financing reform. It will first explore the limits that the law (primarily the Constitution) imposes on federal attempts to establish purchasing exchanges. Second, it will examine the constraints that federal law imposes on states that choose to establish insurance exchanges, considering both what Congress could do to remove these impediments and how the states can deal with them if Congress fails to act. Third, it discusses the legal constraints that the law imposes on private insurance exchanges. Although these constraints are imposed both by federal and state law, this paper will focus on the issues raised by federal law, noting that state law is varied and any concrete proposal for a private exchange would need to be analyzed in detail under the laws of the particular state in which it was to be operated. Finally, the paper will summarize the solutions it has suggested to the legal problems that it has identified.

I. Federal Insurance Exchanges

One possible approach, found in the Obama campaign plan, would be to establish a purchasing exchange at the federal level. Ensuring that health insurance is uniformly available across the country would be valuable in itself, and a national exchange could effectively address the problems of adverse and favorable selection issues that are the central conundrums of health insurance reform by creating massive risk pools. But a single national exchange could also pose serious administrative problems, particularly since there is little expertise in regulating insurance at the national level. It is quite possible, therefore, there would not be one central exchange under a national reform program, but rather exchanges established at the state or regional level. This is the solution that has been reached in regionalizing other federal programs. Examples of regional entities that have administered federal programs include Medicare contractors, Medicare Peer Review Organizations, and the Health Systems Agencies that were established under the National Health Resources and Development Act in the 1970s. Congress might even attempt to require the states themselves to establish purchasing exchanges. Of course, a single national exchange is not an impossibility. The Federal Employees Health Benefits program and the Medicare Advantage program are both administered at the national level.

Were a national plan to be established, it would face difficult design issues. Such issues would include: 1) determining the regions exchanges would cover, specifically whether they would be restricted by state lines or cover regions or multi-state metropolitan areas functioning like a single market; 2) the administrative relationship between exchanges and the central government, and whether the exchanges would be administered by private contractors (as in Medicare) or federal/state entities; and 3) the level of uniformity that would be required in the system, specifically whether premiums, coverage, and eligibility requirements would be the same across the country.[18] I focus here, however, on legal rather than design problems.

A. Federalism Issues

First, implementation of a federal insurance exchange would require resolution of federalism issues. The first of these is the question of whether the federal government has the constitutional authority to regulate health insurance contracts, *i.e.* whether the sale of insurance contracts constitutes interstate commerce. The Supreme Court decided in 1944 that the federal government may constitutionally regulate insurance,[19] and although there have been intervening decisions indicating that the federal government's interstate commerce authority is not unbounded, that power certainly extends to insurance regulation.

Congress would also need to consider the McCarran-Ferguson Act. In response to the Court's recognition in the 1940s that Congress had the power to regulate insurance contracts, Congress adopted a statute providing that "regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."[20] This means that Congress should not be considered to have preempted or superseded state law in the area of health insurance unless it does so expressly. This does not limit the power of Congress to create federal insurance exchanges; it merely means that Congress would have to do so explicitly.

Congress might attempt to implement a federal exchange program through the states, thus taking advantage of the insurance regulation institutions and experience of the states. In doing so, it would need to be mindful of the limitations the Constitution places on the power of the federal government to control the states. The Constitution has been interpreted to preclude Congress from passing laws that "commandeer" the authority of the states for federal regulatory purposes.[21] That is, 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.[22] 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.[23]

B. General Constitutional Constraints (Which Apply Also to State Insurance Exchanges)

In addition to federalism issues, there are a variety of general constitutional issues that would affect government exchanges. These issues would also apply to state and federally-established exchanges, but are discussed only in this section to avoid duplication. One of the functions that an insurance exchange must fulfill is deciding which insurers can sell their products through the exchange. Five possibilities here are readily apparent. First, an exchange could allow any insurer to sell its products through the exchange that wanted to do so. Second, the exchange could permit all insurers to participate that agreed to comply with certain standards to sell their products, effectively an "any willing provider" approach. Third, the exchange could negotiate with insurers and only allow those to participate that concluded satisfactory negotiations to offer their products through the exchange. Fourth, the exchange could decide to limit the number of insurers allowed to offer their products through the exchange, and then devise a process for deciding which insurers would make the cut-off, and which would not. Finally, the state could not only bar some insurers from the exchange, but limit all insurance purchases (perhaps in the individual and small group market) to insurers participating in the exchange, effectively prohibiting any residents of the state from purchasing insurance from non-participating insurers.

One of the primary advantages of an exchange is that it permits choice of insurers, particularly for employees of small businesses. Allowing broad participation of insurers, therefore, would seem desirable. On the other hand, another ideal that grounds health insurance exchanges is that of organizing or structuring competition among insurers. Indeed, there is some evidence that too many choices can be confusing to consumers.[24] Thus it might make sense for exchanges to limit the number of insurers and participating plans and to structure competition among those insurers. Indeed, insurers might be prohibited from selling policies to individuals or small groups except through the exchange. Insurance exchanges might also be required to regulate the rating practices or benefit packages of insurers who sell policies through them, thus limiting participating insurers to those that accept limitations on these practices.

If insurance exchanges are government-run or sponsored, their exclusionary or regulatory interventions may raise constitutional issues.[25] The Due Process Clause of the Constitution requires the government to act rationally when it engages in social and economic regulation, while the Equal Protection Clause requires the government to make rational legislative

classifications and distinctions. The U.S. Constitution and most states' constitutions prohibit the taking of private property for public use without just compensation. Finally, state governments are under an additional constraint of the Contracts Clause of the U.S. Constitution prohibiting states from adopting laws that impair "the obligation of contracts."[26]

Government regulation of economic conduct is acceptable under the Due Process and Equal Protection clauses as long as it bears a rational relationship to a legitimate government interest.[27] Similarly, Contracts Clause challenges will not succeed unless a challenged regulation "substantially impairs a contractual relationship," does not promote a significant and legitimate public interest, and is based on unreasonable conditions unrelated to the public purpose.[28] Finally, a regulatory law can be challenged under the takings clause, which bars the government from taking private property for public use without just compensation, if the law goes "too far" in the severity of its impact and in frustrating distinct "investment-backed expectations."[29]

Insurance has long been a heavily regulated industry, and constitutional challenges to requirements imposed by an exchange through regulation or negotiation are unlikely to succeed unless the requirements are wholly irrational.[30] Courts have repeatedly rejected constitutional challenges to state insurance mandates, including statutes requiring insurers to provide maternity coverage[31] and coverage for mental disorders.[32] In the one reported constitutional case actually involving an insurance purchasing exchange, a federal court in Kentucky rejected Due Process and Commerce Clause challenges brought by an insurer against a statutory requirement that insurers offer only standard plans approved by a health policy board.[33] State statutes that specifically restrict participation in markets by insurers have also been upheld.[34] In analogous areas, courts have upheld the constitutionality of certificate of need programs, which prohibit private health care providers from entering markets or expanding their market participation without permission from the state,[35] as well as federal Medicare amendments that prohibit physicians from selling their services to Medicare beneficiaries outside of the Medicare program unless the physician left the Medicare program for two years.[36]

Probably the category of constitutional challenges most likely to succeed against reform laws establishing exchanges are those brought under the Takings Clause. To this point, all such challenges have been brought against state rather than federal insurance regulation, although the Takings Clause applies equally to both federal and state governments. In a number of cases in recent years particularly severe state laws regulating insurance have been successfully challenged under the Takings Clauses of the U.S. or of state constitutions, prominently among them laws rolling back or freezing rates, requiring insurers to fund residual markets using profits from other states or lines of business, or restricting insurers from exiting markets.[37]

The success of these challenges, however, seems to be specific to particular jurisdictions. For each instance in which a challenge has succeeded against a particular kind of law, similar laws in other jurisdictions have survived similar constitutional challenges. For example, in a case involving New York's attempt to create a risk pooling mechanism, a court observed that an insurer has no "constitutionally protected interest in maintaining a healthier than average risk pool."[38] As insurers face increasingly comprehensive regulation analogous to that traditionally faced by public utilities, a body of federal or state constitutional law may evolve providing insurers the right to make a just and reasonable return on their investment like that currently claimed by public utilities.[39] It remains true; however, that government retains considerable discretion in regulating a wide range of insurer behavior.

Congress must take care that any insurance exchange program it initiates and operates is non-discriminatory and does not engage in confiscatory regulation. It is unlikely that the Constitution will, however, prove a significant barrier to the development of reasonable insurance exchanges.

C. Other Legal Issues Raised by Federal Insurance Exchanges

An insurance exchange established by federal law will presumably be an agency subject to the Administrative Procedures Act, including provisions relating to the freedom of information, records privacy, open meetings, rulemaking, adjudication, and judicial review.[40] Certain aspects of the program might also be subject to the Federal Acquisitions Regulations promulgated pursuant to 41 U.S.C. § 405, which govern federal purchases of products and services. These provisions would need to be considered in designing the exchange.

If Congress were to create federal purchasing exchanges it would also need to amend a number of federal laws to clarify the relationship between federal and state regulatory power. The most obvious of these would be the Employee Income Retirement Security Act of 1974, which is discussed below. Once the design of a federal insurance exchange became clear, a comprehensive review of the federal tax, employee benefit, and public health laws would be necessary to make sure that they properly reflected the balance of federal and state regulatory power contemplated by the purchasing exchange program.

II. State Insurance Exchanges

A. Constitutional Law

The constitutional law issues that affect state insurance exchanges were discussed in the previous section and will not be repeated here.

B. Governance Issues

If an exchange is established as a state agency, it will be subject to state administrative law. About two thirds of the states have adopted some version of the Model State Administrative Procedures Act (APA). The Model State APA prescribes procedures for rule making, adjudication, and judicial review. Each state also has an open meetings and freedom of information statute.[41] State-run insurance exchanges will presumably be subject to these laws unless they are specifically exempted by statute.[42] They will also presumably be subject, like other state agencies, to state laws addressing civil service, government contracting, and government tort claims. These laws vary from state to state, and cannot be discussed in detail here.

Another issue that will have to be addressed is how a state insurance exchange interfaces with other state agencies. This is primarily a design issue, but will require the drafting of new laws or the amendment of existing laws for implementation. The Massachusetts Connector was established as an independent authority, but the Massachusetts Division of Insurance continues to regulate health insurance plans generally, while the Department of Finance is responsible for enforcement of the individual mandate. The National Association of Insurance Commissioners (NAIC) has adopted both a "Single Health Care Voluntary Purchasing Alliance Model Act" (78-

1) and a "Regional Health Care Voluntary Purchasing Alliance Model Act" (80-1) which presents the states with different options for creating exchanges at the state or regional level. These statutes would place regional alliances under the state commissioner of insurance, but establish a separate state agency for the single state exchange authority. The Single State Exchange Model Act states in a drafting note,

> This Act establishes the purchasing alliance as a state agency. However, states may wish to establish the purchasing alliance as a state-chartered nonprofit organization. States may also consider establishment under an existing state agency such as the office of commissioner."[43]

States will also have to coordinate between the purchasing alliance and other state agencies, including: 1) the agency responsible for the Medicaid and State Children's Health Insurance Program, if Medicaid or SCHIP recipients are covered through the purchasing pool; 2) the entity that purchases care for state employees or retirees, if state employees or retirees are covered through the purchasing pool; 3) the state health insurance assistance program; and 4) any separate agency that regulates managed care, if applicable.

C. Issues Raised by Federal Law

If health insurance reform proceeds primarily at the state rather than the federal level, the states will need to come to terms with federal laws that limit their options. To date, as noted above, insurance regulation has primarily been the responsibility of the states. Congress has, however, adopted a number of laws partially preempting state authority over health insurance, particularly in the area of employee benefits. If the federal government assumes responsibility for health care financing or its regulation, these laws will presumably be repealed or comprehensively amended to transfer the responsibility of insurance regulation from the states to the federal government. If Congress decides rather to leave health reform to the states, Congress could repeal or amend these laws to afford the states the freedom to enact their own reform programs. If Congress does nothing, the states will have to adapt to these laws as they exist. This section explores the latter two possibilities.

