

Nos. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL.,

v.

KATHLEEN SEBELIUS, ET AL.

STATE OF FLORIDA, ET AL.,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

**On Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit**

**BRIEF FOR PRIVATE PETITIONERS
ON SEVERABILITY**

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QUESTION PRESENTED

Congress effected a sweeping and comprehensive restructuring of the Nation's health-insurance markets in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 109 (collectively, the "Act" or "ACA"). In No. 11-398, this Court is reviewing whether Congress exceeded its Article I authority when it enacted the ACA's mandate that virtually every individual American obtain health insurance. 26 U.S.C.A. § 5000A(a). Here, the question presented is:

Whether the remainder of the Act must be invalidated in whole or in part because it cannot be severed from the individual mandate.

**PARTIES TO THE PROCEEDING
AND RULE 29.6 STATEMENT**

Three private individuals or organizations were Plaintiffs-Appellees below and are Petitioners in No. 11-393 and Respondents (by rule) in No. 11-400: National Federation of Independent Business (“NFIB”); Kaj Ahlburg; and Mary Brown. NFIB is a nonprofit mutual benefit corporation that promotes and protects the rights of its members to own, operate, and grow their businesses across the fifty States and the District of Columbia. NFIB is not a publicly traded corporation, issues no stock, and has no parent corporation. There is no publicly held corporation with more than a 10% ownership stake in NFIB.

26 States, by and through their Attorneys General or Governors, were Plaintiffs-Appellees/Cross-Appellants below and are Petitioners in No. 11-400 and Respondents (by rule) in No. 11-393: Alabama; Alaska; Arizona; Colorado; Florida; Georgia; Idaho; Indiana; Iowa; Kansas; Louisiana; Maine; Michigan; Mississippi; Nebraska; Nevada; North Dakota; Ohio; Pennsylvania; South Carolina; South Dakota; Texas; Utah; Washington; Wisconsin; and Wyoming.

Six federal officers or agencies were Defendants-Appellants/Cross-Appellees below and are Respondents in Nos. 11-393 & 11-400: Kathleen Sebelius, in her official capacity as Secretary of Health and Human Services; Timothy F. Geithner, in his official capacity as Secretary of the Treasury; Hilda L. Solis, in her official capacity as Secretary of Labor; and the United States Departments of Health and Human Services, of the Treasury, and of Labor.

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BRIEF FOR PRIVATE PETITIONERS

Private Petitioners respectfully submit this brief arguing that the individual mandate is not severable from the remainder of the Act.¹

OPINIONS BELOW

The opinion of the court of appeals (Pet.App. 1a-273a) is reported at 648 F.3d 1235. The summary-judgment opinion of the district court (Pet.App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's motion-to-dismiss opinion (Pet.App. 394a-475a) is reported at 716 F. Supp. 2d 1120.

JURISDICTION

The Eleventh Circuit entered judgment on August 12, 2011. The petitions for writs of certiorari were filed on September 27 and 28, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The appendix hereto reproduces selected provisions from the Act.

STATEMENT OF THE CASE

The Act reflects an intricate deal that emerged from one of the most hard-fought and narrowly decided legislative battles in recent memory. It produced a “comprehensive and complex regulatory scheme” (Pet.App. 22a) that proponents claimed would achieve near-universal health-insurance coverage and reduce health-insurance costs—without increasing the federal budget deficit.

¹ To avoid confusion, all “Pet.App.” citations reference the appendix to the Government's certiorari petition in No. 11-398. “RE” citations reference the Eleventh Circuit Record Excerpts.

A. The Act's Passage

1. Origins Of The Act

Comprehensive change of the Nation's system of health insurance was a central issue in the 2008 Democratic presidential primary, with each major candidate outlining proposals to achieve near-universal coverage while lowering costs. *See, e.g.*, Michael Cooper, *It Was Clinton vs. Obama on Health Care*, N.Y. TIMES, Nov. 16, 2007, at A30. Then-Senator Hillary Clinton was the first to propose a mandate that every individual purchase health insurance—a proposal that then-Senator Barack Obama sharply criticized. *Id.* Clinton responded that universal coverage would be impossible absent an individual mandate. *Id.*

After taking office, President Obama's position on an insurance mandate changed. The shift began after the insurance industry's two main trade associations offered to support comprehensive regulation on the condition that any bill contain "an enforceable mandate for individual coverage." Robert Pear, *Health Insurers Offer to Accept All Applicants, On Condition*, N.Y. TIMES, Nov. 20, 2008, at A30. This offer led to planning sessions between congressional leaders and major healthcare stakeholders, at which the centrality of the mandate became clear. *See, e.g.*, Robert Pear, *Health Care Industry in Talks to Shape Policy*, N.Y. TIMES, Feb. 20, 2009, at A16. In the face of this pressure, the President signaled a willingness to depart from his campaign pronouncements. Robert Pear, *Obama Open to Mandate That People Own Coverage*, N.Y. TIMES, June 3, 2009, at A17. Likewise, the chairs of critical congressional committees agreed "to plow

ahead on the assumptions that individuals would be required to carry insurance” and “that most employers would be required to help pay for it.” Robert Pear, *Team Effort In the House To Overhaul Health Care*, N.Y. TIMES, Mar. 18, 2009, at A12.

2. Goals Of The Legislative Effort

For proponents of change, any legislation had to serve two fundamental goals: (1) ensuring nearly universal coverage, in particular by prohibiting what were described as discriminatory and abusive practices by insurance companies, such as the refusal to insure sick individuals and the pricing of insurance based on individual actuarial risk; and (2) reducing the overall cost of health insurance.

The President made clear throughout the process that his core goal was to expand coverage, especially by eliminating the putative insurer abuses. As he explained in his 2010 State of the Union address:

I took on health care because of the stories I've heard from Americans with preexisting conditions whose lives depend on getting coverage; patients who've been denied coverage; families—even those with insurance—who are just one illness away from financial ruin. ...

The approach we've taken would protect every American from the worst practices of the insurance industry. It would give small businesses and uninsured Americans a chance to choose an affordable health care plan in a competitive market.²

² <http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address>.

Legislators echoed the sentiment. *E.g.*, 155 Cong. Rec. S13295, 13306 (daily ed. Dec. 16, 2009) (Sen. Johnson) (“This legislation ... puts an end to insurance industry abuses that have denied coverage to hard-working Americans”).

