1-18-2011

Liberty University v. Geithner - Brief for Appellants

Liberty University

APPEAL NO. 10-2347

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

LIBERTY UNIVERSITY, a Virginia Nonprofit Corporation; MICHELE G. WADDELL; JOANNE V. MERRILL,

PLAINTIFFS-APPELLANTS

v.

TIMOTHY GEITNER, Secretary of the Treasury of the United States, in his official capacity; KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services, in her official capacity; HILDA L. SOLIS, Secretary of the United States Department of Labor in her official capacity; ERIC H. HOLDER, JR., Attorney General of the United States, in his official capacity,

DEFENDANTS-APPELLEES.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA AT LYNCHBURG

OPENING BRIEF OF APPELLANTS LIBERTY UNIVERSITY, MICHELE G. WADDELL AND JOANNE V. MERRILL

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CORPORATE DISCLOSURE STATEMENT

Appellants hereby state, pursuant to F. R. App. P. 26.1 that there is no parent corporation or publicly held corporation that owns 10 percent or more of their stock.

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STATEMENT OF JURISDICTION

Plaintiffs allege that provisions of the Patient Protection and Affordable Care Act of 2009 (the "Act") are outside of Congress' delegated powers under the United States Constitution, and violate the First, Fifth and Tenth Amendments and the Religious Freedom Restoration Act ("RFRA") 42 U.S.C. §§ 2000bb-1(a)-(b). The district court had jurisdiction under 28 U.S.C. §1331 and 28 U.S.C. §1343.

Plaintiffs appeal from a final judgment dismissing all causes of action of the Second Amended Complaint pursuant to Federal Rule of Civil Procedure 12(b)(6), in which the district court reached the merits of the case. This Court has jurisdiction pursuant to 28 U.S.C. § 1291. The final judgment was entered on November 30, 2010 and Plaintiffs filed a notice of appeal on December 1, 2010.

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Whether Congress has authority under the Commerce Clause to regulate a private citizen's inactivity in commerce (a decision not to purchase health insurance and to otherwise privately manage her own healthcare) and force said citizen to participate in commerce by mandating that she purchase a particular kind of health insurance approved by the federal government or pay a penalty for noncompliance.

2. Whether Congress has authority under the Commerce Clause to mandate that employers offer employees a particular level of health insurance coverage

approved by the government at a price the government determines to be affordable or pay a penalty for noncompliance.

3. Whether Plaintiffs' right to free exercise of religion under the First Amendment is violated when Congress mandates that citizens purchase health insurance with mandated coverage provisions that conflict with their sincerely held religious beliefs or pay a penalty, while simultaneously exempting others from the same requirement because of their religious opposition.

4. Whether Plaintiffs' right to free exercise of religion under the Religious Freedom Restoration Act is violated when Congress mandates that citizens purchase health insurance with mandated coverage provisions that conflict with their sincerely held religious beliefs or pay a penalty, while simultaneously exempting others from the same requirement because of their religious opposition.

5. Whether Congress violates the Establishment Clause by exempting members of certain religious sects from mandated health insurance but not exempting other members of different religious sects solely because they do not belong to or adhere to the tenets of the preferred religious sect.

6. Whether Congress violates the Fifth Amendment Equal Protection Clause by exempting members of certain religious sects from mandated health insurance but not exempting other members of different religious sects solely because they do not belong to or adhere to the tenets of the preferred religious sect.

STATEMENT OF THE CASE

Plaintiffs oppose Congress' unprecedented attempt to force private citizens who have decided not to participate in commerce to engage in commerce by mandating that they purchase a particular kind of health insurance approved by the federal government or pay a penalty. Plaintiffs also oppose Congress' unprecedented attempt to force employers to provide a particular level of health insurance coverage to all their employees under threat of sanction. Plaintiffs challenge provisions in the Patient Protection and Affordable Care Act of 2009, Pub. L. No. 111-148, 124 Stat. 119 (2010) (the "Act") as exceeding Congress' delegated powers under Article I, § 8 and violative of Plaintiffs' constitutional and statutory rights. Plaintiffs challenge §§ 1501 and 1513 of the Act, which establish the "individual mandate" and the "employer mandate." The individual mandate dictates that, with limited exceptions, all citizens obtain health insurance coverage that encompasses what the government determines to be "minimum essential coverage" or pay significant penalties. Section 1501, 26 U.S.C. §5000A. The employer mandate dictates that, with limited exceptions, employers provide employees with health insurance coverage that meets what the government determines to be "minimum essential coverage" at what the government determines is affordable or pay significant penalties. Section 1513, 26 U.S.C. §4980H.

On the day that the Act became law, Plaintiffs filed a Complaint seeking declaratory and injunctive relief under 42 U.S.C. §1983. Plaintiffs alleged, *inter alia*, that the individual and employer mandates exceed Congress' delegated powers under Article I, § 8 of the Constitution, violate Plaintiffs' rights to free exercise of religion under the First Amendment and RFRA, free speech and free association rights under the First Amendment, the Establishment Clause, the Equal Protection under the Fifth Amendment, the Tenth Amendment, the Guarantee Clause, and provisions against direct or capitation taxes.

Defendants brought motions to dismiss under Federal Rule of Civil Procedure 12(b)(1) and 12(b)(6). Defendants argued that Plaintiffs lacked standing, that their claims were not ripe, and that their claims were barred as improper challenges to tax collection under the Anti-Injunction Act, 26 U.S.C. §7421. Defendants further argued that Plaintiffs could not state valid claims on the merits because the individual and employer mandate provisions were valid exercises of Congress' powers under Article I, § 8. Defendants also argued that Plaintiffs could not state valid claims for violation of their other constitutional and statutory rights.

The district court found that Plaintiffs Kathy Byron, Jeff Helgeson and Dr. David Stein did not have standing, but found that the remaining plaintiffs, Liberty University ("Liberty"), Michele Waddell and Joanne Merrill, had standing. ("Joint Appendix," JA 0158). Only Liberty, Miss Waddell and Mrs. Merrill are appealing

the district court's action. On the ripeness issue, the district court found that "the challenged provisions create a direct and immediate dilemma, forcing Plaintiffs to choose between extensively reorganizing their financial affairs before the provisions go into effect, or risking civil penalties, and, thus, Plaintiffs' suit was not premature. (JA 0159). The Anti-Injunction Act did not bar Plaintiffs' claims because the penalties imposed upon citizens who do not obtain the required health insurance coverage are regulatory penalties, not taxes. (JA 0164).

The court then reached the merits of all of Plaintiffs' claims and dismissed them. The court concluded that "Congress acted in accordance with its constitutionally delegated powers under the Commerce Clause when it passed the employer and individual coverage provisions of the Act." (JA 0164). Adopting an expansive definition of the Commerce Clause, the court held that "decisions to pay for health care without insurance are economic activities." (JA 0171). "I hold that there is a rational basis for Congress to conclude that individuals' decisions about how and when to pay for health care are activities that in the aggregate substantially affect the interstate health care market." (JA 0170). "The conduct regulated by the individual coverage provision is also within the scope of Congress' powers under the Commerce Clause because it is rational to believe the failure to regulate the uninsured would undercut the Act's larger regulatory scheme for the interstate health care market." (JA 0172). The court held that the employer

mandate provision was a logical extension of Congress' power to regulate the terms and conditions of employment, exemplified in the wage and hour standards under the Fair Labor Standards Act and similar federal laws. (JA 0173). The court reasoned that "the opportunity provided to an employee to enroll in an employer-sponsored health care plan is a valuable benefit offered in exchange for the employee's labor, much like a wage or salary," and from that proposition reasoned that it is rational for Congress to mandate that employers provide such insurance coverage to employees. (JA 0174).

The court relied upon its conclusion that the Act was a valid exercise of Congress' Commerce Clause power to find that Plaintiffs could not state claims under the Tenth Amendment and Guarantee Clause. (JA 0175, 0196). The court also dismissed Plaintiffs' claims under the First and Fifth Amendments and under RFRA. (JA 0177-0195).

After Plaintiffs filed this appeal, Judge Hudson of the Eastern District of Virginia entered summary judgment in favor of the Commonwealth of Virginia, reaching the opposite conclusion on the merits to that reached by Judge Moon. *Commonwealth of Va. v. Sebelius*, Civil Action No. 3:10cv188-HEH, Eastern District of Virginia, 2010 WL 5059718 (ED Va. December 13, 2010). Judge Hudson concluded that the individual mandate exceeded Congress' constitutional

authority. The Commonwealth's case addressed only the individual mandate, not the employer mandate or other constitutional issues Plaintiffs have raised here.

STATEMENT OF THE FACTS

Congress is seeking to extend its power far beyond any prior precedent by requiring that, with few exceptions, all individuals and all employers of 50 or more people obtain and maintain what is termed (but not defined) "minimum essential coverage" for themselves and/or their employees. Sections 1501, 1513, 26 U.S.C. §§5000A, 4980H. Section 1501 forces individuals who manage their healthcare privately and do not participate in the commercial insurance market to participate in commerce by obtaining "minimum essential coverage" or paying a penalty. 26 U.S.C. §5000A. Section 1513 compels employers to participate in commerce by obtaining "minimum essential coverage" for their employees or paying a penalty. 26 U.S.C. §4980H.

Congress has not defined "minimum essential coverage," except to say that it must at least include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drug coverage, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services, including oral and vision care. Section 1302, 42 U.S.C. §18022(b). The

precise definition is left to the discretion of the Secretary of the Department of Health and Human Services ("HHS"). *Id.*

Individuals who do not qualify for one of four exceptions and do not have "minimum essential coverage" by January 1, 2014 will be subject to a graduated annual penalty payable as part of their income tax return. 26 U.S.C. §5000A(b), (c). The only people exempted from the mandated health insurance (met through either private insurance or federal programs such as Medicaid and Medicare) are those who are incarcerated, not legally present in the country, or who qualify under two limited "religious exemptions." 26 U.S.C. §5000A(d). The "religious exemptions" encompass only (1) members of religious sects which have been in existence continually since December 31, 1950 and have conscientious objections to acceptance of public or private health insurance or retirement benefits, and (2) members of "healthcare sharing ministries," defined as 501(c)(3) organizations in existence since December 31, 1999, which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. 26 U.S.C. §5000A(d)(2). Employers which do not offer "minimum essential coverage" to their employees as of January 1, 2014 will pay a penalty equal to $2,000 per employee per year if *any* employee purchases alternative coverage and receives a federal tax subsidy. 26 U.S.C. §4980H(a). Even if an employer offers "minimum essential coverage" to its employees it can still be

subject to a penalty of $3,000 per employee per year if the coverage is not deemed "affordable" under the Act, *i.e.*, if *any* employee receives a federal insurance premium subsidy. 26 U.S.C. §4980H(b).