1. Employee Retirement Income Security Act of 1974 Preemption

In general, preemption is a legal principle that bars state regulation of a subject if federal law expressly precludes state regulation, if the state regulation would conflict with federal law, or if the federal government comprehensively regulates an area of activity, thus excluding state regulation. For example, the Employee Retirement Income Security Act (ERISA) regulates the administration of employer sponsored benefit plans including health benefits. One of the issues that state established exchanges face is the possibility of ERISA preemption—that is that the federal ERISA statute will bar states from establishing and operating insurance exchanges in the manner they would prefer. The general law of ERISA preemption is fully addressed in another Legal Solutions in Health Reform authored by Peter Jacobson. The importance of ERISA, however, justifies some consideration here. ERISA is also discussed further in the next section with respect to the question of whether its multiple employer welfare arrangements (MEWA) provisions affect private plans.

Section 514 of ERISA explicitly preempts any state law that "relates to" an employee benefits plan.[44] The Supreme Court has interpreted this provision to mean that any state law is preempted that has "a connection with or reference to" a benefits plan.[45] Although ERISA also provides that state laws that regulate insurance are saved from preemption, it further stipulates that states may not regulate self-insured insurance plans. Finally, section 502 of ERISA has been construed by the Supreme Court to preclude any state judicial remedies against ERISA plans.[46]

In the insurance exchange context, ERISA preemption is likely to be an issue only with respect to state laws that seek some way to compel an employer to establish an employee benefit plan or to compel an employee benefit plan to participate in an exchange. It should not affect state insurance exchanges in which participation is strictly voluntary and which do not require action to be taken by either an employer or an employee benefits plan. ERISA would also not affect private exchanges that do not have legal authority to require employers or benefit plans to participate.[47] ERISA explicitly saves from preemption state laws regulating insurance,[48] and thus ERISA would not limit a state's ability to require insurers to sell their products through an insurance exchange or to regulate the products insurers sell through exchanges. This is consistent with the long-standing policy of Congress, articulated in the McCarran-Ferguson Act, to leave the regulation of insurance to the states. ERISA should also not preclude a state from requiring individuals to purchase insurance through an insurance exchange.[49]

ERISA, however, does impose significant limitations on the states. ERISA almost certainly prohibits states from requiring any employer offering health benefits to provide those benefits through an exchange. Such a law would be seen as a law "relating to" an ERISA benefits plan, preempted by federal law.[50] ERISA might also preclude states from imposing a requirement directly on employers who do not currently provide health insurance benefits to begin providing health insurance through an exchange or to pay an assessment to the state. Federal courts are now split on the question of preemption of state "pay or play" laws and the enforceability of such laws may turn on their precise provisions.[51] Finally, it would be unwise for a state insurance exchange statute to explicitly mention ERISA plans lest it fall afoul of the "reference to" prohibition. In one case, for example, the Supreme Court held that a state law prohibiting garnishment of ERISA benefits to be preempted because of the explicit reference to ERISA plans in the law.[52]

One unsettled issue is whether ERISA would prohibit states that establish insurance exchanges from requiring employers who do not otherwise offer health insurance to forward payments, taken out of their employees' wages on a payroll deduction basis, to the exchanges, through a section 125 Cafeteria arrangement.[53] A section 125 Cafeteria arrangement allows an employer to withhold a sum of money specified by the employee on a pre-tax basis from an employee's wages, and allows the employee to use that money to purchase certain specific benefits.[54] States considering health insurance reform in general and health insurance exchanges in particular have found the section 125 option of particular interest. Specifically, the section 125 option allows employees to obtain federal tax subsidies for their own expenditures so that they can purchase insurance through an exchange, assuming that ERISA does not allow the states to require employers to offer their employees health insurance purchased through an exchange. The Massachusetts law, as noted above, requires employers with more than 11 workers (under the threat of a penalty if other conditions are met) to establish section 125 arrangements for their employees, through which funds may be channeled to the Connector to purchase health insurance.

As discussed below, it is arguable that a section 125 arrangement is a "group health plan" under the Internal Revenue Code. It could be argued by extension that it is also an ERISA plan, and thus that ERISA prohibits states from requiring employers to establish section 125 Cafeteria arrangements through which employee contributions can be channeled to insurance exchanges. There are, however, convincing arguments that section 125 arrangements are not ERISA plans. First, ERISA defines an employee benefits plan as a plan "established or maintained" by an employer.[55] In several instances, courts have found that an ERISA plan did not exist when employers simply assisted employees in paying individual health or disability insurance premiums from the employee's own funds without further involvement in the insurance relationship.[56]

Second, the Labor Department regulations establish a safe harbor that excludes from the ERISA plan definition "group or group-type" insurance arrangements if five conditions are met: 1) the employer does not contribute its own funds; 2) employee participation is voluntary; 3) the employer does not "endorse" the arrangement; 4) the employer does nothing more than to allow an insurer to publicize the arrangement to employees and to collect premiums through payroll deductions; and 5) the employer receives no consideration beyond reasonable compensation for administrative services.[57]

There are dozens of cases litigating the application of this safe harbor to particular arrangements, usually in the context of an insurer seeking the protection of ERISA preemption against a state law claim brought by an aggrieved member. This litigation generally focuses on the third safe harbor criterion–the prohibition against endorsement by an employer. The cases tend to hold that if an objectively reasonable employee would conclude that an employer has not simply made a plan available, but has also exercised control over the plan or made it appear to be part of the employer's own benefit package, the arrangement will be considered an ERISA plan. If an employer becomes actively involved in the promotion or administration of a plan funded through a section 125 arrangement, courts are likely to find the plan to be an ERISA plan on employer endorsement grounds.[58]

If, on the other hand, an employer simply collects premiums from employees on a payroll deduction basis and forwards them to insurers, courts should find that no ERISA plan exists.[59] If a section 125 Cafeteria arrangement exists solely by operation of a state law requirement, and the employer has taken no action to endorse the purchase of insurance through the arrangement other than to comply with state law, it is difficult to see why the arrangement would not fit within the ERISA safe harbor.[60] The argument that an employer has not endorsed a plan would be particularly strong if a state directed employee funds collected under a section 125 arrangement to a purchasing exchange rather than to a particular insurance plan, as the employee and not the employer would be choosing the employee's insurance plan through the exchange.[61]

Third and finally, the only Department of Labor advisory opinion examining the question of ERISA and section 125 arrangements concluded that a section 125 arrangement was not "the equivalent of the provision of a benefit enumerated under" the ERISA definition of an ERISA plan.[62] Thus a state requirement that employers allow their employees to pay for health benefits through a state insurance purchasing exchange by way of a section 125 arrangement would not seem to be preempted by ERISA.

Congress could, of course, amend section 125 of the Tax Code and ERISA to clarify that the states can require employers to establish section 125 arrangements to allow employees to purchase individual health insurance policies, including policies purchased through a state-sponsored health insurance exchange. The Department of Labor could probably accomplish the same end through an administrative regulation or ruling, given the uncertainty in this area. Alternatively, Congress could simply extend the tax subsidies currently offered in employment-related health insurance to individual insurance, which would obviate the need for section 125 arrangements. In the absence of any amendments in the federal law, however, it appears that the states are permitted to require employers to establish section 125 plans for the purchase of insurance through health insurance exchanges, as Massachusetts has done.

2. The Health Insurance Portability and Accountability Act

The application of another federal law, the insurance portability provisions of the Health Insurance Portability and Accountability Act (HIPAA), raises other legal issues that would affect the implementation of an insurance exchange at the state level. The specific issue is whether an arrangement where an employer pays insurance premiums for its employees through an insurance exchange creates a group health plan under HIPAA.

HIPAA prohibits group health plans and health insurance issuers from discriminating on the basis of health status in determining eligibility or premiums for members of group health plans. HIPAA imposed these requirements through amendments to ERISA, the Public Health Service Act, and the Internal Revenue Code (the "Tax Code"), all of which are quite similar.[63] These provisions effectively require guaranteed issue and community rating to individuals within group health plans without regard to health status. If HIPAA applies to purchases of insurance for employees through an insurance exchange, insurers would not be able to underwrite individual employees who purchase insurance through the exchange separately, but would need to offer insurance to all otherwise eligible employees of any single employer and offer them the same rate. Other provisions of HIPAA require guaranteed issue and renewal for group plans and limit the use of preexisting conditions clauses within group plans.[64] These provisions would also apply if employees of a single employer who purchase insurance through an exchange were treated as a single group. The application of HIPAA to state health insurance exchanges would not preclude the creation of exchanges, but it would have clear implications for their design. Instead of simply facilitating the purchase of individual insurance policies through a coordinated market, exchanges would rather be coordinating the sale of policies to employment-related groups (in addition to individuals who were not employed).

The ERISA provision of HIPAA, 29 USC § 1182, adopts the ERISA definition of "group health plan" discussed above, under which the key question is whether the plan is "established or maintained" by the employer.[65] If an employer pays part of the cost of the premium or in some other way endorses a plan purchased through an exchange, HIPAA would apply and the above requirements would apply to the plan purchased through the exchange. This is true even though the employer pays for separate individual policies for each employee, a so called "list billing" arrangement.[66] If an employer, however, neither contributes to the cost of insurance for employees nor "endorses" a plan, it would seem that policies purchased on a payroll deduction basis (for example, through a section 125 arrangement) would not be subject to the HIPAA non-discrimination, small group coverage, or pre-existing conditions rules under the ERISA statute, but would simply be individual insurance policies.[67]

The HIPAA requirements, however, are also found in the Tax Code, which incorporates the Tax Code definition of "group health plan." The Tax Code defines the term "group health plan" somewhat differently than does ERISA. It defines a group health plan as a "plan (including a self-insured plan) *of, or contributed to by, an employer* (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees" (emphasis added).[68] This definition raises issues if a state attempts to require employers to fund health insurance purchases by requiring employers to establish section 125 arrangements.

Section 125 regulations recently proposed by the Department of the Treasury explicitly permit payment of individual health insurance premiums from a section 125 arrangement, either directly to the insurer or on an indemnity basis to the employee, suggesting that the individual policies do not become group policies simply because the employer collects and remits premium payments.[69] Section 125, however, only exempts from taxation expenditures for "qualified benefits," *i.e.* benefits otherwise exempt from taxation under other sections of the Tax Code.[70] The relevant provision of the Tax Code exempting health benefits is section 106, which excludes "employer-provided coverage."

Arguably, therefore, insurance provided through a section 125 arrangement is a group health plan under HIPAA because it is "employer-provided." It can also be argued that a section 125 arrangement is a group health plan because it is funded by an employer contribution, because the statute provides that funds in a section 125 arrangement are not part of an employee's gross income, and thus might be considered funds contributed by an employer. The IRS has informally taken the position that the use of section 125 arrangements to purchase individual policies makes them group policies for purposes of the Tax Code, and thus for the HIPAA provisions of the Tax Code.[71] In this view, insurance policies purchased by employees of a single employer through an insurance exchange with the funds provided under a section 125 arrangement would have to comply with the HIPAA non-discrimination, guaranteed access and renewability, and pre-existing conditions requirements of HIPAA.

The entire issue of the application of HIPAA is avoided, of course, if a state itself requires community rating, guaranteed issue and renewal, and limits pre-existing conditions clauses from insurers offering insurance through an insurance exchange. Federal requirements under HIPAA would, in that case, be superfluous. Congress could also amend HIPAA to clarify either that HIPAA does or does not apply to insurance policies purchased through exchanges with section 125 funds. The Internal Revenue Service could also possibly clarify this issue through a regulation or some other form of guidance. Alternatively, Congress could simply extend the requirements of HIPAA to all health insurance policies. If Congress does not change the law, however, and a state allows insurers to underwrite and rate individuals covered through the exchange individually, it would seem that the insurers would not be able to do so within ERISA group health plans and within groups of individuals whose premiums are paid by a single employer through a section 125 arrangement.