Equally “driving” the legislative effort, though, was the fact that costs were “exploding.” Robert Pear, *Obama’s Health Plan, Ambitious in Any Economy, Is Tougher In This One*, N.Y. TIMES, Mar. 2, 2009, at A14 (quoting Melody C. Barnes, director of the President’s Domestic Policy Council). Once again, President Obama was emphatic:

Then there’s the problem of rising cost. ... [This is why] so many employers—especially small businesses—are forcing their employees to pay more for insurance, or are dropping their coverage entirely

The plan I’m announcing tonight ...will slow the growth of health care costs for our families, our businesses, and our government. It’s a plan that asks everyone to take responsibility for meeting this challenge—not just government, not just insurance companies, but everybody including employers and individuals.

Remarks by the President to a Joint Session of Congress on Health Care, Sept. 9, 2009 (“*Remarks to Congress*”).³

Then-Speaker Pelosi, and countless other legislators, echoed this refrain:

³ http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/

We all know that the present ... health insurance system in our country is unsustainable. We simply cannot afford it. ... The best action that we can take on behalf of America's family budgets and on behalf of the Federal budget is to pass health care reform.

156 Cong. Rec. H1891, 1896 (daily ed. Mar. 21, 2010); *see also, e.g.*, 156 Cong. Rec. S1923, 1931 (daily ed. Mar. 24, 2010) (Sen. Levin) (“At its heart, this bill ... aim[s] to tackle the central problems of our health care system—rising costs and the insecurity many Americans rightly feel about the lack of dependability of their insurance.”).

3. Critical Constraints

Despite the urgency with which the President and congressional leaders pushed forward, they faced many obstacles to obtaining the necessary votes.

Significant disagreements, even among proponents of comprehensive legislation, left little room for workable compromise. For example, many supported a strong “public option,” *i.e.*, a government-run insurer, which was said to “remove the profit motive as an obstacle to medical care”;⁴ others argued that the “public option” would produce inefficient and unfair competition with the private sector; and still others offered compromise solutions involving more limited public plans. *See* Robert Pear, *Schumer Points to a Middle Ground on Government-Run Health Insurance*, N.Y. TIMES, May

⁴ David M. Herszenhorn, *Public Option Keeps Toehold in Senate Deal on Health Bill*, N.Y. TIMES, Dec. 9, 2009, <http://www.nytimes.com/2009/12/10/health/policy/10health.html?scp=32&sq=health+care+public+option&st=nyt>.

5, 2009, at A20. Many legislators were concerned about imposing the onerous taxes that would be necessary to fund an expansion in health-insurance coverage. See David M. Herszenhorn, *Democrats Are at Odds on Financing Health Care*, N.Y. TIMES, July 10, 2009, at A14.

Moreover, the Act had no hope of passing if it was scored by the Congressional Budget Office (“CBO”) as increasing the federal deficit. President Obama was emphatic that “[h]ealth care reform must not add to our deficits over the next 10 years—it must be at least deficit neutral.” Letter from President Obama to Senators Kennedy and Baucus (June 3, 2009).⁵ The President bluntly warned: “I will not sign a plan that adds one dime to our deficits—either now or in the future.” *Remarks to Congress, supra*. The Senate Majority Leader agreed that any bill had to not only “lower the cost of staying healthy” but also “reduce the national debt.”⁶ And key, centrist Senators likewise insisted on this constraint. See, e.g., Robert Pear & David M. Herszenhorn, *Democrats Are Considering Additional Tax on Insurers*, N.Y. TIMES, Oct. 9, 2009, at A19 (“[W]e all set goals and we really, really, really worked hard to stay within those goals of making sure that it was deficit-neutral.” (quoting Sen. Lincoln)); *Nelson: Bill Must Be Deficit Neutral*, ORLANDO SENTINEL, Oct. 2, 2009, at A18.

⁵ http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus.

⁶ Press Conference of Sen. Harry Reid at 0:29-0:34, Dec. 19, 2009, available at http://reid.senate.gov/newsroom/121909_finalbill.cfm.

4. Early Versions Of The Act

The Act's first precursor was released by the House Ways and Means Committee. The draft bill:

- Required that insurance companies provide insurance on a “guaranteed-issue” basis, *i.e.*, that they provide coverage for all consumers, regardless of any pre-existing health conditions. H.R. ___ [Discussion Draft], §§ 111-112 (June 19, 2009).⁷
- Required “community-rated” premiums—*i.e.*, premiums reflecting average costs in a particular region, but (with limited exceptions) not individual characteristics reflecting actuarial risk. *Id.* § 113.
- Provided that “[i]n the case of any individual who does not [maintain insurance] at any time during the taxable year, there is hereby imposed a tax.” *Id.* § 401.

This draft was subject to intense negotiations, and sharp disagreements led to three different committee versions.⁸ Ultimately, the House passed, by a vote of 220 to 215, a version that retained the guaranteed-issue and community-rating provisions, and imposed a tax on individuals without insurance (but not a direct mandate to buy it). H.R. 3962, 111th Cong. §§ 211-213, 501 (Nov. 7, 2009). The bill also included a severability clause, providing that if any provision were held to be unconstitutional, the rest of the bill would remain in effect. *Id.* § 255.

⁷ <http://waysandmeans.house.gov/media/pdf/111/hrdraft.pdf>.

⁸ David M. Herszenhorn & Robert Pear, *House Health Care Bill Criticized as Panel Votes for Public Plan*, N.Y. TIMES, July 31, 2009, at A11.

The initial bill reported from committee in the Senate, like the House bill, imposed guaranteed-issue and community-rating rules on insurers. Affordable Health Choices Act § 101, S. 1679, 111th Cong. (as reported by Sen. Comm. on Health, Educ., Labor, and Pensions Sept. 17, 2009). In contrast to the House bill, however, the Senate bill did not apply a tax if an individual was uninsured. Rather, to comport with the President’s campaign pledge not to raise taxes on families earning under \$250,000 per year, it instead imposed a direct legal requirement that “[e]very individual shall ensure that such individual ... is covered under qualifying coverage at all times during the taxable year.” *Id.* § 161; *see also* Adam Nagourney & David M. Herszenhorn, *Republicans Call Health Legislation a Tax Increase*, N.Y. TIMES, Oct. 2, 2009, at A22.