The individual and employer mandates are only a small part of the 2,000+ page Act which makes comprehensive and fundamental changes to the health care and health insurance industries, creates a myriad of new federal bureaucracies and institutes new taxes and penalties. Among the other provisions of the Act is a requirement that all states establish American Health Benefit Exchanges, which are government agencies or non-profit entities created by the state to make "qualified health plans" available to "qualified individuals and employers." Section 1311, 42 U.S.C. §18031. If states do not demonstrate that they will have exchanges in place by January 1, 2014 and that those exchanges will meet the federal standards, then the HHS Secretary will establish and operate exchanges in those states. Section 1321, 42 U.S.C. §18041. States may, but are not required to, prohibit abortion coverage in "qualified health plans" offered through exchanges, but can only prohibit abortion coverage by enacting a law that is subject to repeal at any time. Section 1302, 42 U.S.C. §18022.

Liberty is a private Christian university which employs approximately 3,900 full-time and 1,242 part-time workers. (JA 0018). Approximately 4,340 people are covered by various healthcare reimbursement options in which 1,879 Liberty

employees have chosen to participate. (JA 0018). Liberty offers healthcare reimbursement options that provide the type and level of services that are appropriate to its employees' personal and financial situations and are consistent with Liberty's and its employees' Christian values. (JA 0018-0019). The Act requires Liberty to have in place no later than January 1, 2014 health insurance plans that offer what the government will define as "minimum essential coverage," regardless of whether such coverage provides health care services that are necessary or desirable for Liberty's employees, affordable for Liberty or its employees or compatible with Liberty and its employees' Christian values. (JA 0018-0019). Although Liberty already offers health insurance benefits for its full-time employees, it will nevertheless assuredly face significant penalties under the Act. (JA 0027). Neither Liberty nor its employees can opt out of unnecessary or unwanted medical procedures, including procedures that violate their sincerely held religious beliefs. (JA 0029-0030). Liberty faces significant financial hardship from having to either adjust its health care benefits or pay penalties. (JA 0027).

Miss Waddell and Mrs. Merrill have voluntarily and deliberately decided not to purchase health insurance, but to instead save for and privately manage their health care. (JA 0019-0021). They are Christians who believe in living out their sincerely held religious beliefs in everyday life, including in the lifestyle choices they make, of which managing their health care privately is but one example. (JA

0029-0030). Because of the individual mandate provisions, Miss Waddell and Mrs. Merrill are faced with either paying for "minimum essential coverage" that is unnecessary and undesirable or paying penalties. (JA 0029-0030). When the provision becomes fully effective on January 1, 2014, Plaintiffs will be required to have in place insurance defined as offering "minimum essential coverage" by the government, with no ability to opt out of procedures which violate their sincerely held religious beliefs, or paying a significant annual penalty. (JA 0029-0030). Plaintiffs therefore face the Hobson's choice of paying a penalty or paying for something that collides with their sincerely held religious beliefs. (JA 0029-0030).

SUMMARY OF ARGUMENT

The irresolvable dilemmas posed by the individual and employer mandates coupled with the unprecedented expansion of the Commerce Clause to forcibly reverse personal decisions to not participate in commerce create real and substantial threats not only to Plaintiffs' constitutional rights, but to the liberty of all Americans. The district court reached far beyond the outermost boundary of the Supreme Court's Commerce Clause precedents and crafted an expansive definition of congressional power that, if permitted to stand, will create an unconstitutional national police power that would threaten all aspects of American life. The district court's willingness to expand the Commerce Clause as Congress suggested threatens not only Plaintiffs' constitutional rights, but the bedrock concepts of

federalism and individual freedom upon which the nation was founded. The Founders explicitly withheld a national police power from Congress, reserving that power to the states and the people under the Tenth Amendment. *United States v. Lopez*, 514 U.S. 549, 566 (1995). The Supreme Court has repeatedly rejected Congress' attempts to assume such power, *id.*, and the district court should have done so here. None of the cases cited by the district court change that conclusion or justify the sweeping re-definition of congressional power necessary to justify the individual and employer mandates.

Neither can the mandates be justified as valid exercises of Congress' power under the Necessary and Proper or General Welfare clauses. Those clauses do not provide Congress with *carte blanche* to enact laws that are otherwise outside of their enumerated powers. *United States v. Comstock*, 130 S.Ct. 1949, 1970 (2010) (Alito, J., concurring). Rather than enacting a law in furtherance of its enumerated powers, Congress entered into new territory and assumed a level of power for which there is no prior precedent. *Florida v. United States Dep't. of Health and Human Services*, 716 F. Supp. 2d 1120, 1163 (N.D. Fla. 2010). Congress explicitly enacted the payments for non-compliance with the mandates as penalties, not taxes, and exempted them from the usual enforcement mechanisms available for the non-payment of taxes. 26 U.S.C. §5000A. Consequently, Defendants cannot now claim that the penalties are taxes enacted under the General Welfare Clause.

None of the powers delegated to Congress in Article I §8 give it the authority to enact the expansive, intrusive mandates.

The mandates also trample upon Plaintiffs' free exercise rights under both the First Amendment and RFRA by forcing them to either engage in a commercial transaction that conflicts with their religious beliefs or pay a punitive penalty. Adopting an improperly narrow view of Plaintiffs' claims, the district court erroneously concluded that the individual and employer mandates impose no burden on Plaintiffs' religious exercise. The district court disregarded the threat posed by compelling Plaintiffs to purchase government-approved health insurance coverage that collides with their sincerely held religious beliefs or pay a penalty. That real and substantial threat places Plaintiffs in the kind of dilemma – choosing between their religious beliefs or complying with a government mandate – that the Supreme Court has rejected. *Thomas v. Review Bd.*, 450 U.S. 707, 718 (1981). Despite the presence of individualized exemptions and a gerrymander of some but not all religious viewpoints, the district court concluded that the mandates were neutral laws of general applicability that satisfied the rational basis test. However, Supreme Court precedent establishes that the mandates are neither neutral nor generally applicable and must be analyzed under strict scrutiny, which they fail to satisfy. *Employment Div. v. Smith*, 494 U.S. 872, 884 (1990).

The "religious exemptions" to the insurance mandates grant differential and preferential treatment to certain religious denominations in violation of both the Establishment Clause and Equal Protection. The district court failed to follow precedent when it improperly dismissed Plaintiffs' claims of violation of the Establishment Clause and Equal Protection. This Court should reverse the district court's ruling and find that the individual and employer mandates are unconstitutional.

ARGUMENT

I. STANDARD OF REVIEW

This Court reviews *de novo* the dismissal of Plaintiffs' Complaint under Rule 12(b)(6), *Duckworth v. State Administration Bd. of Election Laws*, 332 F. 3d 769, 772 (4th Cir. 2003), accepts the well-pled allegations of the complaint as true and construes the facts and reasonable inferences derived from therefrom in the light most favorable to the Plaintiffs. *Chisholm v. Transouth Financial Corp.*, 95 F.3d 331, 334 (4th Cir. 1996). A complaint survives a Rule 12(b)(6) motion if Plaintiffs have alleged enough facts to state a claim to relief that is plausible on its face. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). Plaintiffs have exceeded those standards. *See, id.* (factual allegation must "nudge" a plaintiff's claims over the line from being merely possible to plausible); *Ashcroft v. Iqbal*, 129 S.Ct. 1937, 1951 (2009) (same).

This Court also applies *de novo* review to claims that a federal statute is unconstitutional. *U.S. v. Khan*, 461 F.3d 477, 492 (4th Cir. 2006). Questions of law or mixed questions of law and fact are reviewed *de novo. Wright v. West*, 505 U.S. 277, 299-202 (1992) (O'Connor, J. concurring). Where, as here, a decision prejudices constitutional rights, *de novo* review is particularly appropriate since a court's decision that substantially burdens fundamental rights should not be accorded deference. *Brecht v. Abrahamson*, 507 U.S. 619, 642 (1993) (Stevens, J. concurring).

De novo review here reveals that the individual and employer mandate provisions upheld by the district court must be reversed. The Supreme Court has never extended the Commerce Clause as far as the district court did in this case. *See Wickard v. Filburn*, 317 U.S. 111 (1942); *see also Gonzales v. Raich*, 545 U.S. 1 (2005), discussed *infra*. This extraordinary expansion of Congress' enumerated powers should not be given deferential review.

II. DISCUSSION OF THE ISSUES

After finding that Plaintiffs Liberty, Waddell and Merrill had standing, that their claims were ripe for adjudication, and not barred by the Anti-Injunction Act, the district court proceeded to evaluate the merits, not merely the sufficiency of the factual allegations. (JA 0164-0197). The court went beyond its limited role under Rule 12(b)(6) of merely examining the allegations on their face to determine

whether they state a plausible claim. *Duckworth*, 332 F. 3d at 772. The court examined congressional reports, correspondence and other federal statutes to determine the substantive merit of Plaintiffs' claims. (JA 0164-0197). The court effectively transformed the Rule 12(b)(6) motion into a motion for summary judgment under Federal Rule of Civil Procedure 56. *Carter v. Stanton*, 405 U.S. 669, 671 (1972) (per curiam).[1] The district court did not leave open the possibility of amending the Complaint or remanding the case for further consideration. The court ruled that Congress acted within its powers under Art. I §8 and did not violate Plaintiffs' constitutional and statutory rights. Consequently, the central issue of this case–whether the challenged provisions of the Act comport with the Constitution–is squarely presented for this Court's determination. This court can, and should, address the underlying merits of the case.

A. The District Court Erred When It Determined That The Mandates Are Proper Exercises Of Congress' Authority Under The Commerce Clause.

The cornerstone upon which Congress built the Act and the district court based its decision is an unprecedented, expansive definition of Congress' authority

[1] Even if the underlying ruling were regarded as the granting of a motion for summary judgment instead of a motion to dismiss, this Court would still not apply a deferential standard of review. A district court's order of summary judgment is independently reviewable by the Court of Appeals. *Sarfati v. Wood Holly Associates*, 874 F.2d 1523, 1525 (11th Cir. 1989). Where, as here, there are no disputed issues of material fact, this Court must determine whether the district court erred as a matter of law in granting summary judgment. *Id.*

under Article I, §8, and particularly its power under the Commerce Clause. (JA 0169). The district court concluded that "Congress acted in accordance with its constitutionally delegated powers under the Commerce Clause when it passed the employer and individual coverage provisions of the Act," effectively slamming the door on any challenges to the sweeping and extensive intrusion into Plaintiffs' private lives and operations. (JA 0164). If Congress can redefine inactivity as activity and force individuals who have chosen not to participate in commerce to participate in commerce, then Congress can force every American to buy a General Motors vehicle in order to prevent the demise of GM because transportation is essential to the American way of life. Or, Congress could force every American to buy domestically grown vegetables to prop up the local economy under the rationale that eating vegetables is more healthful than fast food and will lower healthcare costs while simultaneously infusing cash into domestic businesses. The implications of the court's opinion are staggering.