D. State Regulation of Underwriting, Premiums, and Benefits

States that regulate non-group insurance or insured ERISA plans are permitted to regulate insurance underwriting, premium rates, and benefits. Most states do so to a greater or lesser extent.[72] States, for example, require insurers to guarantee coverage and renewal to small groups

(implementing HIPAA), while some states go further, requiring insurers to offer community rates to small groups or individuals or limit the dispersion of rates through rating bands. States also require insurance plans to cover specific benefits, providers, and eligible individuals. The extent to which states regulate underwriting, premium rates, and benefit coverage is a matter of public policy rather than law. The policy arguments for and against underwriting, rating, and benefit coverage mandates are well known (and passionately asserted), and will not be repeated here.[73] Since these forms of regulation must be implemented by state law, however, they will be addressed briefly here.

States that create public or authorize quasi-public purchasing exchanges can apply underwriting, rating regulation, and coverage mandates either generally to the entire insurance market or only within the purchasing exchange. A state is free to make its own policy choices in determining which approach to take ,as long as it does not attempt to apply such laws to self-insured ERISA plans or permit the violation of HIPAA requirements with respect to group plans.

If a state attempts to apply underwriting and rating requirements within an insurance exchange that are not applied generally in the relevant market, or attempts to impose benefit mandates within an exchange that are not imposed generally, it exposes the exchange to adverse selection, which might make the arrangement untenable.[74] If insurers are allowed to underwrite in the market generally, but not within the insurance exchange, the exchange may in effect become a high-risk pool. If insurers are required to community rate within the insurance exchange but not otherwise, they may not participate in the exchange. If states require insurers to offer more generous benefits within the exchange than they can outside of it, the rates for exchange products may become comparatively unattractive.

Community rating is not the only available strategy to make insurance purchased through an insurance exchange affordable to persons with poor risk profiles. An insurance exchange could also, for example, collect premiums (and tax credits or other forms of public insurance vouchers) and then pay out premiums on a risk-adjusted basis, as Medicare does with Medicare Advantage and the Part D drug benefit plan premiums. Alternatively, insurers selling their products through the risk pool could be required to participate in a risk reinsurance pool, so that plans would not be disadvantaged by taking higher risk insureds. Third, a public reinsurance program could be provided to backstop insurers who cover the highest risks.[75] Fourth, the simple imposition of an individual mandate could create a large enough risk pool that insurers would be comfortable taking on greater risk exposure. Finally, simply providing substantial state subsidies for individuals who purchase insurance through an exchange (but not otherwise) would go far toward reducing adverse selection against exchange insurers. Each of these solutions, however, may create additional responsibilities for exchanges.

III. Private Exchanges

If exchanges are created neither by the federal nor state government, but rather privately by business coalitions or groups of employers, they face a different set of legal issues.[76] These entities must comply with state laws regulating insurance. The NAIC has a "Private Health Care Voluntary Purchasing Alliance Model Act,"[77] and a number of states have adopted laws or regulations authorizing the creation of insurance exchanges.[78] State insurance laws regulating association health plans should also be reviewed to determine if they affect particular

arrangements, although exchanges should be distinguishable from Association Health Plans (AHPs) because exchanges offer a choice of a number of insurers while AHPs usually provide insurance themselves either through self-insurance or by contract.[79] Some states prohibit list billing, which could close off one approach to funding employee health care through purchasing exchanges.[80]

Exchanges would, moreover, have to comply with their contractual obligations and could face claims under business torts. Both regulatory and common law vary from state to state, and a fifty state survey of all state insurance regulations that might affect an insurance exchange would be less productive than focused analysis of an actual proposal in its own state environment. There are three federal laws that would affect privately operated purchasing exchanges, however: the antitrust laws, ERISA provisions regulating multiple employer welfare associations (MEWAs), and the HIPAA privacy regulations. These will be briefly considered here.

A. Antitrust Law

Section one of the Sherman Antitrust Act prohibits "every contract, combination . . . or conspiracy in restraint of trade," while section two prohibits monopolization.[81] Although the federal antitrust laws are most commonly enforced against sellers of products and services, they also prohibit unreasonable restraints of trade imposed by buyers. Monopsony, or the domination of a market by a buyer, just like monopoly can distort markets, and can potentially reduce the quantity and quality of available products.

The explicit purpose of an insurance exchange is to restrain trade since it organizes the purchase of insurance by individuals and groups. Insurance exchanges can potentially achieve near monopsonistic market power in the private insurance market.

At the same time, antitrust law has long permitted purchasers to engage in joint ventures, including purchasing cooperatives that enhance efficiency and do not create undue purchaser market power. It is a fair question, therefore, whether the federal antitrust laws would limit insurance exchanges.

To begin, federal antitrust laws do not restrict the authority of the states to establish government-run insurance exchanges. The Massachusetts Connector, for example, is not subject to an antitrust challenge. Antitrust law has developed the State Action Doctrine to accommodate the interests of federalism and also permit states to engage in regulatory supervision of commerce in their states. The State Action Doctrine exempts state entities from federal antitrust law if their conduct is compelled or clearly authorized by state law. If the state law pertains to conduct by private actors, that conduct must be compelled or authorized *and* must be actively supervised by the state.[82] Situations arise, however, in which the state explicitly or impliedly authorizes or encourages actors to engage in conduct that violates federal antitrust law, but the level of state supervision may fall short of that required under Supreme Court precedent. Thus, the State Action Doctrine would not apply, leaving the conduct exposed to antitrust enforcement.

If an insurance exchange is created solely by private action, for example, by a coalition of private employers, there is by definition a combination of actors, leaving only the question of whether this combination is a restraint of trade. This is a complex question, the answer to which depends

heavily on the factual situation of a particular exchange. The issues raised by antitrust law for insurance exchanges were analyzed thoroughly by Clark Havighurst a decade ago,[83] and a decade earlier by H. Robert Harper and John J. Miles,[84] and their analysis will not be repeated in detail here.

A few salient points can, however, be made. First, as already noted, private purchasing coalitions are problematic under the federal antitrust laws. Courts applying the antitrust laws may be somewhat less troubled by buyer than by seller cartels, but restraints of trade imposed by buyers can still be antitrust violations. Second, naked price restraints imposed by a combination of buyers and lacking any efficiency justifications can be per se violations of the antitrust laws—that is, illegal regardless of any other justification that may be offered. In most instances, however, courts will evaluate purchasing coalitions under the rule of reason—that is, review their legality in the context of their particular market and consider their "pro" and "anti" competitive effects. Applying the rule of reason, courts will be concerned with pro-competitive justifications for joint purchasing arrangements. Given the market failures present in health care, it may be quite possible to justify joint purchasing as efficiency enhancing in many situations.[85] In particular, purchasing pools are pro-competitive insofar as they offer individuals and small employers the chance to achieve risk pooling and economies of scale not otherwise available. Third, if an exchange does nothing more than organize a market for insurance without negotiating prices, for example, by providing information, structuring choices, and discouraging adverse selection, it is unlikely to be found in violation of the antitrust laws. Indeed, such activities may increase rather than suppress competition.[86]

A coalition without excessive market power is probably safe in any event. Defining the relevant product and geographic markets affected by insurance exchanges itself is a complicated endeavor. Antitrust cases have in various contexts identified insurance markets on the "sell side," the markets in which insurers sell their products, as including individual and small groups, and excluding larger employers and self-insured plans. The 'buy side' market, in which insurers compete with other purchasers in purchasing services, such as physician services, may include other purchasers such as Medicare and Medicaid, and not be limited to private insurers only. A market must be defined for the market share to be determined. If the market is defined narrowly enough, insurance exchanges affecting private plans may be found to have large market shares, but if the market is defined broadly, their share may not be troublesomely large.

The Department of Justice, Federal Trade Commission Statement on Antitrust Enforcement Policy in Health Care on Joint Purchasing Arrangements creates a safe harbor for health care providers whose "purchases account for less than 35 percent of the total sales of the purchased product or services in the relevant market,"[87] a market-percentage that would probably apply to insurance purchasing as well. However, a coalition that offers its members access to a wide variety of insurance plans and products is unlikely to be found to be in restraint of trade even if its share is larger.

Currently existing private insurance exchanges have tended to control only a small share of the market, and thus not to pose antitrust problems. If this were to change, Congress could amend the antitrust laws to exempt health insurance exchanges that allow the participation of multiple insurers from antitrust scrutiny.

Alternatively, the Department of Justice and Federal Trade Commission could promulgate a new enforcement guideline delineating more clearly the circumstances under which they would consider a private health insurance exchange to be in compliance with the antitrust laws.

B. Multiple Employer Welfare Arrangement Regulation

A private insurance exchange that offers health insurance to employees is a multiple employer welfare arrangement (MEWA) under ERISA, and thus subject to regulation under state and federal law. The extent to which a private exchange is subject to state or federal regulation depends, however, on the type of MEWA it would regulate. 29 U.S.C. § 1002(40) defines a MEWA as:

> an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described earlier in the statute, including health insurance, to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries.[88]

An "employee welfare benefit plan," as noted in the above discussion of ERISA , is "any plan, fund, or program which . . .is . . . established or maintained by an employer or by an employee organization, or by both, . . .for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, []medical, surgical, or hospital care or benefits. . . ."[89] Finally, an employer is "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and *includes a group or association of employers acting for an employer in such capacity*" (emphasis added). [90]

Under these definitions, if a group of employers gets together to form an insurance exchange, it would almost certainly be a MEWA, but could be either be 1) a MEWA which is also an employee welfare benefit plan under ERISA established or maintained by an "employer,"(which can be a group or association of employers) or 2) a MEWA which is "any other arrangement . . . established or maintained for the purpose of offering or providing" health insurance to employees of two or more employers or to self-employed individuals."[91] Under the Department of Labor's interpretation of ERISA, a "group or association" of employers can only be an "employer" if it is determined to be a bona fide group of employers, taking into consideration a number of factors, including how members are solicited, who can participate and who in fact participates, the purpose of the organization, any pre-existing relationships among the members, and most importantly, whether the employee-members of the group exercise control over the program.[92] An exchange formed by an association of employers who do not qualify as a bona fide group or by a private entity other than a bona fide employer group could be an "other arrangement" MEWA, but would not be an employee welfare benefit plan.[93]

MEWAs that are also ERISA plans are fully regulated by ERISA, including its disclosure, fiduciary obligation, HIPAA, and benefit mandate provisions. Thus an insurance exchange that was considered to be an ERISA plan-MEWA could be sued in federal court by its members for breach of fiduciary obligation or for a denial of claims and could not discriminate in premiums or eligibility based on health status. A MEWA that is not an employee welfare benefit plan is not itself regulated by ERISA, but each participating employer is considered to each have independently established a single-employer plan subject to ERISA.[94] The administrators of a

non-ERISA plan MEWA are nonetheless still likely to be held to be fiduciaries insofar as they have discretionary duties in administering the terms of the constituent employers' ERISA plans.[95] Federal law also requires MEWAs to file with the Department of Labor.[96]

Under the 1983 Erlenborn Amendment, states are empowered to regulate ERISA plans that are also MEWAs. This amendment to ERISA allows states to regulate both insured and self-insured MEWAs that are ERISA plans, effectively exempting them from the preemptive power of ERISA provisions that prohibit the states from regulating self-insured plans.[97] By definition, insurance exchanges would be insured rather than self-insured MEWAs, since exchanges exist to organize a market in which several insurers offer plans to exchange participants rather than offer insurance themselves. Under this section of ERISA states are limited in their authority to regulate insured MEWAs.[98] States may only impose, "standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due" on an insured MEWA.[99] This would rarely be relevant to insurance exchanges, since they do not normally bear risk. States may also presumably regulate any insurer that sells insurance through an exchange because regulation of insurers would be saved from preemption under the general ERISA savings clause, which saves state insurance regulation from preemption.[100] But the state regulation would probably have to apply to all insurers in the market, which could be the small group or individual market, not just to insurers participating in a particular exchange.