Following intense negotiation among the congressional leadership, a final Senate bill was introduced. S. Amend. No. 2786 to H.R. 3590, 111th Cong. (introduced Nov. 19, 2009). This version included guaranteed-issue and community-rating rules, like each of its predecessors, and it also imposed an individual insurance mandate, with compliance enforced by “payment of [a] penalty.” *Id.* §§ 1201, 1501. Notably, however, the Senate amendment deleted the severability clause that had been included in the House bill. Following further amendments, exactly sixty Senators—just enough under Senate rules, Sen. R. XXII—ended debate on the bill on December 23, 2009; and with the same sixty votes, the Senate passed the bill the next day.⁹

⁹ Bill Summary and Status, H.R. 3590, *available at* <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@X>.

5. Final Passage And Reconciliation

Just a few weeks later, Scott Brown won a special election to fill a Senate seat previously occupied by Paul Kirk, who had voted for the Senate bill. A central plank in Brown's campaign was that he had "vowed to oppose" the bill. Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, N.Y. TIMES, Jan. 19, 2010, at A1. Thus, when he was sworn in, there were no longer sixty supportive Senators, so a filibuster could not be avoided on any future votes.

This was critical, because no single bill had yet been enacted by both houses of Congress, as required by the Constitution. Ordinarily, different House and Senate versions of a bill are reconciled by a conference committee into a final bill, which each house then must pass. But, in this case, any bill remotely resembling the one passed by the Senate in December 2009 was sure to be filibustered in the reconstituted Senate. Accordingly, the House had no choice, if it wanted such a bill, but to pass it in the *exact* form in which it had passed the Senate.

The only way for Congress then to make any changes was to amend the bill through a procedure known as budget reconciliation. By statute, budget reconciliation bills may be debated in the Senate for only twenty hours, 2 U.S.C. § 641(e)(2), which makes filibusters impossible. However, such bills may include only provisions that have direct budgetary impacts. *Id.* § 644(b)(1)(A). Congress was thus precluded from making any *non-budgetary* amendments to the Senate bill.

With no other option, the House adopted a rule providing for all-or-nothing consideration of the Senate bill without amendments, *see* H.R. Res. 1203,

111th Cong. (2010), and passed the Senate bill (the Patient Protection and Affordable Care Act) by a final vote of 219 to 212. The House and Senate then passed, by simple majority vote, the Health Care and Education Reconciliation Act of 2010, a reconciliation bill that adopted certain budgetary amendments. David M. Herszenhorn & Robert Pear, *Final Votes in Congress Cap Battle over Health*, N.Y. TIMES, Mar. 26, 2010, at A17.

B. Operation Of The Act

The Act operates through nine titles (as amended by a tenth). Its heart, contained in Title I, expands insurance coverage by simultaneously requiring insurers to provide broad coverage to all comers and imposing on individuals and employers a “shared responsibility” to buy it. Title I also assists individuals in satisfying the mandate by subsidizing their purchase of insurance through newly created “Health Benefit Exchanges.” Title II fills remaining gaps in coverage, by expanding Medicaid and other public insurance programs. Titles III through VIII aim to increase the availability of various services and the efficiency of health-insurance coverage—*e.g.*, by increasing preventative-care coverage, reducing fraud and abuse in public insurance, and expanding prescription-drug coverage. Finally, Title IX imposes various revenue-raising measures to “offset” the spending measures in the Act.

1. Insurance Regulations

The Act comprehensively regulates various aspects of health insurance. Specifically, Congress banned “discrimination based on health status,” by requiring insurance companies to provide “guaranteed-issue” coverage and charge “community-

rated” premiums. 42 U.S.C.A. §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-4. Relatedly, Congress limited insurers’ ability to restrict the scope and duration of covered services. Insurers thus may not: refuse to pay for certain services, such as “preventative health services,” *id.* §§ 300gg-6(a), 300gg-13; impose annual or lifetime limits on coverage, *id.* § 300gg-11; rescind coverage absent fraud, *id.* § 300gg-12; impose “unreasonable” premium increases, *id.* § 300gg-4(a)(1); or require more than a maximum level of “cost sharing” (*e.g.*, deductibles) from insured individuals, *id.* § 18022(c)(3)(A). *See* Pet.App. 26a-31a (describing the Act’s restrictions on insurance).

The Act thus effectively requires insurers to offer health insurance to any individual, no matter how sick, and to cover limitless amounts of healthcare for the life of the insured, at average rates that ignore actuarial risk. These measures serve the Act’s goal of expanding health-insurance coverage and curbing “discriminatory” insurance practices; but by themselves, they severely undermine the Act’s other principal goal of reducing health-insurance costs. *See* 42 U.S.C.A. § 18091(a)(2)(I). As the Eleventh Circuit noted, according to the CBO, by “requir[ing] private insurers ... to cover the unhealthy,” but forbidding them from “pric[ing] that coverage [based] on actuarial risks,” the Act’s insurance regulations will raise insurance costs in the individual market by 27 to 30%. Pet.App. 126a n.107, 129a n.114.¹⁰

¹⁰ Citing CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009) (“CBO, *Premiums*”), <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>).

2. Individual Mandate

To counteract the cost-increasing effect of the Act's insurance regulations, Congress heeded the insurance industry's lobbying to impose a mandate for individuals to purchase insurance coverage.¹¹

The mandate provides:

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.

26 U.S.C.A. § 5000A(a). This legal "requirement" to obtain health insurance is enforced by a monetary "penalty" for each month of non-compliance. *Id.* § 5000A(b).

The mandate was intended to counteract the inflationary effects of the Act's insurance regulations in two distinct ways. *First*, and most significantly, the mandate directly subsidizes insurance companies by forcing healthy individuals to buy extensive coverage on economically disadvantageous terms, namely, at the same price as unhealthy persons. *Second*, Congress believed the mandate, along with other provisions of the Act, would reduce the costs imposed on doctors, patients, and insurers as a result of uncompensated care.