1. The individual mandate far exceeds the limitations the Supreme Court has placed upon Congress' authority under the Commerce Clause.

Eschewing the most relevant and controlling precedents of *United States v. Lopez*, 514 U.S. 549 (1995) and *United States v. Morrison*, 529 U.S. 598 (2000), the district court claimed "that decisions to pay for health care without insurance are economic activities follows from the Supreme Court's rulings in *Wickard [v.*

Filburn, 317 U.S. 111 (1942)] and [*Gonzales v.*] *Raich*, [545 U.S. 1 (2005)]" (JA 0171). Together, *Wickard* and *Raich* teach that Congress has broad power to regulate purely local matters that have substantial economic effects, even where the regulated individuals claim not to participate in interstate commerce." (JA 0169). Neither *Wickard* nor *Raich*, nor any other Supreme Court precedent, supports the district court's conclusion.

a. Raich does not support the district court's expansive re-definition of Congress' Commerce Clause authority.

The flaw in the district court's reliance upon *Raich* is its failure to recognize that the *Raich* plaintiffs did not challenge Congress' authority to enact the underlying statute under the Commerce Clause. *Raich*, 545 U.S. at 15 The *Raich* plaintiffs agreed that passage of the Controlled Substances Act was within Congress' Commerce Clause power, and did not challenge any of the act's provisions as outside of the reach of the Commerce Clause. *Id.* Instead, they argued that the act's categorical prohibition on the manufacture and possession of marijuana exceeded Congress' Commerce Clause power only when applied to California-based manufacture and possession of medical marijuana because those uses were legal in California. *Id.* Unlike here, there was no dispute that the regulated class of activities–manufacturing, growing, possessing and/or selling illegal drugs–was within the reach of Congress' power under the Commerce Clause. *Id.* at 23. That being the case, the Court could not do what the plaintiffs

requested–excise individual provisions from the law in order to permit them to continue growing and possessing medical marijuana. *Id.*

In this case, the district court attempted to apply that finding in *Raich* to Plaintiffs' claims regarding the mandates. (JA 0172). However, the analogy fails since *Raich* dealt with plaintiffs who did not dispute Congress' authority to enact the underlying statute. *Raich*, 545 U.S. at 23. Here, by contrast, Congress' authority to pass the Act is the central issue. Plaintiffs' claims are built upon the proposition that Congress exceeded its delegated powers under Art. I §8 when it approved the Act, and, in particular, the mandates. (JA 0012-0050). The *Raich* court's analysis of an as-applied challenge to an indisputably proper exercise of Congress' authority is inapposite and cannot "dictate the result in the present matter," as the district court claims. (JA 0167).

Even if the plaintiffs in *Raich* had brought a facial challenge to the power of Congress to reach their acts of growing and possessing medical marijuana, the *Raich* case would still not apply here because *Raich* involved voluntary *activity*, whereas the Act regulates voluntary *inactivity*. The distinction between *activity* and *inactivity* is critical. The plaintiffs in *Raich* could avoid Congress' reach by not manufacturing or possessing marijuana, but here the Plaintiffs cannot avoid Congress' reach even if they are not doing anything. *Raich* does not represent a

broadening of Congress' Commerce Clause authority sufficient to encompass the sweeping and intrusive mandate provisions in the Act.

Raich is not a sea change from the limitations placed upon Congress' Commerce Clause authority in *Lopez* and *Morrison* back to the expansive definition in *Wickard*, 317 U.S. 111. Therefore it cannot be used to shore up the district court's expansive re-definition of the Commerce Clause.

b. Wickard does not support the district court's conclusion that private economic decisions can be regulated under the Commerce Clause.

Even the broadened view in *Wickard* does not provide a foundation upon which the district court can build its new expansive definition of congressional power. According to the district court, "[t]he conclusion that decisions to pay for health care without insurance are economic activities follows from the Supreme Court's rulings in *Wickard* and *Raich*." (JA 0171). Implicit in that statement is the leap of logic that a decision not to engage in economic activity is the same as actions taken to produce a crop. In other words, *inactivity* is the same as *activity*. According to the court's analysis, whether Miss Waddell or Mrs. Merrill bought or declined insurance is the same thing, and whether they acted or refused to act is not meaningfully significant. Under the court's definition, Congress can regulate them because they are legal citizens who merely exist. Mr. Filburn's decision to sow 23 acres and harvest more than 400 bushels of wheat, *Wickard*, 317 U.S. at 114,

would become irrelevant because Congress could regulate Mr. Filburn even if he did not grow and harvest wheat. Yet, it was the fact that Mr. Filburn actively grew wheat beyond the quota, even if for personal use, that was significant in *Wickard*. Congress could not have *forced* Mr. Filburn to grow wheat, but that is exactly what the Act does in this case by forcing individuals to buy insurance.

Critical to the Court's conclusion in *Wickard*, and missing in this case, is the fact that the wheat was planted, cultivated and harvested by Mr. Filburn, *id.*, and it was that activity that constituted economic activity. By contrast, Miss Waddell and Mrs. Merrill have exerted no effort and used no resources. (JA 0019-0021). Mr. Filburn was voluntarily and actively participating in the agricultural industry; Plaintiffs have done nothing. *Wickard* merely expanded the type of economic *activity* over which Congress had authority, *id.*, and this is the outer limits of that authority. *Wickard* did not convert inactivity into activity. It did not give Congress authority over inactivity. (JA 0170-0172). Mr. Filburn could have avoided the reach of Congress by not acting; Miss Waddell and Mrs. Merrill can never avoid the reach of Congress under the district court's reasoning. The district court blazed a new trail into the private economic decisions of law-abiding citizens. No Supreme Court case has trod this lonely path and it would be dangerous to our liberty to do so.

c. Lopez and Morrison illustrate how the district court's decision contradicts the Supreme Court's restrained approach to Congress' Commerce Clause authority.

Far less shocking attempts by Congress to regulate private gun ownership and criminal sentencing in *Lopez* and *Morrison* were rejected by the Supreme Court, and in *Morrison,* also rejected by this Court. *Brzonkala v. Virginia Polytechnic and State Univ.*, 169 F.3d 820 (4th Cir. 1999) *affirmed sub nom. United States v. Morrison*, 529 U.S. 598 (2000). The mandates are more troubling than were the provisions struck down in *Lopez* and *Morrison* since those statutes were at least aimed at *actions* taken by individuals, *i.e.*, obtaining a firearm and possessing it near a school and engaging in criminal conduct against a woman, while the mandates are aimed at people who have not taken any action. If the statutes in *Lopez* and *Morrison* were outside of Congress' authority, then the mandates are even more so.

In overturning Congress' attempt to use the Commerce Clause to prohibit the possession of firearms near local schools, the *Lopez* Court emphasized the importance of limiting Congress' enumerated powers to protect fundamental liberties. 514 U.S. at 552. As Defendants did in this case, the government defendants in *Lopez* presented a chain of events that they claimed brought possession of a firearm in a school zone under the Commerce Clause. *Id.* at 563. The government argued that possessing a firearm in a school zone might result in

violence which might affect the national economy by spreading costs throughout the population, reducing travel and threatening productivity by threatening the learning environment. *Id. Lopez* said, "if we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *Id.* at 564. "To uphold the Government's contentions here, we would have to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States," something the Court was unwilling to do. *Id.* at 566-568.

In *Morrison,* the Court built upon *Lopez* to overturn a portion of the Violence Against Women Act which instituted a civil remedy for female victims of violent crime. *Morrison,* 529 U.S. at 617. As in *Lopez,* the *Morrison* Court rejected the argument that a remote chain of inferences can justify the regulation of non-economic activity. *Id.* at 607. "*Lopez* emphasized . . . that even under our modern, expansive interpretation of the Commerce Clause, Congress' regulatory authority is not without effective bounds." *Id.* at 608. "[T]hus far in our Nation's history our cases have upheld Commerce Clause regulation of intrastate activity *only where that activity is economic in nature.*" *Id.* at 613 (emphasis added). "Gender-motivated crimes of violence are not, in any sense of the phrase, economic activity." *Id.* As it did in *Lopez,* the Court expressed concern for the potential

effects of enlarging Congress' Commerce Clause powers as suggested by the government. *Id.* at 615. "Petitioners' reasoning, moreover, will not limit Congress to regulating violence but may, as we suggested in *Lopez*, be applied equally as well to family law and other areas of traditional state regulation since the aggregate effect of marriage, divorce, and childrearing on the national economy is undoubtedly significant." *Id.* at 615-616. "We accordingly reject the argument that Congress may regulate non-economic, violent criminal conduct based solely on the conduct's aggregate effect on interstate commerce." *Id.* at 617.

Simply because Congress stated that the total incidence of decisions against purchasing health insurance has a substantial impact on the national market for health care does not, as the district court believes, make it so. (JA 0171) *Id.*; *Lopez*, 514 U.S. at 557 n.2. "Under our written Constitution . . . the limitation of congressional authority is not solely a matter of legislative grace." *Morrison*, 529 U.S. at 616.

If the district court's view of the Commerce Clause were true, then Congress could force those who dislike vegetables to purchase and consume them using the rationale that everyone has to eat, and vegetables are more healthful than fast food. There are some things Congress simply cannot do. The mandates are beyond the power of Congress. Neither *Wickard*, *Raich*, *Morrison* nor *Lopez* support the court's expansive re-definition of the Commerce Clause.

2. The Trial Court Erred When It Held That The Employer Mandate Is Valid Under The Commerce Clause.

The district court also expansively redefined "wages" when it concluded that the Commerce Clause gives Congress the power to mandate that employers provide health insurance coverage to their employees. (JA 0174). Comparing the mandate provision to minimum wage and hour laws, the district court concluded that "the opportunity provided to an employee to enroll in an employer-sponsored health care plan is a valuable benefit offered in exchange for the employee's labor, much like a wage or salary." (JA0174). The district court found that "the employer coverage requirement is more accurately described as regulating of the terms of the employment contract." (JA 0174). The court said that employers are already engaged in commerce and the fact that they will need to arrange with third party insurers to offer coverage to their employees "is of no consequence." (JA 0174). The court did not explain how mandating that private employers enter into a contract with other private parties for a particular product to benefit employees has no consequences for employers. The district court did not explain how such a third party contract can be likened to minimum wage laws that the Supreme Court has found permissible as a means of preventing unfair competition and labor strikes. *See*, *United States v. Darby*, 312 U.S. 100 (1941) (upholding the Fair Labor

Standards Act "FLSA"); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937) (upholding the National Labor Relations Act ("NLRA")).