Finally, states may regulate private insurance exchanges that might be classified as MEWAs, but are not ERISA plans, under the states' inherent police power, since state regulation of MEWAs that are not ERISA plans do not "relate to" ERISA plans.[101] States may be limited in their ability to provide judicial remedies for beneficiaries against insurers who provide insurance through such MEWAs, however, because beneficiaries are members of their own employer's single-employer ERISA plan, and only secondarily members of the MEWA. Thus actions against the insurers may be considered to be actions against those plans and thus would be preempted by ERISA's remedial provisions.[102] State law claims brought by employers against a MEWA, on the other hand, are not preempted by ERISA.[103]

Private insurance exchanges are likely to be classified as MEWAs, and thus, in general be subject to state regulation. The power of the states to regulate insurance exchanges operated by "bona fide" employer associations, and thus considered to be ERISA plans, is very limited and does not reach the most important issues that states may want to regulate. Private insurance exchanges that are MEWAs, but not ERISA plans, are subject to state regulation, but are probably also subject to the ERISA requirements that bind plan administrators to the extent that the exchange managers act as administrators of the ERISA plans of the MEWA's member employers.[104] To date, many states have not yet exercised their authority to regulate MEWAs, and few states have regulated MEWAs effectively.[105]

If Congress adopts comprehensive health insurance reform, but leaves a role for private health insurance exchanges, it could take over responsibility for regulating them or clarify the authority of the states to regulate. If Congress takes no action, states would still be free to exercise their authority to regulate MEWAs that are not operated by "bona fide" employer associations. They may also want to test carefully the status of MEWAs that claim to be ERISA plans since they are largely exempt from state regulation.

C. HIPAA Data Privacy Requirements

Private insurance exchanges would, finally, be subject to HIPAA regulations on privacy.[106] The HIPAA Privacy Rule is discussed at length in another Legal Solutions in Health Reform authored by Deven McGraw so it will only be addressed briefly here. The privacy rule applies to any individually identifiable health information in the hands of covered entities. Covered entities include only health care providers, health plans, and health care clearinghouses.[107] "Health plans" include most public and private insurers, including those that would participate in insurance exchanges, but would seem not to include an exchange itself.[108]

Health plans may disclose information without consent for 1) treatment, 2) health care operations, which includes "underwriting, premium rating, and other activities relating to the operation, 3) renewal or replacement of a contract of health insurance or health benefits," and 4) payment, which includes "activities undertaken by a health plan to obtain premiums."[109] Health plans may also disclose "de-identified data,"[110] which is not covered by HIPAA, and may disclose personal health data, which is covered, to "business associates" with appropriate contractual assurances to safeguard data.[111] It would seem that health plans could disclose health information regarding their members to health insurance exchanges under one or more of these provisions, subject however, to a further caveat. Health plans, and therefore insurance exchanges as their agents, may only disclose to "plan sponsors" (i.e. employers) de-identified "summary health information" and information as to whether an individual is participating in the sponsor's group health plan.[112] This would limit information flow from exchanges to employers who purchase insurance through them.

Although HIPAA constraints on the information that health plans can share with exchanges and exchanges with employers are important; data flow in the other direction from employers or employees to exchanges and then to health plans for underwriting or setting premiums is likely to be even more important. Information acquired by a health insurance exchange in this way would in all likelihood only be protected by HIPAA if the exchange were a business associate of a health plan that "allow[ed] a business associate to create or receive protected health information on its behalf."[113] It would be important, therefore, for health insurance exchanges to enter into contracts with health plans that identify the exchange as a "business associate" of the health plans with assurances that the exchange would protect any personal health information it received to be sent on to covered plans. If this is not done, individuals and employers may be reluctant to disclose information to exchanges.

Congress should amend HIPAA to clarify that health insurance exchanges are bound by the HIPAA privacy rule, perhaps by including them within the definition of "health plan" found in HIPAA's language.[114] Even if Congress fails to amend HIPAA specifically for insurance exchange, private health insurance exchanges could enter into business associate contracts with health care plans whose products they sell and could comply with HIPAA requirements, including limitations on the sharing of identifiable health data with employers.

IV. Summary of Potential Solutions

A. Implementation of a Federal Purchasing Exchange

Congress could constitutionally establish an exchange program operated solely by the federal government, which could be operated either at the national or the regional level. Congress, however, cannot simply command the states to implement a federally established and defined health exchange program. It could, however, use its power to spend money to offer the states financial incentives to encourage them to participate in an insurance exchange program. Alternatively, Congress could invite the states to establish exchanges, but also administer a federally-operated fall-back program for states that decline participation, as it does now with respect to HIPAA provisions. Whatever approach it takes, Congress should make certain that any statute it adopts explicitly notes that the program is being established as one that regulates the business of insurance to forestall challenges under the McCarran-Ferguson Act. If Congress establishes a national purchasing exchange program, it must be aware of other applicable federal administrative law requirements, and either amend relevant laws accordingly or ensure that federal exchanges comply with them.

The Due Process, Equal Protection, and Takings Clauses of the Constitution limit the power of Congress to regulate insurers, although the Constitution prohibits only extreme discriminatory or confiscatory actions, and would not preclude most forms of regulation. Government exchanges that allow all insurers that accept exchange rules to participate in exchanges are unlikely to face successful constitutional litigation. If government exchanges exclude insurers from participating, they should do so according to clearly established guidelines and for clearly articulated purposes.

B. State Exchanges

If Congress fails to take action to establish a national health insurance exchange, the states could take the initiative to establish exchanges on their own. States initiating purchasing exchanges would be bound by the same constitutional constraints facing the federal government, in addition to the peculiarities of state constitutions, which, in some instances, impose greater restraints on economic regulation.

State exchanges will also need to comply with state administrative law and other laws governing state agencies, such as state civil service or purchasing requirements. States establishing insurance exchanges will need to clarify relationships between the exchange and other state agencies with jurisdiction over insurance issues. Specifically, an exchange could be part of the state's Department of Insurance or could be a separate entity.

As it is currently written, ERISA precludes states from requiring employee benefit plans to purchase insurance through exchanges. States may require individuals to do so, however, and may regulate insurers that sell their products through exchanges. States may also require employers who do not offer health insurance to allow their employees to purchase insurance through exchanges with pre-tax dollars using section 125 arrangements. To avoid ERISA challenges, employers will have to be careful to ensure that they are not perceived as "endorsing" such arrangements and should not offer discounts only to employees who purchase insurance through the exchange.

If states allow employee groups to participate in an insurance exchange as groups (*i.e.* if the employer contributes to or administers the arrangement), HIPAA will require that participating insurers provide insurance on a guaranteed offer and renewability basis. HIPAA also prohibits discrimination in eligibility or premiums based on health status, and limits pre-existing conditions clauses for participating employee groups. HIPAA would probably impose the same requirements for all employees of a particular employer if the employees purchase insurance through section 125 arrangements, even without employer contributions. If a state requires community rating, guaranteed issue and renewal, and limits preexisting conditions clauses within the exchange, and thus, effectively applies HIPAA protections to all exchange participants, the state may avoid the issue of whether employees who participate in the plan under a section 125 arrangement are independently protected by HIPAA.

Congress could amend ERISA and HIPAA to clarify their requirements for insurance exchanges. It is possible that the Internal Revenue Service could, even in the absence of Congressional action, clarify whether or not the use of a section 125 arrangement automatically creates a group plan for HIPAA purposes.

States could consider applying uniform regulation of underwriting, premiums, and benefits both inside and outside of insurance exchanges to avoid exposing exchanges to adverse selection or limiting the ability of exchanges to compete with insurers selling outside the exchange. Alternatively, states could only allow the purchase of insurance through the exchange in specific markets such as individual and/or small group.

C. Private Insurance Exchanges

If neither Congress nor the states proceed with establishing insurance exchanges, exchanges could still be created by private entities or associations. Congress could create a special antitrust exemption for private insurance exchanges. The Department of Justice and Federal Trade Commission could also clarify the status of exchanges through issuing an enforcement guideline. States may shield private exchanges from antitrust liability if the state explicitly authorizes and actively supervises the exchanges. If the state does not do so, private exchanges should be prepared to limit themselves to 35% of the market and/or be able to offer procompetitive justifications for the restraints they impose on the market.

Private exchanges should be aware that their membership and organizational rules will determine whether they are regulated primarily by the state or federal government. Under the federal law governing MEWAs, "bona fide" employer association exchanges will be primarily regulated by ERISA, while other exchanges by the states. Congress could, of course, expand the power of the states to comprehensively regulate all MEWAs or could extend federal authority over them.

Since HIPAA could implicate private exchanges and the exchange of protected health information, Congress could amend HIPAA's privacy rules to specifically clarify that they cover health insurance exchanges. If Congress fails to amend HIPAA, exchanges could enter into business associate agreements with insurers to the extent that they will need to access health data on insureds. To avoid legal challenges and to protect privacy, exchanges should not disclose personal health data to employers except to the extent permitted by HIPAA.

Conclusion

Health insurance purchasing exchanges have been proposed as a possible means of making insurance more accessible, increasing competition among health plans, and promoting choice of insurer. President Obama and congressional leaders have proposed establishing insurance exchanges through federal legislation. There are no serious constitutional bars to Congress' establishing an insurance exchange, although the Constitution might limit the means that Congress could use if it chose to implement an insurance exchange program through the states. Alternatively, Congress could amend a number of laws such as ERISA, HIPAA, and the antitrust laws to ease the creation of state or private purchasing exchanges. Even in the absence of any congressional action, however, the creation of purchasing exchanges by the states or by private entities and associations are not likely to be precluded by legal considerations. State and private purchasing exchanges do raise a number of important legal issues, however, that would need to be considered by any state or private entity creating an insurance exchange program.

[1] Robert L. Willett Family Professor, Washington and Lee University School of Law. The author wishes to thank Patricia Butler, Thomas Greaney, James Blumstein, Amy Monahan, Christie Hager, Gary Bacher, and the O'Neill Institute Management Team who provided valuable feedback on earlier drafts.

[2] The literature on exchanges is vast, but a useful sampling of recent papers would include A. Lischko, "Health Insurance Connectors & Exchanges: A Primer for State Officials," Academy Health Stateside, Sept. 2007, *available at* http://www.statecoverage.net/pdf/healthinsurance0907.pdf (last visited Dec. 12, 2008); E.F. Haislmaier, "State Health Reform: How Pooling Arrangements can Increase Small-Business Coverage," Heritage Foundation WebMemo 1563, July 23, 2007, *available at* http://www.heritage.org/Research/HealthCare/wm1563.cfm (last visited Dec. 12, 2008); J. Solomon, "Health Insurance "Connectors" Should be Designed to Supplement Public Coverage, Not Replace It," Center on Budget and Policy Priorities, Jan. 29, 2007 *available at* http://www.cbpp.org/1-29-07health.htm (last visited Dec. 12, 2008); M. Kofman, "Group Purchasing Arrangements: Issues for States," State Coverage Initiatives Issue Brief, 4, No. 3 (Apr. 2003): 1-6. One older article also worth reading is M. A. Hall, "The Role of Insurance Purchasing Cooperatives in Health Care Reform," *Kansas Journal of Law & Public Policy*, 3 (1993-94): 95. Empirical studies of health insurance exchanges include, K. Bender and B. Fritchen, "Government-Sponsored Health Insurance Purchasing Exchanges: Do They Reduce Costs or Expand Coverage for Individuals and Small Employees," Oliver Wyman Actuarial Consulting, Inc., 2008, *available at* http://www.oliverwyman.com/de/pdffiles/health_ins_purchasing_arrangements.pdf (last visited Dec. 12, 2008); "Insurance Markets: What Health Insurance Pools Can and Can't Do," California Health Care Foundation Issue Brief, 2005, *available at* http://www.chcf.org/documents/insurance/WhatHealthInsurancePoolsCanAndCantDo.pdf (last visited Dec. 15, 2008); E.K. Wicks, "Health Insurance Purchasing Cooperatives," Commonwealth Fund Issue Brief, Nov. 2002, *available at* http://www.commonwealthfund.org/usr_doc/wicks_coops.pdf?section=4039 (last visited Dec. 15, 2008); R. E. Curtis, et al., "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?," *Health Affairs*, 20, no. 1 (2001): 164-68; S.H. Long and M.S. Marquis, "Have Small-Group Purchasing Alliances Increased Coverage?," *Health Affairs*, 20, no. 1 (2001): 154-63; E.K. Wicks and M. A. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," *Milbank Quarterly*, 78 (2000): 511.

[3] Senator McCain's plan did not include insurance exchange proposals.

[4] S. 2795, 110th Cong. 2008.

[5] These arrangements, authorized by section 125 of the Internal Revenue Code, allow employees to pay for various benefits with their own income on a pre-tax basis.