¹¹ *See, e.g.*, Addressing Insurance Market Reform: Hearing Before the S. Comm. on Health, Education, Labor & Pensions, 111th Cong. (2009) (submission of Ronald A. Williams, Chairman & CEO, Aetna, Inc.) ("Since 2005, we at Aetna have been speaking out in support of an individual coverage requirement").

a. The most significant effect of the mandate is to subsidize insurers, which will in turn hold down the premiums paid by individuals and families. By forcing “millions of new customers [in]to the health insurance market,” the mandate increases the number of customers for insurers. 42 U.S.C.A. § 18091(a)(2)(C). As Senator Franken explained in justifying the insurance regulations, “we are giving these companies a huge influx of new business.” 156 Cong. Rec. S1821, 1862 (daily ed. Mar. 23, 2010). Moreover, this “huge influx” is highly profitable, because it consists of primarily *healthy* individuals, who have sensibly decided that comprehensive insurance is not financially worthwhile. The statutory findings expressly state that the mandate’s “broaden[ing of] the health insurance risk pool to include healthy individuals ... will lower health insurance premiums” and is therefore “essential to creating effective health insurance markets.” 42 U.S.C.A. § 18091(a)(2)(I).

The mandate does not target, and was not needed to capture, the sick or the poor. Regardless of the mandate, unhealthy individuals will voluntarily purchase insurance at favorable rates, under the guaranteed-issue and community-rating provisions.¹² And impoverished individuals will generally be covered either by the Act’s subsidies for participation in health-insurance exchanges or by the expanded Medicaid program. *See infra* at 19-22. Accordingly, the mandate targets healthy individuals who could

¹² CBO, *Premiums*, 19 (“[I]n the absence of [the mandate], people who are older and more likely to use medical care would be more likely to enroll in nongroup plans” than “people who are younger and expect to use less medical care.”).

afford insurance but believe, given their infrequent healthcare needs, that its cost is not warranted, particularly given the 30% increase in premiums caused by the Act's insurance regulations.¹³

Conscripting these individuals into the insurance market will greatly reduce the average payouts required from insurance companies. That is why the mandate *lowers* prices for voluntary insurance customers, inverting the normal economic axiom that increased demand *increases* prices. Specifically, the mandate is supposed to lower premiums in the non-group market by *15-20%*, offsetting roughly two-thirds of the increase caused by the Act's insurance regulations.¹⁴ Based on CBO estimates, this subsidy is worth between \$28 and \$39 billion in 2016 alone.¹⁵ As the Eleventh Circuit noted, Congress used this subsidy “to mitigate [the Act's] regulatory costs on private insurers.” Pet.App. 129a.¹⁶

¹³ CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010) (“CBO, *Effects*”), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf (“[T]he elimination of the mandate would reduce insurance coverage among healthier people to a greater degree than it would reduce coverage among less healthy people.”).

¹⁴ CBO, *Effects*, 2.

¹⁵ The average premium in the non-group market in 2016 will be \$5,800 after the reduction, which would mean the mandate lowered premiums by \$1,024 to \$1,450 for each of the 27 million voluntary participants. CBO, *Premiums*, 6; CBO, *Effects*, 2.

¹⁶ Indeed, as the Government explained below, Congress believed that “the absence of a minimum coverage requirement [to offset] guaranteed-issue and community-rating requirements had undermined health care reform efforts in several states.” Govt. Br. at 31 (11th Cir. Apr. 1, 2011).

In addition to reducing the average payouts by insurance companies, Congress also believed that the mandate protected insurers' incoming revenue stream, by preventing a type of "adverse selection" thought to be enabled by the Act's guaranteed-issue and community-rating rules. Namely, people now "would wait to purchase health insurance until they need[] care." 42 U.S.C.A. § 18091(a)(2)(I). Indeed, some proponents of the mandate claimed that this "adverse selection" phenomenon "tends to lead to a death spiral of individual insurance."¹⁷ Rightly or wrongly, Congress thought the mandate "essential" to prevent such adverse selection. *Id.*¹⁸

b. In addition to directly subsidizing insurance companies by conscripting healthy individuals,

¹⁷ Statement of Uwe Reinhardt, Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong. 11 (Mar. 17, 2009).

¹⁸ As the Eleventh Circuit explained, Congress' concerns about this kind of "adverse selection" are both highly implausible and completely speculative. One "cannot literally purchase insurance on the way to the hospital," because "the Act permits insurers to restrict enrollment to a specific open or special enrollment period," and it additionally allows waiting periods for general coverage eligibility. Pet.App. 178a n.139 (citing 42 U.S.C.A. §§ 300gg-1(b), 300gg-7). Thus, an individual hoping to game the Act's insurance regulations would have to gamble that, if he contracted some catastrophic illness, he would be able to wait until an open enrollment period (generally one month out of each year) and then wait an additional period for coverage to kick in. In this regard, neither Congress nor the CBO offered even a rough estimate, based on the States' experience or otherwise, of the extent to which people might delay purchasing insurance because of the availability of guaranteed-issue and community-rating rules.

Congress also thought the mandate would “lower health insurance premiums” by reducing the alleged premium increase of “over \$1,000 a year” attributable to uncompensated care provided to the uninsured. 42 U.S.C.A. § 18091(a)(2)(F). Congress found that the uninsured “fail to pay the full cost of the services they consume” and instead “shift the costs of their uncompensated care—totaling \$43 billion in 2008—to health care providers.” Govt. Cert. Pet. 6 (citing 42 U.S.C.A. § 18091(a)(2)(A)). Congress believed that providers in turn “pass on the cost to private insurers,” which “increases family premiums by on average over \$1,000 a year.” 42 U.S.C.A. § 18091(a)(2)(F). Congress thus thought that, “[b]y significantly reducing the number of the uninsured, the [mandate] ... will lower ... premiums.” *Id.*

In fact, the mandate will have virtually no impact on uncompensated care. As the Eleventh Circuit explained, the data on which Congress relied for its \$43 billion estimate of uncompensated care show that the vast majority of this sum is attributable to people *not* affected by the mandate. First, \$15 billion is attributable to people who will become eligible for Medicaid under the Act, and are therefore likely to obtain insurance without the mandate. Pet.App. 127a. Another \$8.7 billion is provided to individuals with pre-existing conditions, who will buy coverage *voluntarily* under the new guaranteed-issue and community-rating regulations. *Id.* 127a-28a. An additional \$8.1 billion is attributable to aliens not subject to the mandate. *Id.* 127a. And another \$3.3 billion is caused by the failure of individuals *with insurance* to pay out-of-pocket expenses such as deductibles. *Id.* 128a. Thus,

the amount of uncompensated care even *potentially* attributable to individuals affected by the mandate is less than *\$8 billion*, 0.33% of the \$2.4 trillion healthcare market. *Id.*