The district court cited *Darby* and *Jones & Laughlin*, but then incorrectly expanded their holdings to include not merely minimum wages and hours, but all of the terms and conditions of employment. (JA 0173). Utilizing that expansive misinterpretation of *Darby* and *Jones & Laughlin*, the court concluded that "a rational basis exists for Congress to conclude that the terms of health coverage offered by employers to their employees have substantial effects cumulatively on interstate commerce." (JA 0174). However, *Darby* and *Jones & Laughlin* do not support this conclusion. In both cases, the Supreme Court carefully discussed the interplay between the challenged provisions and interstate commerce. *Darby*, 312 U.S. at 115; *Jones & Laughlin*, 301 U.S. at 31. The Court was concerned about the effects of strikes on the movement of goods and services and the effects of underpaying workers and cutting prices on competition, and on those bases found that the wage and hour laws comported with the Commerce Clause. *Jones & Laughlin*, 301 U.S. at 31; *Darby*, 312 U.S. at 115. Neither case supports the district court's proposition that all aspects of the employment relationship can be subject to Congress' control.

In *Jones & Laughlin*, the Court was careful to qualify its conclusion that the NLRA was a valid exercise of Congress' Commerce Clause authority in a way that

is fatal to the district court's conclusion here. 301 U.S. at 31. The Court noted that the definitions of "commerce" and "affecting commerce" were carefully drafted to complement Congress' authority under the Commerce Clause. *Id.* "Commerce" was defined to include only interstate and foreign commerce, and "affecting commerce" was defined as "'in commerce, or burdening or obstructing commerce or the free flow of commerce, or having led or tending to lead to a labor dispute burdening or obstructing commerce or the free flow of commerce.'" *Id.*

> This definition is one of exclusion as well as inclusion. The grant of authority to the Board does not purport to extend to the relationship between all industrial employees and employers. Its terms *do not impose collective bargaining upon all industry regardless of effects upon interstate or foreign commerce.* It purports to reach only what may be deemed to burden or obstruct that commerce and, *thus qualified, it must be construed as contemplating the exercise of control within constitutional bounds.*

Id. (emphasis added). "The act *does not compel* agreements between employers and employees. *It does not compel any agreement whatever*." *Id.* at 45. (emphasis added). "The act does not interfere with the normal exercise of the right of the employer to select its employees or to discharge them." *Id.* By contrast, the employer mandate does compel employers to provide health insurance or pay a penalty. Section 1513, 26 U.S.C. §4980H. It mandates that private employers enter into agreements with other private businesses to provide health insurance dictated by the government. *Id.*

The employer mandate is also dissimilar to the wage and hours laws found constitutional in *Darby*, 312 U.S. at 115. As was true of the laws validated in *Jones & Laughlin*, the standards upheld in *Darby* did not intrude into all aspects of the employment relationship. *Id.* Instead, the challenged provisions were carefully worded to prohibit only the shipment of goods in interstate commerce which were produced by workers who were not paid at least a minimum wage and were required to work more than a maximum number of permitted hours per week. *Id.* at 110. Unlike the provisions at issue here, the wage and hour provisions in *Darby* applied only to employees who produced goods to be used in interstate commerce and did not prescribe what must be contained within the employment contract, other than setting a floor for wages and a ceiling for hours. *Id.* The Court found that the law "is thus directed at the suppression of a method or kind of competition in interstate commerce which it has in effect condemned as 'unfair.'" *Id.* at 122.

By contrast, the mandates are not targeted to address only particular anti-competitive conduct that will adversely affect interstate commerce, but are expansive regulations of the intimate details of the employer-employee relationship. Congress is not merely setting parameters within which those who want to engage in interstate commerce can operate, but is mandating that all those who employ other people in any type of endeavor must contract with a private party to provide a government-defined product at a government-defined price to

their employees or pay penalties. 26 U.S.C. §4980H. The Supreme Court has not permitted Congress to intrude that far into the employer-employee relationship.

Congress' efforts to protect the integrity of the national economy through targeted statutes aimed at preventing the violation of employees' rights while protecting employers' rights, exemplified by the laws in *Jones & Laughlin* and *Darby*, are a far cry from Congress' efforts here. Rather that acting to prevent abuses that could adversely affect the flow of commerce, Congress is interfering with the flow of business by compelling employers to transact business with third parties. Under that logic, Congress could compel employers to offer employees expense accounts, company cars, or any other perquisites it deems valuable in exchange for labor. That scenario far exceeds the boundaries of Congress' power established in *Lopez*, 514 U.S. at 552 and *Morrison*, 529 U.S. at 616, and even the definition of commerce in *Wickard*, 317 U.S. at 128-129.

3. The trial court's finding that the mandates are reasonable extensions of Congress' enumerated powers contradicts the foundational principle that Congress' enumerated powers are to be exercised within the boundaries of federalism.

The district court utterly disregarded the dual system of government set forth by the Founders. "[E]ven [our] modern-era precedents which have expanded

congressional power under the Commerce Clause confirm that this power is subject to outer limits." *Lopez*, 514 U.S. at 557.

In *Jones & Laughlin Steel*, the Court was careful to explain that its holding was limited. 301 U.S. at 37. The Court warned that the scope of the interstate commerce power "must be considered in the light of our dual system of government and may not be extended so as to embrace effects upon interstate commerce so indirect and remote that to embrace them, in view of our complex society, would effectually obliterate the distinction between what is national and what is local and create a completely centralized government." *Id.* That is precisely what will happen if the district court's decision stands. Congress will have obtained the right to intrude upon the private decisions of individuals and employers, to force them to buy or provide a product, and to mandate the details of that product.

If Congress is permitted to force individuals to purchase health insurance of a particular type at a particular price, it will be "difficult to perceive any limitation on federal power, even in areas such as criminal law enforcement or education where States historically have been sovereign." *Lopez*, 514 U.S. at 564.

> The Constitution creates a Federal Government of enumerated powers. *See* Art. I, § 8. As James Madison wrote: "The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite." The Federalist No. 45, pp. 292-293 (C.

> Rossiter ed. 1961). This constitutionally mandated division of authority "was adopted by the Framers to ensure protection of our fundamental liberties." *Gregory v. Ashcroft*, 501 U.S. 452, 458, 111 S.Ct. 2395, 2400, 115 L.Ed.2d 410 (1991) (internal quotation marks omitted). "Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in any one branch, a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front." *Ibid.*

Lopez, 514 U.S. at 552. The Founders deliberately withheld from Congress "a plenary police power that would authorize enactment of every type of legislation. *See* Art. I, § 8." *Id.* at 566. "[W]e *always* have rejected readings of the Commerce Clause and the scope of federal power that would permit Congress to exercise a police power; our cases are quite clear that there are real limits to federal power." *Lopez*, 514 U.S. at 584 (Thomas, J., concurring) (emphasis in original).

When analyzing a challenge to Congress' exercise of an enumerated power, the court's task is to understand and apply "the framework set forth in the Constitution." *United States v. New York*, 505 U.S. 144, 157 (1992). "The question is not what power the Federal Government ought to have but what powers in fact have been given by the people." *Id.* Nevertheless, the district court re-wrote those parameters by upholding the mandates. The conclusion by the district court is antithetical to the Constitution.

4. The trial court erred in equating the mandate provisions with Congress' regulation of the business of health insurance.

The district court also mistakenly characterized the mandate provisions as merely a further example of Congress exercising its power to regulate the business of health insurance. Congress cited to *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), as authority for the mandate provision. Section 1501(a)(3), 42 U.S.C. § 18091(a)(3). The district court cited *South-Eastern Underwriters*, and compared the mandate provisions to Medicare, the Employee Retirement and Income Security Act of 1974 ("ERISA"), Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), and Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (JA 0176). As is true about the district court's analysis of Supreme Court precedent, its attempt to analogize Congress' intrusion into the private lives of law-abiding citizens to its regulation of certain aspects of the insurance industry fails.

In *South-Eastern Underwriters*, the Supreme Court confirmed that the insurance industry is subject to regulation under the Commerce Clause. *South-Eastern Underwriters*, 322 U.S. at 553. The plaintiffs in *South-Eastern Underwriters* challenged indictments charging violation of the Sherman Anti-Trust Act, claiming that insurance was not subject to the Sherman Act or Congress' power over interstate commerce. *Id.* at 536. The Supreme Court rejected both

contentions. *Id.* at 552-553. "No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance." *Id.* at 553. Congress' "power to determine the rules of intercourse across state lines was essential to weld a loose confederacy into a single, indivisible nation; its continued existence is equally essential to the welfare of that nation." *Id.* at 552. But, the authority to regulate aspects of the insurance industry does not grant Congress the power to dictate that all citizens participate by either purchasing government-defined policy or paying a penalty. Regulating an interstate industry to protect against anti-competitive or other injurious conduct is one thing; demanding participation in the industry is quite another. Congress' enactment of ERISA, COBRA, HIPAA and similar laws are examples of the former, not the latter. Notably, in those enactments, unlike the Act here, Congress made clear that it was not interfering with individual freedom. Those laws permitting some federal regulation of the insurance industry are inapposite to the Act and the mandates. Insurance companies and employers are only regulated if they chose to enter into the insurance market by either insuring or offering insurance. Neither insurance companies nor employers are forced to insure or offer insurance. Here, however, the Act forces employers to offer a government-defined insurance program at the level and cost set by the government. Moreover, none of

the laws relied on by the district court regulate individuals per se, and none of them force individuals to buy insurance. Here, the Act forces unwilling individuals to purchase a government-defined health insurance package. Being forced into the market is critically different than being regulated after one voluntarily participates in the market.

Congress emphasized the continuing importance of individual liberties when it enacted what became known as Medicare in 1965.

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

42 U.S.C. §1395. Congress was explicit about its concern regarding individual freedom in what became 42 U.S.C. §1395a, stating: "Basic freedom of choice-Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services." In the Health Insurance for the Aged and Disabled Act (Medicare), Congress did not attempt to override the will of individuals or employers and compel participation under penalty. The mandate provisions are not merely a natural extension of Medicare. Individuals may choose to not take Medicare and

doctors may choose not to accept Medicare patients. By contrastr, the Act forces individuals to obtain insurance and employers to provide it.