[6] See R. E. Moffit, "State-Based Health Reform: A Comparison of Health Insurance Exchanges and the Federal Employees Health Benefit Program," Heritage Foundation WebMemo, June 20, 2007, *available at* http://www.heritage.org/research/healthcare/wm1515.cfm (last visited Dec. 16, 2008).

[7] Barak Obama's Plan for a Healthy America, no longer available on-line.

[8] *Id.*

[9] *Id.*

[10] S. 334, 110th Cong. 2008.

[11] Some commentators attempt to draw a clear distinction between the purchasing cooperatives and health alliances that were widely discussed in the 1970s, 80s and 90s and were at the heart of the Clinton Health Security Act, and the contemporary health insurance exchange. See Lischko, *supra* note 2 at 2; Moffit, *supra* note 6. Because the terms purchasing cooperative, health alliance, and health insurance exchange cover or have covered a broad assortment of models among which there is considerable variety and overlap, I do not believe it is possible to draw a clear line between the modern insurance exchange and its antecedents. (See Bender & Fritchen, *supra* note 2 at 12, for an analysis of exchanges written for the Blue Cross/Blue Shield Association that strongly supports this conclusion.) Insofar as there are differences, they are 1) that health insurance exchanges, as some commentators define them, do not act as purchasing agents or regulators but rather simply connect insurance purchasers with insurers, and 2) that some commentators in the past have included as purchasing cooperatives entities that purchase services directly from providers, while contemporary health insurance exchanges generally contract only with insurers. Believing that the terms are in fact largely interchangeable, I will use the term insurance exchange throughout this paper instead of the terms purchasing cooperative (or pool) or health alliance.

[12] These include, by one list, California, Connecticut, Georgia, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, New Jersey, Oregon, Texas, Virginia, Washington, and Wisconsin. See J. E. Schneider, et al., "Legal and Economic Analysis of Health Insurance Exchange Mechanisms," Health Economics Consulting Group, 2007, *available at* http://www.hecg-llc.com/health_care_regulation.htm (last visited Dec. 16, 2008).

[13] See C. L. Hager, "Massachusetts Health Reform: A Social Compact and a Bold Experiment," *University of Kansas Law Review*, 20 (2007): 1313-29. M.A. Chirba-Martin, "Universal Health Care in Massachusetts: Setting the Standard for National Reform," *Fordham Urban Law Journal*, 35 (2000): 409-449.

[14] See Hager, *supra* note 13; E. A. Zelinsky, "The New Massachusetts Health Law: Preemption and Experimentation," *William and Mary Law Review*, 49 (2007): 229-87, 235.
[15] Hager, *supra* note 13 at 1316.
[16] See E.K. Wicks and M.A. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects, *78 Milbank Quarterly* 511: (2000).
[17] See, e. g. J. Quadagno, *One Nation Uninsured: Why the U.S. Has no National Health Insurance* (New York: Oxford University Press, 2005).
[18] See H.T. Greely, "Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity," *Health Matrix*, 5 (1995): 37-81.
[19] *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944).
[20] 15 U.S.C. § 1011 (2007).
[21] *Printz v. United States*, 521 U.S. 898 (1997); *New York v. United States*, 505 U.S. 144 (1992); C. Hoke, "Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles," *Hastings Constitutional Law Quarterly*, 21 (1994): 489-575.
[22] This is the approach Congress took with the portability provisions of the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 300gg-22(a)(2) and 300gg-44(b)(3)(2007), and with eliminating state limits on high deductible policies coupled with health savings accounts. See T. S. Jost and M. A. Hall, "The Role of State Regulation in Consumer-Driven Health Care," *American Journal of Law & Medicine*, 31 (2005): 395-418.
[23] See *South Dakota v. Dole*, 483 U.S. 203, 206 (1987); *New York v. United States*, 505 U.S. 144 (1992). Another issue that might arise involves the provisions of the Constitution that require uniform taxation among the states. See U.S. Const. Art. 1, Sec. 2, cl. 3; U.S. Const. Art. 1, Sec. 8, cl. 1. If the federal government were to require individuals to purchase insurance through purchasing exchanges, the premiums might be characterized as taxes, and if premiums varied from state to state or region to region, as would be likely, the question of whether these "taxes" were direct and uniform would need to be reached. This is a difficult question, but would probably ultimately not prove an insurmountable barrier to the establishment of exchanges by federal law. It is discussed comprehensively by H. Greely, *supra* note 18, and will not be addressed further here.
[24] See B. Schwartz, *The Paradox of Choice: Why More is Less*, (New York: Harper Perennial, 2004).
[25] If exchanges are private entities, on the other hand, their exclusionary or regulatory practices will not raise constitutional issues, as private entities are not bound by the constitutional provisions discussed here.
[26] U.S. Const. Art. 1, Sec. 10, cl. 1. The Due Process and Takings Clauses are found in the 5th Amendment, and the States' Due Process and Equal Protection Clauses are found the 14th Amendment.
[27] See, e.g. *Exxon Corp. v. Eagerton*, 462 U.S. 176 (1983); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955). Some states, however, have interpreted their state constitutions more restrictively to strike down economic regulation. See, e.g. *In re Certificate of Need for Aston Park Hosp. Inc.*, 193 S.E.2d 729 (N.C.1973).
[28] *Energy Reserves Group Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 410 - 412 (1983); *Liberty Mut. Ins. Co. v. Texas Dept. of Ins.*, 187 S.W.3d 808 (Tx. App. 2006).
[29] *Connelly v. Pension Benefit Guar. Corp.* 475 U.S. 211 (1986); *Vesta Fire Ins. Corp. v. State of Fla.*, 141 F.3d 1427 (11th Cir. 1998).
[30] See *O'Gorman & Young, Inc. v. Hartford Fire Ins. Co.*, 282 U.S. 251 (1931); *Gerling Global Reinsurance Corp. of America v. Low*, 296 F.3d 832 (9th Cir. 2002); *Stephens v. State Farm Mut. Auto. Ins. Co.*, 894 S.W.2d 624 (Ky 1995) (discussing the application of the takings clause to insurance regulation cases).
[31] Health Ins. Ass'n of America v. Harnett, 44 N.Y.2d 302, 376 N.E.2d 1280, 1284-1285, 405 N.Y.S.2d 634, 639 (1978).
[32] *New Hampshire-Vermont Health Service v. Whaland*, 119 N.H. 886, 410 A.2d 642 (1979).
[33] *Golden Rule Ins. Co. v. Stephens*, 912 F.Supp. 261 (E.D.Ky. 1995).
[34] See, e.g. *Massachusetts Indem. and Life Ins. Co. v. Texas State Bd. of Ins.*, 685 S.W.2d 104 (Tex.App.1985) (limiting the number of temporary life insurance agents available to an insurer); *Matter of Plan for Orderly Withdrawal From New Jersey of Twin City Fire Ins. Co.*, 591 A.2d 1005 (N.J. Super .A.D.1991) (prohibiting an insurer from continuing to do business in some insurance lines if it dropped others). Although insurance regulations generally survive due process challenges, they are usually challenged in state court and some states have their own particular lines of doctrinal development. In Florida, for example, statutes that prohibit discounted sales of insurance have been held unconstitutional. *Chicago Title Ins. Co. v. Butler*, 770 So.2d 1210 (Fla. 2000); *Department of Insurance v. Dade County Consumer Advocate's Office*, 492 So.2d 1032 (Fla.1986).
[35] *Goodin v. State of Oklahoma, ex rel. Oklahoma Welfare Commission, Dept. of Institutions, Social and Rehabilitative Services*, 436 F.Supp. 583 (D.C.Okl. 1977); *Attoma v. State Department of Social Welfare*, 270 N.Y.S.2d 167 (1966); *Merry Heart Nursing and Con. Home v. Dougherty*, 330 A.2d 370 (1974).
[36] *United Seniors Ass'n, Inc. v. Shalala*, 2 F.Supp.2d 39 (D.C.1998).

[37] R. E. Brown, "Constitutional Limits on State Insurance Regulation," *Tort & Insurance Law Journal*, 29 (1994): 651-683.
[38] *Colonial Life Ins. Co. v. Curiale*, 617 N.Y.S.2d 377 (1994).
[39] *F.P.C. v. Hope Natural Gas*, 320 U.S. 591 (1944) (analyzing the implications of the takings clause for utility rate-setting).
[40] 5 U.S.C. §§ 552, 552a, 552b, 553, 554 & 702 (2007).
[41] These can be found at the Open Government Guide, *available at* http://www.rcfp.org/ogg/index.php (last visited Dec. 16, 2008) and the Freedom of Information Center of the Missouri School of Journalism, *available at* http://www.nfoic.org/state-foi-laws (last visited Dec. 16, 2008).
[42] Presumably much of the information received by insurance exchanges would be exempt from public disclosure under state law equivalents to the federal freedom of information act exemptions for "commercial and financial information obtained from a person and privileged and confidential," 5 U.S.C. § 552(b)(4)(2008), and "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." 5 U.S.C. § 552(b)(6) (2008).
[43] NAIC Model Laws, Regulations and Guidelines 78-1, Table of Contents.
[44] 29 U.S.C. § 1144 (2007).
[45] *Shaw v. Delta Airlines*, 463 U.S. 85, 97 (1983).
[46] 29 U.S.C. § 1132. See *Aetna Health Inc., v. Davila*, 542 U.S. 200, 201 (2004).
[47] The MEWA provisions of ERISA, however, allocate responsibility between the federal and state government to regulate private purchasing pools. See section III below.
[48] 29 U.S.C. § 1144(b)(2)(A) (2007).
[49] One commentator has observed that if a state requires every resident to be covered by a health insurance policy, meeting specific minimum coverage requirements, it effectively requires employers to provide that level of coverage, which could raise ERISA concerns. See Zelinsky, *supra* note 14 at 276.
[50] 29 U.S.C. § 1144(a) (2007).
[51] Cf. *Retail Industry Leaders Ass' v. Fielder*, 475 F.3d 180 (4th Cir. 2007); *Retail Industry Leaders Ass'n v. Suffolk County*, 497 F.Supp.2d 403 (E.D.N.Y. 2007) (finding ERISA preemption of Maryland and New York pay or play laws) and *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639, 2008 WL 4401387 (9th Cir. 2008) (finding no preemption). This issue is discussed in another Legal Solutions in Health Reform Paper authored by Peter Jacobson, JD, MPH. See also A. B. Monahan, "Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts," *University of Kansas Law Review*, 55 (2007): 1203-1232; P. A. Butler, ERISA Implications for State Health Care Access Initiatives: Impact of Maryland "Fair Share Act: Court Decision, Academy Health State Coverage Initiatives, 2006, *available at* http://www.statecoverage.net/SCINASHP.pdf (last visited Dec. 16, 2008).
[52] *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988).
[53] For the analysis in this section and in the section on HIPAA that follows, I am greatly indebted to Amy Monahan, Mark Hall, and Pat Butler. A monograph on "Section 125 Plans for Individual Insurance and HIPAA's Group Insurance Provisions," by Amy Monahan and Mark Hall was made available to me as I was drafting this paper and is now *available at* http://www.phs.wfubmc.edu/public/pub_insurance/HIPAA_125_Policy_Brief_final.pdf (last visited Dec. 16, 2008). See also P. Butler, "Employer Cafeteria Plans: States' Legal and Policy Issues," California Healthcare Foundation, Oct. 2008, *available at* http://www.chcf.org/topics/download.cfm?pg=insurance&fn=EmployerCafeteriaPlans%2Epdf&pid=511167&itemid=133770 (last visited Dec. 16, 2008).
[54] I.R.C. § 125 (1996).
[55] 29 U.S.C. § 1002(1) (2007).
[56] See *New England Mut. Life Ins. Co. v. Baig*, 166 F.3d 1 (1st Cir. 1999); *O'Brien v. Mutual of Omaha Ins. Co.*, 99 F.Supp.2d 744 (E.D. La. 1999). Where employers are more involved in the insurance relationships or individual insurance policies seem to be part of a larger employee plan, however, the arrangements will be held subject to ERISA. *Burrill v. Leco Corporation*, 1998 WL 340781444 (W.D. Mich. 1998).
[57] 29 C.F.R. § 2510.3-1(j) (2007).
[58] See, e.g. *Butero v. Royal Maccabees Life Ins. Co.* 174 F.3d 1207 (11th Cir. 1999); *Hrabe v. Paul Revere Life Ins. Co.*, 951 F.Supp. 997, 1001 (M.D.Ala. 1996). There is also a line of ERISA cases that have held that a scheme under which an employer pays for individual insurance premiums on a payroll deduction basis is a group policy if the employee receives a discount that is otherwise not available for purchasing through the employer. See *Tannenbaum v. Unum Life*, 2006 U.S.Dist. LEXIS 6623 (E.D. Pa. Mar. 18, 2005); *Kuehl v. Provident Life & Accident*, 1999 U.Dist. LEXIS 22946 (Sep. 30, 1999). One case has even held that a disability plan was an ERISA plan because it was funded with pre-tax income, *Brown v. Paul Revere Life Ins. Co.*, 2002 WL 1019021 (E.D. Pa.