Moreover, other data show that even this \$8 billion figure is substantially overstated. As a threshold matter, many uninsured individuals obtain *no* healthcare in a given year, and most others actually pay in full. The uninsured on average obtain *no* uncompensated care from non-emergency providers and actually pay *more* for those services than the insured do.¹⁹ As for emergency care, less than 20% of the full-year uninsured visit emergency rooms, which is the only place where federal law requires that the indigent receive limited “stabilizing” care.²⁰

Thus, as detailed by *amicus curiae* in the court below, the voluntarily uninsured obtain, on average, only \$854 in healthcare services per year.²¹ And when it comes to *emergency-room care*, “the data show that the targets of the mandate consume only \$56 per year on average in total emergency-room care, which includes both the mandated emergency stabilization care (which may still be billed to patients) and the more routine care administered there.”²² Given CBO estimates that the individual

¹⁹ Jonathan Gruber & David Rodriguez, *How Much Uncompensated Care Do Doctors Provide?*, 26 J. HEALTH ECON. 1151, 1159-61 (2007).

²⁰ CDC, *Health*, 337; 42 U.S.C. § 1395dd.

²¹ See *Amicus Curiae Economists Br.* at 13-16 (11th Cir. May 11, 2011).

²² *Id.*

mandate will cause 16 million people to buy insurance,²³ it will only affect people consuming about *\$900 million* (16 million x \$56) in emergency-room care, and an even smaller amount of *uncompensated* care. The full \$900 million equals approximately 2% of Congress' inflated estimate of \$43 billion in uncompensated care, and .038% of the \$2.4 trillion healthcare market. In short, the mandate targets individuals who are *unlikely* to obtain healthcare at all and who mostly *pay* when they do.

In truth, Congress's professed concern with cost-shifting attributable to uncompensated care is somewhat ironic, given the extent to which the Act affirmatively requires cost-shifting in other respects. By any measure, uncompensated care attributable to those affected by the individual mandate is a small fraction of the \$28 to \$39 billion in costs that will be shifted from the new, healthier customers affected by the individual mandate to insurance companies and their voluntary, less-healthy customers.

In addition, even after 2014, the Act does not allow insurers to subject those who refuse to buy insurance to pre-existing condition bans or higher premiums. Moreover, the Act exempts millions of individuals from the penalty for violating the mandate, *see* 26 U.S.C.A. § 5000A(e), and the relatively modest penalties are not used to offset the costs of insuring those who purchase insurance only once ill. For all of these reasons, private insurance customers will continue to bear the cost of millions of people failing to buy insurance after 2014.

²³ CBO, *Effects 2*.

Moreover, Medicaid pays substantially lower rates than private insurers.²⁴ On Congress' view that hospitals shift unrecovered costs to private insurers, such rates would likely shift costs to private insurance. Indeed, the Act exacerbates that cost-shifting by *expanding* Medicaid while *cutting* Medicaid reimbursements. Likewise, "[t]he current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent" to those receiving employer-based insurance, another amount far greater than any subsidy for uncompensated care provided to the voluntarily uninsured.²⁵

3. Exchanges And Federal Subsidies

Title I of the Act also requires the creation of state "Health Benefit Exchanges" by January 1, 2014. 42 U.S.C.A. § 18031. These are marketplaces through which individuals (or small businesses) can purchase the mandated insurance.

To sell insurance on an exchange, an insurer must be certified as offering "qualified health plans," *id.* § 18031(d)(2)(B)(I), which must pay for certain "essential health benefits," *id.* § 18021(a)(1)(B). These include a wide range of services including substance-abuse treatment, behavioral health treatment, prescription drugs, rehabilitative services, and preventive services. *Id.* § 18022(b)(1). Insurers must limit "cost sharing" by insureds—*i.e.*, out-of-pocket costs like deductibles. *Id.* § 18022(c).

²⁴ CBO, *Key Issues in Analyzing Major Health Insurance Proposals*, at 114-15 (Dec. 2008), <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf>

²⁵ *Id.* at XVII.

Insurers also must calibrate their plans to pay for a specific percentage of the healthcare costs for all enrollees: A “bronze” plan must pay for 60% of the healthcare costs obtained by enrollees, a “silver” plan must pay 70%, a “gold” plan 80%, and a “platinum” plan 90%. *Id.* § 18022(d)(1). Insurers may offer the option of a “catastrophic plan,” which provides no benefits until a certain level of out-of-pocket costs is met, but only to individuals who are under 30 or exempt based on economic hardship from the penalty for violating the mandate. *Id.* § 18022(e).

The Act provides extensive subsidies for low-income individuals to participate in exchanges. 26 U.S.C.A. § 36B; 42 U.S.C.A. § 18071. Specifically, tax credits are available for individuals who purchase health insurance through an exchange and have income between 100% and 400% of poverty levels. 26 U.S.C.A. § 36B(a), (b), (c)(1). The credits are tied to the lesser of (i) the actual premiums paid by the individual on a plan purchased on an exchange, or (ii) the community-rated premiums for the second-cheapest “silver” plan offered through an exchange for the geographic “rating area” where the individual resides. *Id.* §§ 36B(b)(2), (b)(3)(C).

The CBO has predicted that, by 2019, 24 million people will be insured through exchanges, and 20 million of them will receive federal subsidies of, on average, \$6,460 per person.²⁶ That amounts to an annual federal subsidy of almost \$13 billion.

²⁶ CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 19 (Mar. 30, 2011) (“CBO, *Analysis*”), <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>.