Similarly, when it enacted ERISA, 29 U.S.C. §§ 1001 *et. seq.*, Congress was cognizant of the voluntary nature of employee pension plan benefits. H.R. Rep. 93-533 on Public Law 93-406 1974 USCCAN 4639. Congress enacted ERISA to protect the interests of participants in existing employee benefit plans. *Yates v. Hendon*, 541 U.S. 1, 6 (2004). ERISA established reporting requirements, vesting and funding standards and fiduciary obligations to protect employees' investments in pension plans, and, in particular, to protect employees from losses when pension plans are under funded. *Id.* at 6-7. Congress was clear that it wanted to encourage employers to offer these plans to employees, but that employers and employees retained their freedom to make decisions regarding the plans. 1974 USCCAN at 4647. Unlike the mandate provisions here, ERISA does not compel employers to offer such plans, nor employees to participate in them. Instead, as is true with other Commerce Clause legislation, ERISA regulates those who have *voluntarily* engaged in an *activity* or *entered* into an *agreement*. Employers do not have to create and offer pension plans, but if they decide to, then they will have to comply with ERISA. ERISA is unlike the mandates established under the Act and does not support the district court's finding that the Act is a valid exercise of Congress' enumerated powers.

In Title X of COBRA Congress instituted standards to protect employees who voluntarily agreed to participate in group health plans that their employers voluntarily agreed to offer. Public L. No. 99-272, §§ 10001-10003 (1986), 100 Stat. 82, The relevant provisions in COBRA provide that an employee must be permitted to continue participating in the group health insurance program for a period of time after the employment ends. *Id.* at § 10001(c). COBRA provides that if an employer decides to no longer offer group health plans to its employees, then the continuation provisions in COBRA no longer apply. *Id.* In other words, employers retain their freedom to not offer or discontinue offering employee health insurance benefits. *Id.* As is true with ERISA, COBRA contains provisions that regulate employers who have voluntarily agreed to provide group health plan benefits and benefit employees who have voluntarily agreed to participate in the plans. *Id.* If either party decides to no longer participate in the program, then no one is compelled to do so. *Id.* COBRA does not support the proposition that Congress can use its authority under the Commerce Clause to compel employers to offer group health plans and employees to participate in them, as the district court implies. (JA 0176).

HIPAA also does not support the district court's conclusion that the mandate provisions are a natural extension of Congress' regulation of the health insurance industry. Pub. L. No. 104-191, 110 Stat. 1936 (codified in various sections

beginning with 42 U.S.C. §300gg). As is true with ERISA and COBRA, HIPAA does not mandate that companies or individuals participate in the health insurance industry, but regulates companies which have voluntarily agreed to offer health insurance to individuals and groups. *See id.*, Title I, 110 Stat. at 1939-1991. No individual or organization is compelled to offer or purchase health insurance against his/its will. *Id.* Instead, organizations that want to provide health insurance coverage to others must agree, as a part of engaging in that business, to abide by certain rules and regulations sent forth in HIPAA. *Id.* Unlike the Act here, HIPAA does not demand that companies either partake in the health insurance industry or pay punitive sanctions.

Far from merely being a logical extension of Congress' authority to regulate the insurance industry, the mandate provisions are a giant leap into uncharted territory. Congress is attempting to move from regulating voluntary conduct that affects the national economy to managing private decisions and even inactivity. Congress is attempting to extend its reach from economic activities to non-economic non-activities and to regulate personal decision making. The intrusive and expansive power exemplified in the mandates is without precedent.

B. The Mandates Exceed Congress' Authority Under The Necessary and Proper Clause.

Although the Necessary and Proper Clause grants Congress broad authority to pass laws in furtherance of its constitutionally-enumerated powers, its authority

is not unbridled. *Commonwealth v. Sebelius*, 2010 WL 5059718 at *10. [2] The Necessary and Proper Clause only permits Congress to enact laws that are authorized by one of its *enumerated powers*. *McCulloch v. Maryland*, 17 U.S. 316, 405, 421 (1819). "As the Supreme Court noted in *Buckley v. Valeo,* 'Congress has plenary authority in all areas in which it has substantive legislative jurisdiction, ... so long as the exercise of that authority does not offend some other constitutional restriction.'" *Id.* at 9 (citing *Buckley v. Valeo*, 424 U.S. 1, 132 (1976)). In other words, the Necessary and Proper Clause "does not give Congress *carte blanche*," but must be premised upon an existing enumerated power. *United States v. Comstock*, 130 S.Ct. 1949, 1970 (2010) (Alito, J., concurring).

As Chief Justice John Marshall observed in *McCulloch*, "'[l]et the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consistent with the letter and spirit of the constitution, are constitutional.'" *Commonwealth v. Sebelius*, 2010 WL 5059718 at *10 (quoting *McCulloch*, 17 U.S. at 421). Citing that language from *McCulloch*, the *Comstock* Court described the means-end test that should be used to determine whether Congress has exceeded its authority. *Comstock*, 130 S.Ct. at 1956. "[I]n determining whether the

[2] The district court did not reach the question of whether the mandates are valid under the Necessary and Proper or General Welfare Clause. U.S. Const., art I § 8, cl. 18, 1.

Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Id.* Since there is no constitutionally enumerated power upon which Congress could base its attempt to compel Americans to engage in commerce or pay a penalty, the analysis will necessarily result in a finding that the mandates exceed Congress' power under the Necessary and Proper Clause.

This conclusion is further borne out by Judge Vinson's observations regarding the nature of the mandates. *Florida v. United States Dep't. of Health and Human Services*, 716 F. Supp. 2d 1120, 1163 (N.D. Fla. 2010). "The Commerce Clause and Necessary and Proper Clause have never been applied in such a manner before." *Id.* "The power that the individual mandate seeks to harness is simply without prior precedent." *Id.*

> The Congressional Research Service (a nonpartisan legal 'think tank' that works exclusively for Congress and provides analysis on the constitutionality of pending legislation) advised Congress on July 24, 2009, long before the Act was passed into law, that 'it is unclear whether the [Commerce Clause] would provide a solid constitutional foundation for legislation containing a requirement to have health insurance." The analysis goes on to state that the individual mandate presents "the most challenging question ... as it is a novel issue whether Congress may use this clause to require an individual to purchase a good or service." Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, July 24, 2009, at 3.

Clearly, Congress was not relying upon existing precedent or an enumerated power when it enacted the mandates. Since the mandates are not authorized by an Article I §8 power they cannot be valid.

C. The Mandates Are Not Valid Exercises of Congress' Authority Under The General Welfare Clause.

The Taxing and Spending or General Welfare Clause does not vest Congress with the authority to enact the mandates. The Supreme Court has long held that Congress cannot enact a tax to indirectly regulate what it cannot directly regulate under its enumerated powers. *Child Labor Tax Case*, 259 U.S. 30, 37 (1922) (citing *McCulloch*, 17 U.S. at 423). Congress cannot use the penalty provision in Sections 1501 and 1513 to compel individuals and employers to purchase government-approved health insurance policies when Congress cannot otherwise compel such conduct under the Commerce Clause.

Congress has made it clear that the penalties under Sections 1501 and 1513 are just that–penalties–and not taxes, and the Defendants cannot ignore that intent to posture its last minute litigation tactic. *Helwig v. United States*, 188 U.S. 605 (1903). A provision will not be regarded as a tax if it "clearly appears" that Congress did not intend to enact a tax. *Id.* at 613.

Congress referred to the payments as "penalties," not "taxes," while using the term "taxes" elsewhere in the Act. Compare Section 1501(b), 26 U.S.C. §5000A(b) ("penalty"), with Sections 9001, 26 U.S.C. § 4980I (a) ("excise tax" on

high cost employer-sponsored health coverage), 9007(b), 26 U.S.C. §4959 ("excise tax" on failure to meet hospital exemption requirements), and Section 10907, 26 U.S.C. § 5000B ("excise tax" on indoor tanning services). Although the noncompliance penalties were added to the Internal Revenue Code, Congress specifically exempted them from the criminal penalties, liens and levies imposed upon nonpayment of taxes, because they were not to be regarded as taxes. Section 1501(g)(2), 26 U.S.C. §5000A(g)(2). Congress did not identify any revenue-generating purposes for the payments, which is required for imposition of a tax. *See Rosenberger v. Rector and Visitors of the University of Virginia*, 515 U.S. 819, 841 (1995) (a "tax" as used in the Constitution is an exaction for support of the government). Congress relied exclusively upon the Commerce Clause in its findings. Section 1501(a), 42 U.S.C. §18091. From these factors it "clearly appears" that Congress intended that the noncompliance payments be penalties, not taxes.[3]

The legislative history of the Act shows that Congress intentionally changed the terminology from "tax" to "penalty." Each of the earlier versions of the bill in

[3] This conclusion is further supported by public statements made by President Obama, the Act's chief proponent.: "For us to say you have to take responsibility to get health insurance is absolutely not a tax increase," and "Nobody considers that a tax increase." http://www.cnn.com/2009/POLITICS/09/20/obama.health.care/index.html (last visited January 11, 2011).

both the House of Representatives and the Senate used the term "tax" when referring to the assessment for noncompliance with the insurance mandate, as explained by Judge Hudson and, in greater detail by Judge Vinson in *Florida v. HHS*, 716 F. Supp. 2d at 1133:

> For example, America's Affordable Health Choices Act of 2009" (H.R. 3200) was introduced in the House of Representatives on July 14, 2009. Like the Act, it contained an individual mandate and concomitant penalty. However, it called the penalty a tax. Section 401 was unambiguously titled "Tax on Individuals Without Acceptable Health Care Coverage," and went on to refer to the exaction as a "tax" no less than fourteen times in that section alone. *See, e.g., id.* (providing that with respect to "any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax"). H.R. 3200 was thereafter superseded by a similar bill, "Affordable Health Care for America Act" (H.R. 3962), which was actually passed in the House of Representatives on November 7, 2009. That second House bill also included an individual mandate and penalty, and it repeatedly referred to the penalty as a "tax." See, e.g., Section 501 (providing that for any person who does not comply with the individual mandate "there is hereby imposed a tax," and referring to that "tax" multiple times); Section 307(c)(1)(A) (further referring to the penalty as a "tax[ ] on individuals not obtaining acceptable coverage").
>
> While the above bills were being considered in the House, the Senate was working on its healthcare reform bills as well. On October 13, 2009, the Senate Finance Committee passed a bill, "America's Healthy Future Act" (S. 1796). A precursor to the Act, this bill contained an individual mandate and accompanying penalty. In the section titled "Excise Tax on Individuals Without Essential Health Benefits Coverage," the penalty was called a "tax." See Section 1301 ("If an applicable individual fails to [obtain required insurance] there is hereby imposed a tax").