2002), although that court seems to have inappropriately applied COBRA regulations in interpreting ERISA and the case is in any event distinguishable from our situation on several grounds. See Butler, *supra* note 51. Other courts have held, however, that the fact that employees receive a discount for purchasing through their employer does not in itself make a plan an ERISA plan. See, e.g. *Rubin v. Guardian Life*, 174 F.Supp. 2d 1111 (D.Or. 2001). If the only discount that is offered employees participating in a state insurance exchange is the benefit of paying for insurance using pre-tax income available under §125, this alone is unlikely to turn the § 125 arrangement into an ERISA plan.

[59] See *Schwartz v. Provident Life and Accident*, 280 F.Supp. 2d 937 (D.Ariz. 2003); *Murdock v. Unum Provident Co.*, 265 F.Supp. 2d 539 (W.D. Pa. 2002); *Merrick v. Northwestern Mutual Life*, F.Supp.2d, 2001 WL 34152095 (N.D.Iowa 2001); *Byard v. Qualmed Plans for Health*, Inc. 966 F.Supp. 354 (E.D. Pa. 1997); *Levett v. American Heritage Life Ins. Co.*, 971 F.Supp. 1399 (M.D. Ala. 1997).

[60] Although there is no authority addressing this question, it would seem that participation by an employee in a state-mandated § 125 arrangement would still be "voluntary" under the terms of the safe harbor because it would not be required by the employer, which is the concern of the regulation.

[61] See Butler *supra* note 51.

[62] U.S. Dept. of Labor, Advisory Opinion 96-12A, July 17, 1996. In the particular situation at issue in the opinion the § 125 arrangement was used to pay premiums for an ERISA plan, and thus became part of the ERISA plan.

[63] 26 U.S.C. §§ 9801 (2007); 29 U.S.C. § 1182 (2007); 42 U.S.C. § 300gg-1 (2007); I.R.C. § 9802.

[64] *Id.*

[65] 29 U.S.C. § 1002(1). See 42 USC § 300gg-1 and 42 USC § 300g-91.

[66] 29 C.F.R. § 2590.702 (2008).

[67] Section 125 also has its own non-discrimination provisions that apply to discrimination in favor of highly-compensated employees and key employees. These provisions are not discussed here (see Butler, *supra* note 51 at 3-4 for thorough analysis of these provisions.) If they are violated, however, favored employees may not be able to take advantage of the tax advantages offered by § 125.

[68] I.R.C. § 5000(b)(1).

[69] Dept. of the Treasury, Proposed Rule, 72 Fed. Reg. 43938 (Aug. 6, 2007) to be codified at 26 C.F.R. § 125-1(m). It would seem to make no sense for the Treasury Department to specify that individual policies could be purchased through a § 125 arrangement if all health insurance purchases made through a § 125 arrangement automatically became part of a group health plan due to the fact that § 125 contributions are considered employer contributions for tax purposes.

[70] I.R.C. § 125(d) and (f).

[71] See Butler, *supra* note 51; Monahan, *supra* note 51 at 3. The one case that has interpreted the tax code definition (for the purposes of a different law that uses the same definition) held that the fact that individual policies paid for on a payroll deduction basis were issued to employees rather than through a group policy conclusively determined that the policies were individual rather than group policies. *Brooks v. Blue Cross & Blue Shield of Florida*, 116 F.3d 1364 (11th Cir. 1997) (interpreting the definition for the Medicare as secondary payer statute.) This would not, of course, be persuasive authority for interpreting the definition for HIPAA purposes. The tax definition of group plan is also used for COBRA continuation coverage requirements. Regulations implementing COBRA regulation seem to extend the reach of that definition. 26 C.F.R. § 54.4980B-2 provides that insurance provided through individual policies by an employer could constitute group coverage "even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization." This definition is not directly relevant to HIPAA coverage, but might be used by a court to interpret ERISA.

[72] See S.S. Laudicina et al., "State Legislative Health Care and Insurance Issues, 2007 Survey of Plans," BlueCross BlueShield Association, 2007, *available at* http://www.cahc.net/documents/Acr17.pdf (last visited Dec. 16, 2008).

[73] On coverage mandates, see F.A. Sloan and C. J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, 39 (1998): 118; A. C. Monheit and J. Rizzo, Mandated Health Insurance Benefits: A Critical Review of the Literature, New Jersey Dept. of Human Services and Rutgers Center for State Health Policy, Jan. 2007, *available at* http://www.cshp.rutgers.edu/Downloads/7130.pdf (last visited Dec. 16, 2008). On rating reforms, see K.I. Simon, "What Have We Learned From Research on Small Insurance Reforms?" in A. C. Monheit and J. C. Cantor, eds., *State Health Insurance Market Reform* (New York: Rutledge , 2004) and D. Chollet, "What Have We Learned From Research on Individual Market Reforms?" in A. C. Monheit and J. C. Cantor, eds., *State Health Insurance Market Reform* (New York: Rutledge, 2004).

[74] See Wicks & Hall, *supra* note 2 at 535-37.

[75] K. Swartz, *Reinsuring Health: Why More Middle Class People are Uninsured and What Government Can Do* (New York: Russell Sage, 2006).

[76] It should be noted that the line between private and public purchasing exchanges might not always be bright. The state may become so entwined with private actors that their actions can become state action for purposes of constitutional constraints. See *Brentwood Academy v. Tennessee Secondary School Athletic Ass'n*, 531 U.S. 288 (2001) (stating actions of private entities will be viewed as state actions when the two are irreparably entwined).
[77] NAIC Model Laws, Regulations and Guidelines, 82-1.
[78] According to the NAIC, 22 states have adopted the Model Act or related legislation or regulations. See also J. L. Kaminski, "Health Insurance Purchasing Cooperatives," OLR Research Report, 2006 *available at* http://www.cga.ct.gov/2006/rpt/2006-R-0005.htm (last visited Dec. 16, 2008).
[79] See M. Kofman et al., "Association Health Plans: What's All the Fuss About?," *Health Affairs*, 25 no. 6 (2006): 1591-1602.
[80] M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, 19 no. 2, (2000): 173-184 at 178-179.
[81] 15 U.S.C. §§ 1 & 2 (2007).
[82] *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980); *Parker v. Brown*, 317 U.S. 341 (1943); J. Blumstein, "Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation," *Cornell Law Review*, 79 (1994): 1459-1506; F. Miller, "Health Insurance Purchasing Alliances: Monopsony Threat or Procompetitive Rx for Health Sector Ills?" *Cornell Law Review*, 79 (1994): 1546-1572.
[83] C. Havighurst, "Antitrust Issues in the Joint Purchasing of Health Care," *Utah Law Review*, 1995 (1995): 409-450.
[84] H. R. Harper and J.J. Miles, *Antitrust Guide for Health Care Coalitions* (George Washington University: National Health Policy Forum, 1983).
[85] See T. Greaney, "Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation," *Connecticut Law Review*, 21 (1989): 605-665. In a 1994 business review letter, the Department of Justice stated that it would not challenge a purchasing group representing sixteen large private firms and the California Public Employees Retirement System that proposed to negotiate a price for two standard benefit plans with Health Maintenance Organizations (HMOs) for its members, with an understanding that the members would not negotiate independently with the HMOs (although they could contract outside the group with other HMOs), because the Justice Department concluded that the arrangement had the potential to create efficiencies and bring about lower health care costs. Bay Area Business Group on Health, Letter Number 94-4, Trade Regulation Reporter (CCH), ¶ 44,094 (Feb. 18. 1994).
[86] *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918); Havighurst, *supra* note 83 at 417.
[87] See U.S. Dept. of Justice, *Statements of Antitrust in Health Care Policy Issued By the Dept. of Justice and Federal Trade Commission,* Aug. 1996, 68 *available at* http://www.usdoj.gov/atr/public/guidelines/0000.pdf (last visited Dec. 16, 2008).
[88] 29 U.S.C. § 1002(40) (2008).
[89] 29 U.S.C. § 1002(1) (2008).
[90] 29 U.S.C. § 1002(5) (2008).
[91] It could perhaps be argued that insurance exchanges are not formed for the purpose of "offering or providing" benefits, but rather merely to facilitate access to insurers who independently offer benefits. This seems to be an implausible argument.
[92] U.S. Dept. of Labor, "MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," 2004, *available at* http://www.dol.gov/ebsa/pdf/mwguide.pdf (last visited Dec. 16, 2008); S. Stadtmauer, "Self-Insured MEWAs: Are the Risks Worth the Reward?," *Quinnipiac Health Law Journal*, 7 (2003-4): 284-87.
[93] *Moideen v. Gillespie*, 55 F.3d 1478 (9th Cir. 1995).
[94] U.S. Dept. of Labor, *supra* note 92.
[95] See *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982); *Chao v. Crouse*, 346 F.Supp.2d 975 (S.D.Ind. 2004.). They may also be subject to other ERISA obligations imposed on administrators as opposed to obligations imposed on plans. See, e.g., 29 C.F.R. § 29 C.F.R. § 2560.503-1(f) – (j) (2007).
[96] U.S. Dept. of Labor, Employee Benefits Security Administration, "FAQS on the Form M-1," *available at* http://www.dol.gov/ebsa/faqs/faq-FormM1.html (last visited Dec. 16, 2008).
[97] 29 U.S.C. § 1144(b)(2)(B) (2008).
[98] 29 U.S.C. § 1144(b)(6)(A) (2008).
[99] *Id.*
[100] Under 29 U.S.C. § 1144, a MEWA is considered to be "fully insured", "only if the terms of the arrangement provide for benefits . . . guaranteed under a contract, or policy of insurance, issued by an insurance company,

insurance service, or insurance organization, qualified to conduct business in a State." 29 U.S.C. § 1144(b)(6)(D) (2008).

[101] *MDPhysicians & Associates, Inc. v. State Bd. of Ins*, 957 F.2d 178 (5th Cir. 1992).

[102] *Niethammer v. Prudential Ins. Co. of America*, 2007 WL 1629886 (E.D.Mo. 2007); *May Hollingshead v. Matsen*, 40 Cal.Rptr.2d 603 (Cal.App. 1995).

[103] *Independent Distributors Co-op. USA v. Advanced Ins. Brokerage of America*, Inc. 264 F.Supp.2d 796 (S.D. Ind. 2003).

[104] *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982); *Chao v. Crouse*, 346 F.Supp.2d 975 (S.D.Ind. 2004).

[105] Stadtmauer, *supra* note 92 at 268;.M. Kofman et al., "MEWAs: The Threat of Plan Insolvency and Other Challenges," Commonwealth Fund, March 2004 *available at* http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf?section=4039 (last visited Dec. 15, 2008); M.Kofman et al., "Insurance Markets, Group Purchasing Arrangements: Implications of MEWAs," California Healthcare Foundation, Issue Brief, July 2003 *available at* http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=21070 (last visited Dec. 15, 2008).

[106] 45 C.F.R. § 164.500(b) (2007).

[107] 45 C.F.R. §§ 160.103. (2007). Although the term "health care clearinghouses" would seem to apply to insurance exchanges, in fact it refers to specific kinds of entities that standardize health data.