4. Employer “Responsibility” Assessment

Subtitle F of Title I imposes “Shared Responsibility for Health Care,” not just on individuals subject to the mandate, but on employers as well. Immediately after creating the mandate requiring “Individual Responsibility” for insurance in Part I, Subtitle F creates “Employer Responsibilities” in Part II. In contrast to the individual mandate, employers’ “responsibility” does not include a direct legal requirement to offer insurance to their employees. Instead, it consists of an exaction that is triggered if at least one employee of an employer with at least 50 full-time employees obtains a federal subsidy to purchase health insurance on an exchange, whether because (a) the employer fails to offer “minimum essential coverage” in an employer-sponsored plan, 26 U.S.C.A. § 4980H(a), or (b) the employer offers “minimum essential coverage,” but it is unaffordable or does not cover the same level of benefits as a “bronze” plan on an exchange, *id.* § 4980H(b). *See also* Pet.App. 45a-47a.

5. Expansion Of Medicaid

In keeping with the Act’s theme of “shared responsibility,” Title II compels the States to expand Medicaid coverage for many individuals who would likely not be able to obtain other insurance. Starting in 2014, states must offer Medicaid to adults under age 65 with incomes up to 133% of federal poverty levels. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII). States must likewise offer Medicaid to all children whose families earn up to 133% of federal poverty levels. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D), 2(C). As the Eleventh Circuit explained, “[t]his is a significant change, because previously the Medicaid Act did not

set a baseline income level [and] many states currently do not provide Medicaid to childless adults and cover parents only at much lower income levels.” Pet.App. 49a.

6. Revenue-Raising And Deficit-Neutrality “Offset” Measures

To ensure a CBO score of deficit-neutrality, the Act includes various tax increases and spending cuts necessary to fund the subsidies, Medicaid expansion, and other expenditures in the Act. As the Federal Government itself explained below, “[w]hen Congress passed the ACA, it was careful to ensure that any increased spending ... was offset by other revenue-raising and cost-saving provisions.” RE 1024.

Title IX adopts a series of new healthcare-related taxes and fees expressly described as “Revenue Offset Provisions,” which fall, *inter alia*, on individuals, employers, insurance companies, pharmaceutical companies, and manufacturers of medical devices. *E.g.*, 26 U.S.C.A. §§ 1401(b)(2), 1411, 3101(b)(2) (imposing additional Medicare taxes on high-income taxpayers); *id.* § 4980I (taxing so-called “Cadillac” plans); *id.* §§ 106(f), 125(i), 220(d)(2)(A), 223(d)(2)(A) (restricting ability to pay for healthcare with pre-tax dollars); *id.* § 213(a) (limiting itemized deduction for medical expenses); *id.* § 139A (eliminating deduction for employers who provide prescription-drug coverage for retirees); ACA §§ 9008-9010 (various fees).

The Act also cuts various payments under public programs such as Medicare. For example, it reduces “disproportionate share hospital payments,” which are special payments to hospitals that provide a disproportionate share of uncompensated care. 42

U.S.C.A. §§ 1396r–4(f)(7), 1395ww(r). According to the President, this was a “common-sense change[]” because “if more Americans are insured, we can cut payments that help hospitals treat patients without health insurance.” Sheryl Gay Stolberg & Robert Pear, *Health Plan May Mean Payment Cuts*, N.Y. TIMES, June 14, 2009, at A20.

7. Miscellaneous Additions

The Act also includes hundreds of measures ostensibly aimed at improving the quality, efficiency, and availability of healthcare. Many of these operate through public programs like Medicare. *E.g.*, ACA §§ 2501, 2503 (adjusting reimbursement formulas for prescription drugs); *id.* § 3401 (adjusting payments for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers according to productivity); 42 U.S.C.A. § 1395ww(q) (reducing Medicare payments to hospitals with specified percentages of preventable readmissions); *id.* § 1395ww(p) (reducing Medicare payments for hospital-acquired conditions).

Other measures involve direct federal spending. *E.g.*, 42 U.S.C.A. § 1315a (creating Center for Medicare and Medicaid Innovation to study more efficient payment methods for public programs); *id.* § 300hh–31 (establishing grants for epidemiology laboratories); *id.* § 1320e (establishing “Patient-Centered Outcomes Research Institute” to research effectiveness of various medical treatments).

And yet other provisions impose direct requirements on employers or individuals. *E.g.*, 29 U.S.C.A. § 207(r)(1) (requiring employers to provide reasonable break times for nursing mothers); 21 U.S.C.A. § 343(q)(5)(H) (requiring chain restaurants

to “disclose in a clear and conspicuous manner” the nutritional content of standard menu items).

Many provisions of the Act, though not directly related to the individual mandate or the insurance regulations, were added as *quid pro quo* measures needed to secure the votes of specific legislators. For example, legislators such as Congressman Bart Stupak and Senator Ben Nelson insisted that the bill clearly prohibit the use of federal funds to pay for abortions. *See* ACA § 1303; David D. Kirkpatrick, *Abortion Fight Adds to Debate on Health Care*, N.Y. TIMES, Sept. 29, 2009, at A1. Other provisions in the Act were, even more explicitly, included to benefit individual legislators. For example, § 10323 of the Act extends Medicare coverage to “individuals exposed to environmental health hazards” in an area “subject to an emergency declaration made as of June 17, 2009.” In fact, this “cryptic, mysterious” provision, demanded by Montana Senator Max Baucus, refers specifically to “people exposed to asbestos from a vermiculite mine in Libby, Montana.” Robert Pear, *Buried in Health Bill, Very Specific Beneficiaries*, N.Y. TIMES, Dec. 21, 2009, at A1. Likewise, § 2006 increases Medicaid payments to certain “states recovering from a major disaster.” In fact, this would give hundreds of millions of dollars to a single state, Louisiana, and was inserted at the behest of wavering Louisiana Senator Mary Landrieu. Brian Montopoli, *Tallying the Health Care Bill’s Giveaways*, CBS NEWS, Dec. 21, 2009.²⁷

²⁷ http://www.cbsnews.com/8301-503544_162-6006838-503544.html.

Still other provisions were not identified as part of specific *quid pro quos*, but provide suspiciously targeted benefits. For example, § 10502 of the Act grants \$100 million to an unnamed “health care facility” affiliated with a health center at a public university in a state where there is only one public medical and dental school. *Buried in Health Bill, Very Specific Beneficiaries, supra* (“Senators and their aides ... were not sure who would qualify for this money ... [but] a new school in Scranton, Pa., was a likely candidate.”); *see also Tallying the Health Care Bill’s Giveaways, supra* (“Also in the bill ... is an item that increases Medicare payments to hospitals and doctors in states where half the counties are ‘frontier counties’ Montana, North Dakota, South Dakota, Utah and Wyoming.”).