See also, Commonwealth v. Sebelius, 2010 WL 5059718 at *9. In the final version of the Act enacted by the Senate on December 24, 2009, the term "penalty" was substituted for "tax" in Section 1501(b)(1). 26 U.S.C. §5000A. "A logical inference can be drawn that the substitution of this critical language was a conscious and deliberate act on the part of Congress. *Commonwealth v. Sebelius*, 2010 WL 5059718 at *18 (citing *Russello v. United States*, 464 U.S. 16, 23-24 (1983)). "Congress's conspicuous decision to not use the term "tax" in the Act when referring to the exaction (as it had done in at least three earlier incarnations of the legislation) is significant. *Florida v. HHS*, 716 F. Supp. 2d at 1134. "'Few principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language.'" *Id.* at 1134-1135 (citing *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442 (1987)).

Congress' actions and its words clearly communicate that the penalty provisions in the individual and employer mandates are penalties, not taxes, and therefore could not have been enacted pursuant to Congress' power to tax and spend for the general welfare under Article I, §8.

D. The Mandates Violate Plaintiffs' Free Exercise Rights By Compelling Plaintiffs To Choose Between Their Sincerely Held Religious Beliefs And Paying A Penalty.

Despite explicit references to individualized exemptions in the text of the Act, the district court concluded that the Act is a neutral law of general applicability which survives rational basis review. (JA 0184). The district court's conclusion is in error.

1. The Mandates Violate Plaintiffs' Free Exercise Rights Under the First Amendment.

The district court pointed to the "religious conscience" exemptions in Section 1501 as examples of Congress' attempt to accommodate religious belief instead of efforts to carve out individualized exemptions for particular categories of believers. (JA 0184). Relying upon that premise, the district court concluded that the Act is a neutral law of general applicability that only incidentally burdens religion and is subject only to rational basis review under *Employment Div. v. Smith*, 494 U.S. 872 (1990). Under *Smith*, a law which is neutral and of general applicability need not be justified by a compelling governmental interest even if the law has the incidental effect of burdening a particular religious practice. *Id.* at 878. However, if the law contains individualized exemptions, it is not a neutral law of general applicability and will not survive a free exercise challenge unless the government can establish that it is justified by a compelling interest and narrowly tailored to advance that interest. *Id.* at 884; *Church of the Lukumi Babalu Aye, Inc.*

v. City of Hialeah, 508 U.S. 520, 531 (1993). The "Free Exercise Clause protects against governmental hostility which is masked, as well as overt." *Lukumi*, 508 U.S. at 534. "The Court must survey meticulously the circumstances of governmental categories to eliminate, as it were, religious gerrymanders." *Id.* The court must look carefully at the exemptions permitted to "protect religious observers against unequal treatment." *Id.* at 542. Categories of selection are of "paramount concern when a law has the incidental effect of burdening religious practice." *Id.*

The Act subjects religious observers such as Plaintiffs to unequal treatment and are just the type of "religious gerrymanders" that the Supreme Court warned against in *Lukumi*, 508 U.S. at 534, 542. Section 1501 exempts those who "cannot afford coverage," defined according to a premium to income ratio; those who have incomes below 100 percent of the poverty line, members of Indian tribes and those whom the Administration determines have suffered a hardship affecting their ability to purchase insurance. 26 U.S.C. §5000A(e). The exemptions for some, but not all, religious beliefs are particularly problematic since they grant preferred status only to certain religious adherents. 26 U.S.C. §5000A(d)(2). The "religious conscience" exemption provides that individuals who are members of religious sects which have been in existence since December 31, 1950, which have tenets against participation in government support programs, and which have

demonstrated that they provide care for dependent members are not subject to the penalties described in Section 1501. 26 U.S.C. §5000A(d)(2) (citing 26 U.S.C. § 1402). The "health care sharing ministry exemption" provides that people who are members of nonprofit organizations in existence continuously since December 31, 1999 which share a common set of ethical or religious beliefs and have since December 31, 1999 continuously shared medical expenses among members in accordance with those beliefs and without regard to members' states of residence or employment are not subject to the sanctions imposed by Section 1501. 26 U.S.C. §5000A(d)(2).

Individuals like Plaintiffs must comply but parties who demonstrate financial hardship do not. Plaintiffs, who have religious objections to the compelled purchase of a prescribed health insurance product, will be subject to penalty but those who have similar religious objections will be exempt because they are members of specified religious sects. Individuals who share common ethical beliefs and would like to share medical expenses, but failed to form an organization by December 31, 1999, will be unable to exempt themselves from Section 1501's requirements, but those who did form an organization by December 31, 1999 will be exempt. 26 U.S.C. §5000A(d)(2). The Act clearly includes

individualized exemptions and a gerrymander of some but not all religious viewpoints, and thus strict scrutiny is applicable under *Smith*.[4]

The mandates burden Plaintiffs' sincerely held religious beliefs by compelling them to obtain health insurance for those medical services that the government deems are "minimum essential coverage," regardless of whether the services are essential, affordable or objectionable to Plaintiffs. 26 U.S.C. §5000A. Plaintiffs will not be permitted to opt out of paying for medical procedures that violate their sincerely held religious beliefs, but will be faced with the choice of compromising their religious beliefs or paying a penalty. *Id.* The district court dismissed Plaintiffs' assertion of burden by claiming that Plaintiffs' only objection was to subsidizing abortion and that there allegedly are provisions within the Act to protect against such subsidies. (JA 0184-0187). While objection to funding abortion is certainly of vital importance to Plaintiffs, it is not the only aspect of the Act that burdens Plaintiffs' religious beliefs. (JA 0018-0021). Plaintiffs allege that being forced to obtain what the government defines as minimum essential

[4] Further evidence of the fact that the Act is not generally applicable can be seen in exemptions the Department of Health and Human Services has granted to relieve companies from some of the other provisions of the Act. For example, as of December 3, 2010, 222 companies have been granted one-year waivers of the Act's annual limit restrictions on health insurance policies. The waivers affect more than 1.5 million people. http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html (last visited January 10, 2011).

coverage, with no opportunity to opt out, will require that they pay for medical procedures even if they are antithetical to their religious beliefs. (JA 0018-0021). In addition, Miss Waddell and Mrs. Merrill will be compelled to abandon their religious beliefs that they should live their lives so that they provide for their own medical needs without relying upon third party insurance companies. (JA 0018-0021). The Defendants must prove that the provisions are justified by a compelling interest and narrowly tailored to advance that interest. *Smith*, 494 U.S. at 884. They cannot meet that burden.

Congress asserts that the mandate provisions are necessary to increase the supply of and demand for health care services, increase the number of Americans who have health insurance, achieve near-universal health insurance coverage by strengthening the employer-based health insurance market, and improve financial security for families. 42 U.S.C. § 18091. Improving financial stability by adding customers to a large interstate health insurance market is not a compelling interest, and the mandates are not narrowly tailored to advance those interests at any rate. The mandate provisions will not necessarily increase the number who have health insurance or even provide revenue targeted to providing coverage. Section 1501 says that individuals purchase health insurance or pay a penalty, but the penalty is not a revenue generator designed to cover the costs of the uninsured. The Act does not specify that revenues realized from the penalties will be used to purchase

insurance for those who are uninsured, so the penalties will not advance the goal of insuring more individuals. The provisions do not advance the goal of near-universal coverage since they do not ensure that every uninsured person, or even the majority of uninsured people, will have insurance. The mandate provisions will not necessarily increase the supply or demand for health insurance or health care services since uninsured people will not necessarily become insured. Finally, a requirement that families either pay for health insurance that they do not presently pay for, adapt their coverage to meet "minimum essential coverage," presumably at a higher cost, or be subject to an increased tax liability does not improve "financial security." Congress' intrusion into the private decisions of American citizens does not advance the interests asserted in the Act, and therefore the mandates cannot withstand strict scrutiny.

The relationship between the "religious exemptions" and the asserted interests under the Act is even more tenuous. If, as Congress asserts, the goal is to increase the number of insureds, then exempting uninsured Americans who belong to certain religious organizations does not advance that interest. Even if Congress tries to justify the "religious exemptions" by saying that the exempted groups have alternative programs that meet the goal of paying for health care needs, it still would not explain why only the specified groups have an exemption and similar groups do not. Denying Plaintiffs the ability to participate in such an exemption

does nothing to advance Congress' stated goal of improving the level of coverage for health care costs.

The mandate provisions are not neutral or generally applicable, impose substantial burdens upon Plaintiffs' religious beliefs, and are not narrowly tailored to advance a compelling state interest. They fail the strict scrutiny test required under *Smith*, 424 U.S. at 884.

2. The mandates violate Plaintiffs' free exercise rights under RFRA.

Even if the mandate provisions were found to be laws of general applicability, they would still be subject to and fail strict scrutiny under RFRA. 42 U.S.C. §§ 2000bb-1(a)-(b); *see also Gonzales v. O. Centro Espirita Beneficiente Uniao de Vegetal*, 546 U.S. 418, 424 (2006). RFRA provides that the government cannot substantially burden religious exercise, *even if the burden results from a rule of general applicability*, unless the government can "demonstrat[e] that application of the burden to the person–(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." *Id.* (citing 42 U.S.C. §§ 2000bb-1(a)-(b)) (emphasis added). RFRA imposes a more demanding strict scrutiny review than does the First Amendment under *Smith* in that it "requires the Government to demonstrate that the compelling interest test is satisfied through application of the challenged law 'to the person'–the particular claimant whose sincere exercise of

religion is being substantially burdened. *Id.* at 430-431. Defendants cannot meet that burden.

That is particularly true in light of the fact that the statutory provision invalidated in *Gonzales*, like the mandate provisions here, contained a religious exemption that was applied to one religious group but not to the plaintiffs. *Id.* at 433-434. In *Gonzales*, the existing religious exemption in the Controlled Substances Act was fatal to the government's claim that members of the plaintiff church were not entitled to an exemption for their sacramental use of *hoasca* tea. *Id.* at 433-434. The Court reasoned that if the use of a controlled substance, peyote, was permitted for hundreds of thousands of Native Americans under the existing religious exemption, then the government could not preclude a similar exception for the 130 or so UDV church members who wanted to similarly use a controlled substance to practice their faith. *Id.* at 433. The same is true in this case. If exemption from the mandate is permitted for adherents of certain religious sects, then Defendants cannot justify precluding followers of other religious traditions who object to the mandate. If exemption from the mandate is permitted for members of health care sharing ministries established before January 1, 2000, then Defendants cannot preclude others who form similar ministries after January 1, 2000.

"Where the state conditions receipt of an important benefit upon conduct proscribed by a religious faith, or where it denies such a benefit because of conduct mandated by religious belief, thereby putting substantial pressure on an adherent to modify his behavior and to violate his beliefs, a burden upon religion exists. While the compulsion may be indirect, the infringement upon free exercise is nonetheless substantial." *Thomas v. Review Bd.*, 450 U.S. 707, 718 (1981). Plaintiffs have alleged that the Act compels them to either purchase health insurance that collides with their religious convictions. (JA 0018-0021, 0029-0030). This places substantial pressure upon Plaintiffs to modify their behavior and participate in a government-defined system in violation of their religious beliefs. (JA 0019-0021). Defendants cannot meet their burden of showing that the provisions are narrowly tailored to advance a compelling state interest. The mandates violate RFRA.