[108] Unless it could be argued that an exchange is described by the part of the health plan definition that refers to "any other individual or group plan, or combination of individual or group plans that provides or pays for the cost of medical care." 45 C.F.R. §§ 160.103 (2007).

[109] 45 C.F.R. § 164.501 (2007).

[110] 45 C.F.R. §§ 164.502(d), 164.514(a) & (b) (2007).

[111] 45 C.F.R. §§ 160.103, 164.502(e), 164.504(e) (2007).

[112] 45 C.F.R. § 160.504(a) & (f) (2007).

[113] 45 C.F.R. § 164.502(e)(1)(i) (2007).

[114] 42 U.S.C. § 1320d(5) (2008).

House, Senate View Health Exchanges Differently

by JULIE ROVNER

January 12, 2010 4:00 AM

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Morning Edition **4 min 20 sec**

Getting a final health overhaul bill to President Obama's desk by the end of the month or early February remains the goal of lawmakers who are returning to Washington this week. But the task remains a tricky one. Even some of the things the House and Senate appear to agree on hide some key disputes.

One example is the so-called "health care exchanges," the marketplaces where individuals and small businesses would be able to shop for health insurance in an overhauled system. Both the House and Senate call for the creation of such exchanges in the bills they passed in November and December, respectively. But the different versions would work in very different ways.

The basic idea is the same. In fact, it's the same as one of the best-known health insurance exchanges already up and running: Massachusetts' Commonwealth Connector.

"We're a little bit like Travelocity for health insurance," says Jon Kingsdale, executive director of the Commonwealth Health Insurance Connector Authority. "It's an electronic, automated store for insurance."

Because almost everyone in Massachusetts is required to have insurance as a result of a law passed in 2006, Kingsdale says, he and his staff have worked hard to make the process as simple as possible.

"Literally, you get on our Web site, you give us three pieces of information that are required for determining the premium: age, zip

code and family size," he says. Then individuals get to choose the level of benefits.

"Do they want gold-level benefits — kind of a Cadillac plan — or do they want silver or bronze? And then we can array for them on the Web easy-to-compare options — typically three to five health plans that meet the specifications they've given us."

Kingsdale says it typically takes people 20 to 30 minutes to evaluate their options, decide which plan to purchase "and [they] push a button and they're enrolled."

Massachusetts' program is just one example of a health insurance exchange. Timothy Jost, a professor at Washington and Lee University School of Law, says there are other examples within the federal government.

"The federal employee health benefits program and, in fact, the Medicare Advantage and Medicare prescription drug program look a lot like exchanges as well," he says.

As envisioned in the health overhaul bills, the new health exchanges would provide even more tools for consumers than many existing health exchanges. For example, Jost says, "Under the Senate bill, one of the things that they would provide would be sort of little scenarios: So if you get breast cancer, these are the kinds of things we would cover, these are the kinds of things we wouldn't cover, this is the cost-sharing that you're going to face."

The exchanges will also be responsible for handling a lot of the new paperwork that will come with the new law — things like sorting out subsidies and tax credits for people and businesses eligible for government help.

And if the exchanges work correctly, they could do even more than just help consumers make better choices.

"The comparison shopping and the bidding dynamics that this insurance store would create would add some significant downward pressure on premiums," Kingsdale says. "Just like Wal-Mart: It's just a store, but it's done a pretty remarkable job in pushing prices down. With enough volume and enough expertise, I think exchanges can have a similar impact."

But while House and Senate lawmakers envision the exchanges performing similar functions, there are some key differences.

For example, not everyone will be able to use the exchanges. In both bills, at least at first, only individuals who don't have access to insurance at work and small businesses could buy coverage through the exchanges. But while the House bill might open up the exchanges to more people and larger firms later on, the Senate bill would not.

Another very big difference is that in the House bill, the exchange would be national, set up and run by the federal government. In the Senate bill, each state will have to set up its own exchange, complete with its own state law on the subject.

Liberals tend to support the House's national approach; moderates, the insurance industry and the state insurance commissioners prefer the Senate approach that gives each state responsibility for its own exchange.

Jost worries about the Senate's approach: "It seems to me to be a much more complicated process that has a lot more room for failure and, frankly, I think a lot less accountability," he says. "Because if the state fails to do it, then the federal government is supposed to step in, but I think it's going to be difficult for the federal government to step in — to say to a state, 'You failed; we're taking over.' "

Indeed, on Monday a group of Democratic House members from Texas wrote to President Obama urging that the House approach be preserved in the final bill. They 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.

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U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans

Posted on Monday, January 11th, 2010

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Doggett, Members of the Texas Democratic Delegation Urge President Obama, House Leadership to Adopt National Health Insurance Exchange

Washington— Today, U.S. Congressman Lloyd Doggett (D-TX-25), a senior Member of the Ways and Means Health Subcommittee, and Members of the Texas Democratic Delegation, urged President Obama, Speaker Pelosi, and Majority Leader Hoyer, to adopt a single, national health insurance exchange, to protect Texans from second-rate care. A state-based plan reduces the market leverage of the exchange, increases complexity, and relies on laggard state leadership that, in Texas, would be unwilling or unable to administer the exchange, leaving millions of Texans no better off. Larger exchanges and stronger regulators are better exchanges with more competition and more protection for consumers. The Members urged adoption of the House's national exchange.

"With 1 in 4 Texans living without insurance, we should not settle for second-rate care. Instead we should ensure access to the lowest cost, highest-quality insurance plans, which means we need a national health insurance exchange," said Rep. Doggett.

Historically in Texas, relying on state authority to provide care for its citizens has proved a treacherous path. As it stands today, not one Texas child has received any benefit from the *Children's Health Insurance Program Reauthorization Act* approved by Congress early last year.

The U.S. House of Representatives and U.S. Senate are currently working to merge their two bills, which will be sent to President Obama's desk for signature.

[The full text of the letter follows below]

A letter was sent to Speaker Pelosi and Majority Leader Hoyer and President Obama.

President Barack Obama

The White House

1600 Pennsylvania Ave NW

Washington, D.C. 20500

Dear Mr. President:

In adjusting the House and Senate versions of health insurance reform legislation, we know you share our goal of achieving reform that is real and meaningful. Any bill that we support must not shortchange Texans by including weak, state-based health insurance exchanges. We cannot support second-rate coverage in our state with the highest rate of uninsured in the country – where 1 in 4 Texans lack insurance and health insurance premiums

have increased more than 100% since 2000. In order to ensure that Texans have access to the lowest cost, highest-quality health insurance plans as soon as possible, the bill we pass should include a single, national health insurance exchange, as adopted by the House in the Affordable Health Care for America Act.

The House bill establishes a national insurance exchange, but allows states with the political will and the resources available to establish their own exchanges, as long as the state-based exchange meets the same strong standards as the national health insurance exchange. This approach protects existing state exchanges and allows innovation, while ensuring that consumers enjoy the same coverage and protections afforded in the national exchange.

As you know, the Senate bill does not establish a national health insurance exchange. Instead, each state is required to set up its own exchange. If the state does not set up the exchange, then the Secretary of Health and Human Services is required to set up an exchange for the state. The states will set up one exchange for individual coverage and another exchange for small businesses. The state may also set up regional exchanges within the state, which would create multiple exchanges in one state.

This approach not only reduces the market leverage of the exchange and increases complexity, but it also relies on states with indifferent state leadership that are unwilling or unable to administer and properly regulate a health insurance marketplace. A number of states opposed to health reform have already expressed an interest in obstruction.

In Texas, we know from experience that the dangers to the uninsured from greater State authority are real. Not one Texas child has yet received any benefit from the Children's Health Insurance Program Reauthorization Act (CHIPRA), which we all championed, since Texas declined to expand eligibility or adopt best practices for enrollment. We also know that when states face difficult budget years, among the first programs to see reductions is Medicaid. The Senate approach would produce the same result — millions of people will be left no better off than before Congress acted. Further, multiple exchanges fracture the market, diluting the risk pooling benefits of the exchange. This will be especially true if the state sets up multiple exchanges. Also, many states currently only have one or two dominant insurers. State-based exchanges will do nothing to bring more insurers into the area. The Senate bill also allows insurance companies to continue offering insurance outside of the exchange. This further weakens the risk pooling effect of the exchanges and creates incentives for adverse selection.

Reforming our nation's health care system is a national effort that requires a national solution, not a piecemeal approach. A single, national health insurance exchange will not only administer federal affordability credits and receive federal start-up funds, but will also be charged with enforcing federal laws and regulations. As the Commonwealth Fund recently reported, a single, national health insurance exchange would ensure uniform, national availability of health insurance plans, better serve consumers, and have the resources to appropriately regulate insurers.

As we work toward the conclusion of the health care bill, please help us ensure that our constituents receive the care they deserve. We are grateful for your leadership in advancing this reform and we stand ready to support your efforts to establish a national health insurance exchange.

Lloyd Doggett	Gene Green
Henry Cuellar	Solomon Ortiz
Sheila Jackson Lee	Ciro Rodriguez
Silvestre Reyes	Eddie Bernice Johnson
Charles Gonzalez	Al Green
Ruben Hinojosa	

Posted in: Harlingen.

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FORMER FEDERAL JUROR CHARGED WITH JURY TAMPERING →

5 Comments

1. *The IRS Has Gone Rogue : Sandhu Homes Adult Care* says:
   Thursday, September 27, 2012 at 10:39 am

   [...] could clear both chambers. On January 11, eleven House Democrats from the Texas delegation sent a letter to President Obama, House Speaker Nancy Pelosi (D., Calif), and House Majority Leader Steny Hoyer [...]

2. *The IRS Has Gone Rogue - ALIPAC* says:
   Saturday, September 29, 2012 at 5:35 am

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

ASSISTANT SECRETARY

July 31, 2013

The Honorable Darrell Issa
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Issa:

I write in response to your July 25, 2013 letter to Secretary Lew concerning the process by which the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) developed and finalized the regulations for section 36B under the Internal Revenue Code. For the past nine months, Treasury has been cooperating with the Committee to address its questions about the rationale behind the regulations while also protecting the legitimate confidentiality interests of the Executive Branch in the deliberative stages of the rulemaking process.

You have asked for the factors Treasury and the IRS considered in determining that premium tax credits are available to all eligible individuals who purchase health insurance through federally facilitated exchanges. In response, Treasury has written three letters, made available more than 500 pages of documents, and participated in three separate briefings with Committee staff regarding the details of our determinations.

You also have asked for information about the discussions between Treasury and IRS personnel during the 36B rulemaking process. We are committed to working with the Committee to provide the information that you need. At the same time, we need Treasury and IRS personnel to be able to engage in free, full, and unfettered discussions about policy and legal matters. Public disclosure of such discussions could have a significant chilling effect on their deliberations and could inhibit the ability of agency staff to fulfill their statutory responsibilities. In addition, Treasury is facing active litigation in federal court regarding these very regulations.

As part of our ongoing dialogue with the Committee, below we summarize the information provided thus far related to the 36B rulemaking process. We also address the Committee's request for additional information.

I. Correspondence, Documents, and Briefings Describe our Rationale

In three previous letters, dated October 12, 2012, October 25, 2012, and February 5, 2013, we described the standard process by which Treasury and the IRS develop tax regulations. We also described how we followed that process for drafting and approving the regulations implementing section 36B. In addition, the letters described the legal basis for our interpretation that the Affordable Care Act (ACA) did not limit the tax credit solely to state exchanges.

Beyond these letters, we have made available more than 500 pages of materials responsive to the Committee's requests. Included were the internal Treasury memoranda that accompanied the clearance packages for both the proposed and final regulations. The memoranda outline considerations raised and issues resolved during the drafting process. They discuss comments Treasury received in response to the proposed regulations and how those comments were addressed in the final regulations. They describe the legal analysis supporting the conclusion that Congress did not intend section 36B to provide a tax credit to taxpayers enrolled through a state exchange while denying a tax credit to taxpayers enrolled through a federal exchange.

In addition to the letters and documents, we have provided three separate briefings for Committee staff on the legal analysis and the drafting process behind the 36B regulations. At the staff's request in those briefings, Treasury and IRS personnel reviewed the text of section 36B, the text of other provisions of the ACA, and the legislative history to explain our legal conclusions about the federally facilitated exchanges and why those conclusions were consistent with the statute.