The Senate Majority Leader, one of the chief architects of the legislative deal, candidly admitted doubting “if there’s a senator that doesn’t have something in this bill that was important to them.”²⁸

C. Private Petitioners’ Challenge

Private Petitioners NFIB, Ahlburg, and Brown, along with 26 States, brought this action challenging the ACA’s facial validity. Pet.App. 2a. As relevant here, they argued that the individual mandate exceeds Congress’ Article I authority and cannot be severed from the remainder of the Act. *Id.* 3a.

The district court granted summary judgment to the challengers. Holding the mandate to be unconstitutional and non-severable, the court

²⁸ David Welna, *On Health Bill, Reid Proves The Ultimate Deal Maker*, NATIONAL PUBLIC RADIO, Dec. 23, 2009, <http://www.npr.org/templates/story/story.php?storyId=121791736>.

invalidated the Act in its entirety. *Id.* 362a-364a. The Eleventh Circuit affirmed in part and reversed in part. In an opinion jointly authored by Chief Judge Dubina and Judge Hull, that court held the mandate unconstitutional, but concluded that it was severable from the remainder of the Act, including even the insurance regulations that the Government had *conceded* were non-severable. *Id.* 186a & n.144.

After the parties filed their certiorari petitions, Petitioner Brown, whose standing had been conceded by the Government in the Eleventh Circuit (*id.* 8a), filed a voluntary petition for bankruptcy. *See* Letter from G. Katsas to D. McNerney (Dec. 7, 2011). Private Petitioners do not believe that Brown's pending bankruptcy undermines her standing; to the contrary, her worsened financial state exacerbates the degree to which future costs from the mandate are "immediately and directly affect[ing]" her "financial strength[] and fiscal planning." *Clinton v. City of New York*, 524 U.S. 417, 431 (1998). Moreover, Brown's standing obviously does not affect the standing of Petitioners Ahlburg or NFIB, both of whom the courts below held had standing: Ahlburg is an unrelated individual, and NFIB has additional members who filed declarations materially indistinguishable from Brown's in support of NFIB's associational standing. *See* Pet.App. 8a-10a, 290a-293a, 439a; JA 151-56. Nevertheless, in an abundance of caution, on January 4, 2011, Private Petitioners, with the support of the Government and the State Petitioners, moved to add two of these additional NFIB members as formal parties, thereby eliminating any possible concerns. That motion is pending as of this filing.

SUMMARY OF ARGUMENT

Severability of an unconstitutional statute turns on congressional intent. By any fair measure, the text, structure, and operation of the ACA—not to mention its tortured path through the legislative process—make it evident that, without the individual mandate at its heart, no statute remotely resembling the Act would or could have been enacted. Once the mandate is invalidated, the entire Act must fall with it.

In constructing the ACA, Congress sought to restructure the health-insurance market to obtain near-universal coverage, bring down costs, and keep the federal deficit from growing. Ambitious goals, but Congress believed it had a magic bullet to achieve them—the individual mandate. By forcing healthy individuals to buy full-scale insurance at artificially inflated prices, the mandate handed an annual \$30 billion subsidy to insurance companies. That subsidy allowed Congress to force the insurers, in turn, to sell coverage to the old and the sick at artificially low prices. The Federal Government could then provide limited assistance to those who could not afford even the premiums as reduced by the mandate’s subsidy. Miscellaneous taxes and spending cuts could balance out this new spending and thus maintain deficit-neutrality. And, with individuals and insurance companies bearing such a substantial amount of the Act’s costs, employers and States could be co-opted into filling some residual gaps—by, respectively, sponsoring affordable insurance for employees and expanding public-insurance programs like Medicaid.

Without the mandate, the remainder of the Act cannot operate as Congress intended. Absent the mandate's mammoth subsidy to insurance companies, the Act's insurance regulations would dramatically drive up premiums—reversing Congress' goal of reducing health-insurance costs. That is why Congress found the mandate “essential” to these provisions, and why the Government concedes that at least some of them cannot survive alone. But without the mandate *and* the new regulations prohibiting the insurance practices that Congress condemned as abusive and discriminatory, *none* of the Act's primary goals would be satisfied. These provisions are the heart of the Act, its central *raison d'être*. To remove them would be to fundamentally alter the legislation; this Court has *never* used severability to effect such a major change to such a major part of such a major bill.

Moreover, without the mandate and insurance regulations, none of the Act's major planks would operate as intended by Congress. Federal subsidies would no longer be linked to community-rated premiums; instead, they would *pay* private insurance companies for the very “abusive” practices Congress intended to *forbid*. Other actors, like healthcare providers and the States, would bear burdens well beyond those intended, as elimination of the mandate and insurance regulations would destroy the bill's careful allocation of shared responsibility. And new taxes would reap revenue no longer being used to further the Act's primary goals. At best, the parts of the Act unaffected in operation by the foregoing measures would amount to a hodge-podge of minor, miscellaneous measures, many added only to secure passage of provisions no longer intact.

That is nothing like what Congress enacted, and it is not an Act that Congress would have enacted. The ACA was the fragile product of extensive legislative deal-making; to strip out its centerpiece would fundamentally alter the original legislative bargain. Particularly in light of the *deletion* of a severability clause from an earlier version of the bill, and the House's determination to consider the Act on an all-or-nothing basis, it is clear that Congress intended this unique legislative deal to rise or fall as a whole. Invalidation of the mandate therefore requires that the entire Act be stricken; this Court should leave to Congress the complex and political task of revisiting comprehensive health-insurance reform.

ARGUMENT

I. UNCONSTITUTIONAL PROVISIONS MAY BE SEVERED ONLY WHERE CONSISTENT WITH CONGRESSIONAL INTENT

When a court invalidates part of a statute, it faces the question of what happens to the rest. Can the stricken provision be severed, so that the remainder of the statute survives? Or would severance—the slicing of legislation into a new, judicial creation—be an inappropriate intrusion into the lawmaking process? The answer, as this Court has explained, depends on legislative intent: whether Congress would have enacted the bill absent the stricken provision, or whether omission of that provision would have scuttled legislative bargains or undermined statutory objectives. If the latter is true, judicial revision through severance is improper, particularly where it entails complex line-drawing that is best left to the legislature.