E. The Preferential Treatment Of The Religious Views Of Those Who Would Qualify For The Religious Exemptions Violates The Establishment Clause.

The preferential treatment accorded to those who qualify for the "religious exemptions" to the mandates violates the "clearest command of the Establishment Clause," *i.e.,* that one religious denomination cannot be officially preferred over another. *Larson v. Valente,* 456 U.S. 228, 244 (1982). In *Larson,* the Court noted "no State can 'pass laws which aid one religion' or that 'prefer one religion over another.'" *Id.* at 246 (citing *Everson v. Board of Education,* 330 U.S. 1, 15 (1947)).

"'The fullest realization of true religious liberty requires that government ... effect no favoritism among sects ... and that it work deterrence of no religious belief.'" *Id.* (citing *Abington School Dist. v. Schempp,* 374 U.S. 203, 305 (1963) (Goldberg, J., concurring)). Consequently, "when we are presented with a state law granting a denominational preference, our precedents demand that we treat the law as suspect and that we apply strict scrutiny in adjudging its constitutionality." *Id.*

The "religious exemptions" in Section 1501 grant preferences to members of particular religious sects, *i.e.* those which have been in existence since December 31, 1950, have tenets against participation in government support programs, and have demonstrated that they provide care for dependent members. 26 U.S.C. § 5000A(d)(2); 26 U.S.C. § 1402. Members of religious denominations which meet those criteria do not have to comply with the mandates and will not be subject to the penalties for non-compliance. *Id.* However, Plaintiffs, who are not part of those denominations, must comply with the requirements or pay the penalties, placing them at a disadvantage for no reason other that they do not belong to the preferred religious group. *Larson* makes clear that the provision is not valid. *Larson,* 456 U.S. at 246.

The district court erred when it applied the test established in *Lemon v. Kurtzman*, 403 U.S. 602 (1971) to find that the exemptions did not violate the Establishment Clause. (JA 0178-0183). The *Lemon* test is intended to apply only to

laws affording a uniform benefit to all religions, and not to provisions that discriminate among religions. *Larson*, 456 U.S. at 252. *Lemon* is inapplicable.

F. The Differential Treatment Accorded To Plaintiffs' Religious Beliefs Violates Equal Protection.

Equal protection under the Fifth Amendment requires that all people similarly situated be treated alike. *Plyler v. Doe*, 457 U.S. 202, 216 (1982). Classifications such as the "religious exemptions" in Section 1501 must bear some fair relationship to a legitimate public purpose. *Id.* The pertinent inquiry is whether the classification advances legitimate legislative goals in a rational fashion. *Schweiker v. Wilson,* 450 U.S. 221, 234 (1981). The classification must have some rational basis and the court cannot substitute its personal notions of good public policy for those of Congress, *id.*, which is precisely what the district court did.

Congress did not explain how exempting certain uninsured people from the provisions meet the goals of increasing demand for health insurance, decreasing the number of uninsureds, and attaining near universal coverage. 42 U.S.C. §18091; 26 U.S.C. §5000A. Congress did not explain how exempting members of 50-year-old religious sects with member care programs and conscientious objections to insurance, but not members of similar sects that are less than 50 years old advances its stated goals. *Id.* Nor did Congress explain how exempting members of "healthcare sharing ministries" that are at least 10 years but not members of similar ministries that are less than 10 years old advances its

legislative goals. *Id.* The district court devised its own reasons, but did not offer a rational basis for the exemptions. (JA 0189-0190). Even if the court's explanation were true, it would not account for the differentiation based upon the relative ages of the religious organizations.

Absent a rational basis for the distinctions made in the exemptions, the district court should have found that the mandates violate equal protection.

CONCLUSION

Congress exceeded its authority under Art. I §8 of the Constitution when it enacted the Act, and, particularly, the mandates. The provisions cannot be reconciled with Congress' limited powers under the Commerce Clause. Nor do the Necessary and Proper Clause, or the General Welfare Clause support the Act. The mandate provisions also violate Plaintiffs' free exercise rights under the First Amendment and RFRA, along with the Establishment Clause and Equal Protection Clause. This court should reverse the district court on the merits and declare the Act, and particularly the individual and employer mandates unconstitutional.

REQUEST FOR ORAL ARGUMENT

Plaintiffs request oral argument under F.R.App.P 34 because this case addresses issues of first impression and of great constitutional significance, *i.e.*, whether Congress has authority to force individuals to buy and employers to provide a government approved health insurance product and a government-

defined price. The Act is an unprecedented extension of congressional authority and has far reaching consequence well beyond health insurance.

The decision below is in conflict with a decision in the Eastern District of Virginia on the individual mandate portion of the Act. *Commonwealth of Va. v. Sebelius*, 2010 WL 5059718. Therefore, it is particularly important for this court to resolve the conflict, and Plaintiffs believe that oral argument will be important in that regard. Consequently, Plaintiffs respectfully request oral argument.

Dated: January 14, 2011.

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CERTIFICATE OF COMPLIANCE

1. This brief has been prepared using 14 point, proportionately spaced Times New Roman typeface in Microsoft Office Word 2007.

2. Exclusive of the corporate disclosure statement; table of contents; table of citations; statement with respect to oral argument; addendum of statutes and the certificate of service, the brief contains 13,331 words.

I understand that a material misrepresentation can result in the Court's striking the brief and imposing sanctions.

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CERTIFICATE OF SERVICE

I hereby certify that on January 14, 2011, I served the Opening Brief and Statutory Addendum by placing a copy in an envelope, with First Class postage affixed and placing it for mailing with the United States Postal Service addressed as follows:

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STATUTORY ADDENDUM

United States Code Annotated
Title 26. Internal Revenue Code
Subtitle A Income Taxes
Chapter 2. Tax on Self-Employment Income
§ 1402. Definitions

(g) Members of certain religious faiths.--

(1) Exemption.--Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by--

(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof as the Secretary may require for purposes of determining such individual's compliance with the preceding sentence, and

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person,

and only if the Commissioner of Social Security finds that--

(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

(2) Period for which exemption effective.--An exemption granted to any individual pursuant to this subsection shall apply with respect to all taxable years beginning after December 31, 1950, except that such exemption shall not apply for any taxable year--

(A) beginning (i) before the taxable year in which such individual first met the requirements of the first sentence of paragraph (1), or (ii) before the time as of which the Commissioner of Social Security finds that the sect or division thereof of which such individual is a member met the requirements of subparagraphs (C) and (D), or

(B) ending (i) after the time such individual ceases to meet the requirements of the first sentence of paragraph (1), or (ii) after the time as of which the Commissioner of Social Security finds that the sect or division thereof of which he is a member ceases to meet the requirements of subparagraph (C) or (D).

(3) Subsection to apply to certain church employees.--This subsection shall apply with respect to services which are described in subparagraph (B) of section 3121(b)(8) (and are not described in subparagraph (A) of such section).

United States Code Annotated
Title 26. Internal Revenue Code
Subtitle D. Miscellaneous Excise Taxes
Chapter 42. Private Foundations; and Certain Other Tax-Exempt Organizations
Subchapter D. Failure by Certain Charitable Organizations to Meet Certain Qualification Requirements

§ 4959. Taxes on failures by hospital organizations

If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.

United States Code Annotated Currentness
Title 26. Internal Revenue Code (Refs & Annos)
Subtitle D. Miscellaneous Excise Taxes (Refs & Annos)
Chapter 43. Qualified Pension, Etc., Plans (Refs & Annos)

§ 4980H. Shared responsibility for employers regarding health coverage

(a) Large employers not offering health coverage.--If--

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

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

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

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

(1) In general.--If--

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

(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

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

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

(3) Special rules for employers providing free choice vouchers.--No assessable payment shall be imposed under paragraph (1) for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.

(c) Definitions and special rules.--For purposes of this section--

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

(2) Applicable large employer.--

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

(B) Exemption for certain employers.--

(i) In general.--An employer shall not be considered to employ more than 50 full-time employees if--

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

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

(ii) Definition of seasonal workers.--The term "seasonal worker" means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

(C) Rules for determining employer size.--For purposes of this paragraph--

(i) Application of aggregation rule for employers.--All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) Employers not in existence in preceding year.--In the case of an employer which was not in existence throughout the

preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Predecessors.--Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) Application of employer size to assessable penalties.--

(i) In general.--The number of individuals employed by an applicable large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating--

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

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

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

(E) Full-time equivalents treated as full-time employees.--Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

(3) Applicable premium tax credit and cost-sharing reduction.--The term "applicable premium tax credit and cost-sharing reduction" means--

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

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

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

(4) Full-time employee.--

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

(B) Hours of service.--The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

(5) Inflation adjustment.--

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

(i) such dollar amount, and

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

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

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

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

(d) Administration and procedure.--

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

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

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

[(e) Redesignated (d)]

United States Code Annotated
Title 26. Internal Revenue Code
Subtitle D. Miscellaneous Excise Taxes
Chapter 43. Qualified Pension, Etc., Plans

§ 4980I. Excise tax on high cost employer-sponsored health coverage

(a) Imposition of tax.--If--

(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

United States Code Annotated
Title 26. Internal Revenue Code
Subtitle D. Miscellaneous Excise Taxes
Chapter 48. Maintenance of Minimum Essential Coverage

§ 5000A. Requirement to maintain minimum essential coverage

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

(b) Shared responsibility payment.--

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

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

(3) Payment of penalty.--If an individual with respect to whom a penalty is imposed by this section for any month--

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

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

(c) Amount of penalty.--

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

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

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

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

(A) Flat dollar amount.--An amount equal to the lesser of--

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

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

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

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

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

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

(3) Applicable dollar amount.--For purposes of paragraph (1)--

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

(B) Phase in.--The applicable dollar amount is $95 for 2014 and $325 for 2015.