The November 2, 2012 briefing involved three Treasury personnel and lasted over one hour. The April 4, 2013 briefing involved four Treasury personnel (two from November), lasted almost 3.5 hours, and included 24 pages of questions. The June 13, 2013 briefing involved three personnel (one from Treasury and two from the IRS), lasted more than three hours, and included largely the same questions as those asked in April. All told, eight different personnel from Treasury's Office of Tax Policy, Office of General Counsel, and Office of the Executive Secretary, as well as from the IRS's Office of Income Tax and Accounting and Office of Health Care Counsel, have briefed Committee staff for approximately eight hours regarding the rulemaking process and legal conclusions underlying the 36B regulations.

It is important to note that our responses are not the only sources of information regarding our approach to the 36B rulemaking. For example, your letter cites a July 2012 Congressional Research Service report about our regulations. We respectfully take issue with your characterization of that report, as the authors do not reach any conclusions about the merits of our determinations. Moreover, in discussing the language of section 36B, the authors indicate that the definition of "exchange" in the ACA "arguably links a federally created exchange to one established by a state pursuant to the requirements of § 1311."[3]

[3] Jennifer Staman and Todd Garvey, *Legal Analysis of the Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act,* CONG. RESEARCH SERV. (Jul. 23, 2012).

Additionally, the non-partisan Congressional Budget Office (CBO) has released a letter regarding its assumptions in estimating the effects of the ACA. According to Director Elmendorf, "to the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state."[4]

II. Additional Documents Implicate Confidentiality and Litigation Interests

Your letter also requests information concerning the deliberative process behind the 36B regulations. In addition, you describe a telephone conversation with Treasury staff from March 2013 regarding such information. We disagree with your description of that conversation.

Treasury conducted a search for responsive materials after receiving the initial request. We identified a number of relevant documents. We have made over 500 pages of those documents available to the Committee during the past nine months. There also is a subset of documents that we have not made available.

The subset includes deliberations from the 36B rulemaking process. Your request for these documents implicates well-established Executive Branch confidentiality interests. The public release of agency rulemaking deliberations could have a significant chilling effect on the Executive Branch's ability to fulfill its statutory obligations. Agency staff and counsel must be able to engage in free, full, and unfettered discussions about policy and legal matters. This is a longstanding principle of Administrations from both parties. Our confidentiality interests are particularly acute here because of Treasury's involvement in ongoing litigation on these regulations.

Committee staff have requested a narrative description of the materials that implicate our confidentiality and active-litigation interests. The documents at issue range from December 2010 through July 2012. They reflect the information Treasury and IRS personnel described during the course of the three briefings.

The documents prior to August 2011 reflect the deliberations of Executive Branch personnel as they participated in the rulemaking process for developing the 36B regulations. They show that Treasury and IRS personnel formed a working group that identified and addressed various legal issues that arose in the rulemaking process; engaged in interagency deliberations regarding ACA implementation; considered the availability of the premium tax credit for federally facilitated exchanges prior to the publication of the proposed regulations; and performed legal analysis of that issue. They reflect that the analysis led Treasury and the IRS to conclude that the tax credit

[4] Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Darrell E. Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, (Dec. 6, 2012).

was intended to be available for eligible taxpayers who purchased insurance through federally facilitated exchanges.

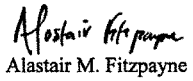
The documents after August 2011 show additional analysis and interagency coordination related to Treasury and the IRS's promulgation of the final rule, issues identified in comments to the proposed regulations, and how such issues were addressed. The final regulations include Treasury and the IRS's conclusions that the tax credits should be available for eligible taxpayers who purchased insurance through federally facilitated exchanges, which is consistent with the proposed regulations. The documents also show internal discussion about issues raised in response to publication of the final regulations.

III. Conclusion

Treasury remains committed to cooperating fully with the Committee. Emily McMahon, Deputy Assistant Secretary for Tax Policy, is testifying at the upcoming hearing before the House Oversight and Government Reform Subcommittee. Ms. McMahon was the Acting Assistant Secretary when both the proposed and final regulations were published. She also participated in the April briefing with Committee staff, where she described the decision-making process and legal analysis behind the 36B regulations. She can address Members' questions concerning the regulations, subject to the legitimate confidentiality and active-litigation interests already described.

Thank you for your letter. We look forward to continuing to work with you and your staff on important matters related to implementation of the ACA.

Sincerely,



Alastair M. Fitzpayne
Assistant Secretary for Legislative Affairs

Identical letter sent to:
The Honorable Dave Camp
The Honorable James Lankford
The Honorable Charles W. Boustany, Jr.

cc: The Honorable Sander Levin
The Honorable Elijah Cummings
The Honorable Jackie Speier

Post Hearing Questions for the Record for Emily McMahon
House Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements
"Oversight of IRS's Legal Basis for Expanding ObamaCare's Taxes and Subsidies"
July 31, 2013

Chairman Lankford

Question 1:

How many members of the 36B working group were involved with the discussions around the tax credits in federal Exchanges issue? Who were these individuals and what were their roles?

Members of the 36B working group changed over time from when the group was formed in late 2010 to final publication of the 36B regulations in May 2012, but in general, the working group was comprised of representatives from IRS Chief Counsel's Income Tax and Accounting division, IRS's Healthcare Counsel's office, and Treasury's Office of Tax Policy. The process for considering the issue was consistent with the process that Treasury and the IRS normally use in preparing regulations. Under standard procedure, the development of Treasury regulations implementing the Internal Revenue Code begins with the IRS Office of Chief Counsel, and IRS and Treasury Office of Tax Policy lawyers subsequently work together to draft proposed regulations. In this case, first IRS lawyers, and then lawyers from Treasury's Office of Tax Policy, analyzed the text of section 36B, as well as the other relevant provisions of the Affordable Care Act (ACA) and the legislative history of the ACA. After deliberation and debate, their conclusions were reflected in the proposed regulations. Treasury and IRS then reviewed the written and oral comments received in response to the proposed regulations, and concluded that the statute should be interpreted as in the proposed regulations on this point. The final regulations published in May 2012 adopted that view.

Question 2:

What was the organizational structure of the 36B working group and who was in charge?

Members of the 36B working group changed over time from when the group was formed in late 2010 to final publication of the 36B regulations in May 2012. In general, the working group was comprised of representatives from IRS Chief Counsel's Income Tax and Accounting division, IRS's Healthcare Counsel's office, as well as lawyers from Treasury's Office of Tax Policy. The IRS's work on the project was under the supervision of the IRS's Healthcare Counsel, and Treasury's work on the project was under the supervision of Treasury's Tax Legislative Counsel.

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Question 3:

Before it was ruled unconstitutional by the Supreme Court , not only did the PPACA offer 100 percent match to States that expanded Medicaid but it withdrew *all* Medicaid funds to States that did not expand Medicaid. Withdrawing all Medicaid funds in noncompliant States appears inconsistent with the purpose of Obamacare to make health insurance affordable for all Americans who cannot otherwise afford it as you described it to Committee staff in April 2013. Did the IRS working discuss the similarities in the statute between the incentives for States to expand Medicaid and for States to establish Exchanges? Can you provide any evidence of such discussions if they did occur?

Treasury and IRS interpreted the language of the Affordable Care Act in a manner that is consistent with the purpose and structure of the statute as a whole, pursuant to longstanding and well-established principles of statutory construction. Lawyers from the IRS and Treasury's Office of Tax Policy considered the express language of section 36B, as well as the other relevant provisions of the ACA and the legislative history of the ACA.

Question 4:

If Section 1311 and 1321 exchanges are equivalent in all functional respects, as the administration argues, why was it necessary to mention both Sections 1311 and 1321 in the reporting requirement added by reconciliation? Isn't a single reference to Exchange sufficient?

The regulations reflect that where a state chooses not to establish an Exchange pursuant to section 1311 of the ACA, Congress provided in section 1321(c) of the ACA that the Secretary of Health and Human Services "shall…establish and operate such exchange within the State" to serve the residents of that state. In other words, Congress made a federally facilitated Exchange the equivalent of a state Exchange in all functional respects, including making qualified individuals eligible for tax credits to purchase insurance through a federally facilitated exchange.

The regulations take into account the fact that the reporting requirement in section 36B(f)(3) requires federally facilitated Exchanges to report certain information to the IRS, including the aggregate amount of any advance payment of tax credits or cost-sharing reductions that the taxpayer receives under the ACA, and any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit. This requirement would be pointless unless the enrolling individuals were eligible for the premium tax credit. Accordingly, this requirement demonstrates Congress's intent to have premium tax credits available on federally facilitated Exchanges.

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Question 5:

If an applicant receives an advanced premium tax credit, the U.S. Treasury is going to be sending the payment directly to the insurance company. Most individual will still pay a portion of the premium. If individuals stop paying their share of the premium, how will Treasury or IRS know?

Under the ACA, the Financial Management Service, which is a bureau of the Treasury Department, processes advance payments of the premium tax credit. This question concerns the rules for who can receive those advance payments, which are addressed in regulations promulgated by HHS.

It is my general understanding that the following provisions would apply: Section 1412(c)(2)(B)(iv)(II) of the ACA requires an issuer to "allow a 3-month grace period for non-payment of premiums before discontinuing coverage." HHS regulations at 45 CFR § 156.270(d)(2) require these issuers to "notify HHS of such non-payment." My general understanding is that, if advance payments should be stopped, HHS will notify the Financial Management Service. For more information, please see HHS Regulations at 45 CFR § 156.270.

Question 6:

How long can individuals go without paying their share of the premium before Treasury stops sending checks to the health insurance company?

Under the ACA, the Financial Management Service, which is a bureau of the Treasury Department, processes advance payments of the premium tax credit. This question concerns the eligibility rules for who can receive those advance payments, which are addressed in regulations promulgated by HHS.

It is my general understanding that the following provisions would apply: Section 1412(c)(2)(B)(iv)(II) of the ACA requires an issuer to "allow a 3-month grace period for non-payment of premiums before discontinuing coverage." HHS regulations at 45 CFR § 156.270(d)(2) require these issuers to "notify HHS of such non-payment." It is my general understanding that advance credit payments will continue during this 3-month period. My general understanding also is that if a taxpayer does not pay premiums in full for 3 months, the issuer will terminate coverage retroactive to the end of the first of those months and will be required to return any advance payments received for the second and third of those months.

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Question 7:

Will IRS or Treasury recoup advanced subsidies that have been sent to insurance companies? Will the tax credit recipient be required to repay the subsidy when the credit is reconciled at the end of the year if they stopped paying their share of the premium at some point?

Section 36B(f) provides that a taxpayer must reconcile on their income tax return for the taxable year the premium tax credit allowed under section 36B with the advance payments paid during the course of that year and must pay the amount of any excess advance payments as additional tax. For taxpayers with household income below 400 percent of the federal poverty level, Section 36B(f)(2)(B) caps the amount of additional tax liability the taxpayer must repay.

Question 8:

An applicant residing in a state that established an Exchange but did not expand Medicaid, overestimates their expected income and qualifies for an exchange subsidy. If the applicant's income is later determined to be below 100 percent of the FPL, and ineligible for subsidies, will the applicant be forced to repay the subsidy when the credit is reconciled at the end of the year? Please explain.

Generally, an applicant who is authorized by a Marketplace to receive an advance payment of the premium tax credit and who turns out to have household income for the year below 100 percent of the federal poverty line will not be required to pay back the advance payments, if the applicant is otherwise eligible for the premium tax credit. This rule is laid out as follows in the final regulations under section 36B: "A taxpayer…whose household income for a taxable year is less than 100 percent of the Federal poverty line for the taxpayer's family size is treated as an applicable taxpayer if (i) The taxpayer or a family member enrolls in a qualified health plan through an Exchange; (ii) An Exchange estimates at the time of enrollment that the taxpayer's household income will be between 100 and 400 percent of the Federal poverty line for the taxable year; (iii) Advance credit payments are authorized and paid for one or more months during the taxable year; and (iv) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was between 100 and 400 percent of the Federal poverty line for the taxpayer's family size." See 26 CFR 1.36B-2(b)(6).

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