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

(D) Indexing of amount.--In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to--

(i) $695, multiplied by

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

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

(4) Terms relating to income and families.--For purposes of this section--

(A) Family size.--The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating

to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.--The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of--

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

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

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

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

(C) Modified adjusted gross income.--The term "modified adjusted gross income" means adjusted gross income increased by--

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

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

[(D) Repealed. Pub.L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) Applicable individual.--For purposes of this section--

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

(2) Religious exemptions.--

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

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

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

(B) Health care sharing ministry.--

(i) In general.--Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.--The term "health care sharing ministry" means an organization--

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

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

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

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been

shared continuously and without interruption since at least December 31, 1999, and

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

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

(4) Incarcerated individuals.--Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.--No penalty shall be imposed under subsection (a) with respect to--

(1) Individuals who cannot afford coverage.--

(A) In general.--Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.--For purposes of this paragraph, the term “required contribution” means--

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

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

(C) Special rules for individuals related to employees.--For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

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

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

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

(4) Months during short coverage gaps.--

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

(B) Special rules.--For purposes of applying this paragraph--

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

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

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

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

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

(f) Minimum essential coverage.--For purposes of this section--

(1) In general.--The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.--Coverage under--

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

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

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

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

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

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

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

(B) Employer-sponsored plan.--Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market.--Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.--Coverage under a grandfathered health plan.

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

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

> (A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or
>
> (B) any other plan or coverage offered in the small or large group market within a State.
>
> Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.--The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits--

> (A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or
>
> (B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.--Any applicable individual shall be treated as having minimum essential coverage for any month--

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

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

(5) Insurance-related terms.--Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.--

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

(2) Special rules.--Notwithstanding any other provision of law--

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

(B) Limitations on liens and levies.--The Secretary shall not--

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

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

United States Code Annotated
Title 26. Internal Revenue Code
Subtitle D. Miscellaneous Excise Taxes
Chapter 49. Cosmetic Services

§ 5000B. Imposition of tax on indoor tanning services

(a) In general.--There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter III. Available Coverage Choices for All Americans
Part A. Establishment of Qualified Health Plans

§ 18022. Essential health benefits requirements

(a) Essential health benefits package

In this chapter, the term "essential health benefits package" means, with respect to any health plan, coverage that--

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential health benefits

(1) In general

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) Limitation

(A) In general

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) Notice and hearing

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for consideration

In defining the essential health benefits under paragraph (1), the Secretary shall--

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that--

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 18031(b)(2)(B)(ii) of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains--

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) Rule of construction

Nothing in this chapter shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) Requirements relating to cost-sharing

(1) Annual limitation on cost-sharing

(A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

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

(2) Annual limitation on deductibles for employer-sponsored plans

(A) In general

In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed--

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the

Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) Indexing of limits

In the case of any plan year beginning in a calendar year after 2014--

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

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

(C) Actuarial value

The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) Coordination with preventive limits

Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 300gg-13 of this title.

(3) Cost-sharing

In this chapter--

(A) In general

The term “cost-sharing” includes--

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) Exceptions

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage

For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of coverage

(1) Levels of coverage defined

The levels of coverage described in this subsection are as follows:

(A) Bronze level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value

(A) In general

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application

In determining under this chapter, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) Plan reference

In this chapter, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic plan

(1) In general

A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if--

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides--

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 300gg-13 of this title); and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollment

An individual is described in this paragraph for any plan year if the individual--

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this chapter that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of--

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) Restriction to individual market

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only plans

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) Payments to Federally-qualified health centers

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title for such item or service.

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter III. Available Coverage Choices for All Americans
Part B. Consumer Choices and Insurance Competition through Health Benefit Exchanges

§ 18031. Affordable choices of health benefit plans

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

(1) Planning and establishment grants

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

(2) Amount specified

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

(3) Use of funds

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

(4) Renewability of grant

(A) In general

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

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

(I) establishing an Exchange; and

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

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

(B) Limitation

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

(5) Technical assistance to facilitate participation in SHOP Exchanges

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

(b) American Health Benefit Exchanges

(1) In general

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

(A) facilitates the purchase of qualified health plans;

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

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

(2) Merger of individual and SHOP Exchanges

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

(c) Responsibilities of the Secretary

(1) In general

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

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

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

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 256b(a)(4) of this title and providers described in section 1396r-8(c)(1)(D)(i)(IV) of this title, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

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

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

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

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

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

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 280j-2 of this title, as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1320b-9a of this title.

(2) Rule of construction

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

(3) Rating system

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

(4) Enrollee satisfaction system

The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction

information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) Internet portals

The Secretary shall--

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

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

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 300gg-16 of this title and to a copy of the plan's written policy.

(6) Enrollment periods

The Secretary shall require an Exchange to provide for--

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

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

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

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

(d) Requirements

(1) In general

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

(2) Offering of coverage

(A) In general

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

(B) Limitation

(i) In general

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

(ii) Offering of stand-alone dental benefits

Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 18022(b)(1)(J) of this title).

(3) Rules relating to additional required benefits

(A) In general

Except as provided in subparagraph (B), an Exchange may make available a

qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

(B) States may require additional benefits

(i) In general

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

(ii) State must assume cost

A State shall make payments--

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

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

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

(4) Functions

An Exchange shall, at a minimum--

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

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

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

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

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 300gg-15 of this title;

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 18071 of this title;

(H) subject to section 18081 of this title, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because--

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

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

(I) transfer to the Secretary of the Treasury--

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

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the

premium tax credit under section 36B of the Internal Revenue Code of 1986 because--

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

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

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

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

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

(5) Funding limitations

(A) No Federal funds for continued operations

In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds

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

(6) Consultation

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

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

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

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

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs

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

(e) Certification

(1) In general

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

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

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

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

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

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) Premium considerations

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

(3) Transparency in coverage

(A) In general

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

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

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

(vi) Data on rating practices.

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

(viii) Information on enrollee and participant rights under this title.

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

(B) Use of plain language

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

(C) Cost sharing transparency

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

(D) Group health plans

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

(f) Flexibility

(1) Regional or other interstate Exchanges

An Exchange may operate in more than one State if--

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

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

(2) Subsidiary Exchanges

A State may establish one or more subsidiary Exchanges if--

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

(B) the area served by each such Exchange is at least as large as a rating area described in section 300gg(a) of this title.

(3) Authority to contract

(A) In general

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

(B) Eligible entity

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

(i) a person--

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

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of

the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

(g) Rewarding quality through market-based incentives

(1) Strategy described

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

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

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

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

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

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

(2) Guidelines

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

(3) Requirements

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

(h) Quality improvement

(1) Enhancing patient safety

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

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

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

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

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

(2) Exceptions

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

(3) Adjustment

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

(i) Navigators

(1) In general

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

(2) Eligibility

(A) In general

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

(B) Types

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

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

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

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

(3) Duties

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

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

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section

18071 of this title;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 300gg-93 of this title, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) Standards

(A) In general

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

(i) be a health insurance issuer; or

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

(5) Fair and impartial information and services

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

(6) Funding

Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) Applicability of mental health parity

Section 300gg-26 of this title shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) Conflict

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

CREDIT(S)

(Pub.L. 111-148, Title I, § 1311, Title X, §§ 10104(e) to (h), 10203(a), Mar. 23, 2010, 124 Stat. 173, 900, 927.)

ERISA SELECTED SECTIONS

United States Code Annotated Currentness
Title 29. Labor
Chapter 18. Employee Retirement Income Security Program (Refs & Annos)
Subchapter I. Protection of Employee Benefit Rights (Refs & Annos)
Subtitle A. General Provisions
§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided

assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter V. Shared Responsibility for Health Care
Part A. Individual Responsibility
§ 18091. Requirement to maintain minimum essential coverage

(a) Findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly

increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

CREDIT(S)

(Pub.L. 111-148, Title I, § 1501(a), Title X, § 10106(a), Mar. 23, 2010, 124 Stat. 242, 907.)

HIPAA Title I Selected Sections

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 6A. Public Health Service
Subchapter XXV. Requirements Relating to Health Insurance Coverage Part A. Individual and Group Market Reforms
Subpart 1. Portability, Access, and Renewability Requirements

§ 300gg-5. Non-discrimination in health care

(a) Providers
A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

(b) Individuals
The provisions of section 218c of Title 29 (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 6A. Public Health Service
Subchapter XXV. Requirements Relating to Health Insurance Coverage
Part A. Individual and Group Market Reforms
Subpart 1. Portability, Access, and Renewability Requirements

§ 300gg-6. Comprehensive health insurance coverage

(a) Coverage for essential health benefits package

A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title.

(b) Cost-sharing under group health plans

A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 18022(c) of this title.

(c) Child-only plans

If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 18022(d) of this title, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

(d) Dental only

This section shall not apply to a plan described in section 18022(d)(2)(B)(ii)(I) of this title.

COBRA TITLE X -- PRIVATE HEALTH INSURANCE COVERAGE

SELECTED SECTIONS

SEC. 10001. EMPLOYERS REQUIRED TO PROVIDE CERTAIN EMPLOYEES AND FAMILY MEMBERS WITH CONTINUED HEALTH INSURANCE COVERAGE AT GROUP RATES (INTERNAL REVENUE CODE AMENDMENTS).

(a) DENIAL OF DEDUCTION FOR EMPLOYER CONTRIBUTION TO PLAN. -- Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

> "(2) PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS. –
>
> "(A) IN GENERAL. -- No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k).
>
> "(B) EXCEPTION FOR CERTAIN SMALL EMPLOYEES, ETC. -- Subparagraph (A) shall not apply to any plan described in section 106(b)(2).".

(b) DENIAL OF EXCLUSION FOR HIGHLY COMPENSATED INDIVIDUALS. -- Section 106 of the Internal Revenue Code of 1954 (relating to contributions by employer to accident and health plans) is amended by inserting

> "(a) IN GENERAL. -- " before "Gross" and by inserting at the end thereof the following new subsection:
>
> "(b) EXCEPTION FOR HIGHLY COMPENSATED INDIVIDUALS WHERE PLAN FAILS TO PROVIDE CERTAIN CONTINUATION COVERAGE. –
>
> "(1) IN GENERAL. -- Subsection (a) shall not apply to any amount

contributed by an employer on behalf of a highly compensated individual (within the meaning of section 105(h)(5)) to a group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of section 162(k).

***

(c) CONTINUATION COVERAGE REQUIREMENTS. -- Section 162 of the Internal Revenue Code of 1954 is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection:

"(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS. –

"(1) IN GENERAL. -- For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

*****

SEC. 10002. TEMPORARY EXTENSION OF COVERAGE AT GROUP RATES FOR CERTAIN EMPLOYEES AND FAMILY MEMBERS (ERISA AMENDMENTS).

(a) IN GENERAL. -- Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end thereof the following new part:

"PART 6 -- CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

"SEC. 601. PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL. -- The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

SEC. 10003. CONTINUATION OF HEALTH INSURANCE FOR STATE AND LOCAL EMPLOYEES WHO LOST EMPLOYMENT-RELATED COVERAGE (PUBLIC HEALTH SERVICE ACT AMENDMENTS).

(a) IN GENERAL. -- The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XXII -- REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE
AND LOCAL EMPLOYEES

"SEC. 2201. STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL. -- In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

PL 99-272, 1986 HR 3128