Severability questions invariably raise serious separation-of-powers issues. By severing invalid provisions, courts may save Congress from having to go back to the drawing board. On the other hand, severance creates a law that Congress never enacted, and risks having it operate differently than intended—*e.g.*, by preserving a *quid* enacted only because of the now-invalidated *quo*. Such partial invalidation of integrated statutes thus may produce a serious invasion of the legislative domain. To respect the distinct legislative and judicial roles, severability analysis must recognize the separation-of-powers concerns on *both* sides of the calculus.

A. An Unconstitutional Provision Cannot Be Severed If The Remainder Of The Act Would Not Operate As Congress Intended, And So Would Not Have Been Enacted On Its Own

“The inquiry into whether a statute is severable is essentially an inquiry into legislative intent.” *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999); *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) (“[T]he touchstone for any decision about remedy is legislative intent.”). The ultimate question is whether Congress “would have been satisfied with what remained” after the unconstitutional provisions were removed. *Champlin Rfg. Co. v. Corp. Comm’n of Okla.*, 286 U.S. 210, 235 (1932). Courts should avoid “nullify[ing] more of a legislature’s work than is necessary,” *Ayotte*, 546 U.S. at 330, but it would likewise be improper for judges to “substitute, for the law intended by the legislature, one they may never have been willing by itself to enact,” *Pollock v. Farmers’ Loan & Trust Co.*, 158 U.S. 601, 636 (1895).

If “the balance of the legislation is incapable of functioning independently,” then certainly “Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute.” *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987). But even if the remainder of the act could stand alone from an operational perspective, the question remains whether “it is evident that the Legislature would not have enacted those provisions independently of that which is invalid.” *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (“*FEF*”). Thus, “[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress.” *Alaska Airlines*, 480 U.S. at 685.

To determine whether the rest of the legislation would operate in the “manner” intended by Congress, courts look to various objective factors, including: “the nature” of the stricken provision, *Alaska Airlines*, 480 U.S. at 685; its role “in the original legislative bargain,” *id.*; the “historical context” of the legislation, *FEF*, 130 S. Ct. at 3162; the economic connection between the invalidated provision and the remainder of the statute, *Carter v. Carter Coal Co.*, 298 U.S. 238, 314-15 (1936); and the impact of that provision on the “dominant aim of the whole statute,” *R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 362 (1935). If these considerations show that Congress “would not have been satisfied with what remains” after invalidation of the unconstitutional provision, then severance is improper. *Williams v. Standard Oil Co.*, 278 U.S. 235, 242 (1929).

In undertaking the analysis, courts consider clauses that expressly address severability—text that apprises the judiciary whether Congress intends the statute’s provisions to survive, and to operate independently of, any one that may be invalid. Thus, inclusion of a severability clause “gives rise to a presumption that Congress did not intend the validity of the Act as a whole, or of any part of the Act, to depend upon whether” a particular provision “was invalid.” *INS v. Chadha*, 462 U.S. 919, 932 (1983). But the absence of a severability clause is treated simply as silence, creating no presumption at all, neither “against severability,” *Alaska Airlines*, 480 U.S. at 686, nor for it, *see* Br. of Amici Curiae Family Research Council et al. at 4-14 (Nos. 11-393 & 11-400). If, however, a severability clause was specifically *removed* from a law during the legislative process, that “does suggest that Congress intended to have the various components of the [legislative] package operate together or not at all.” *Gubiensio-Ortiz v. Kanahale*, 857 F.2d 1245, 1267 (9th Cir. 1988) (Kozinski, J.); *accord United States v. Croxford*, 324 F. Supp. 2d 1230, 1245 (D. Utah 2004) (Cassell, J.); *see also Russello v. United States*, 464 U.S. 16, 23-24 (1983) (drawing inference of congressional intent from fact that Congress included text “in an earlier version of a bill but delete[d] it prior to enactment”).

B. Severability Analysis Must Account For The Separation-Of-Powers Dangers Inherent In Both Potential Courses of Action

This Court has observed that the refusal to sever unconstitutional provisions “frustrat[es] the intent of the elected representatives of the people.” *Regan v.*

Time, Inc., 468 U.S. 641, 652 (1984) (plurality opinion). Accordingly, courts should “act cautiously” and “refrain from invalidating more of the statute than is necessary.” *Id.* Conversely, however, if the Court does sever part of a statute, the necessary result is a new law that was never enacted by the political branches through the required means of bicameral passage and presentment to the President, *Chadha*, 462 U.S. at 951-59. Judicial creation of such new laws poses obvious dangers of intrusion into legislative function: “This would, to some extent, substitute the judicial for the legislative department of the [G]overnment,” and in substance “make a new law, not ... enforce an old one.” *United States v. Reese*, 92 U.S. 214, 221 (1876). Indeed such partial invalidation “may call for a ‘far more serious invasion of the legislative domain’ than [the Court] ought to undertake,” especially “where linedrawing [would be] inherently complex.” *Ayotte*, 546 U.S. at 330 (quoting *United States v. Nat’l Treasury Employees Union*, 513 U.S. 454, 479, n.26 (1996)).

The Court has therefore repeatedly held it improper to rewrite a statute to solve constitutional flaws. To “dissect an unconstitutional measure and reframe a valid one,” by “inserting limitations it does not contain,” would be “legislative work beyond the power and function of the court.” *Hill v. Wallace*, 259 U.S. 44, 70 (1922); *see also FEF*, 130 S. Ct. at 3162 (courts lack “editorial discretion” to “blue-pencil” statute). Given the “many different possible ways the legislature might respond” to the law’s defects, courts should let *Congress* “rewrite those provisions.” *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

Partial judicial deletion of an enacted statute can pose similar problems of judicial usurpation. As this Court noted in holding that Congress cannot authorize the President to delete parts of an enacted statute, selective deletion impermissibly amends an enacted law: “In both legal and practical effect, the President has amended two Acts of Congress by repealing a portion of each.” *Clinton*, 524 U.S. at 438; *cf. Hill*, 259 U.S. at 71 (reiterating that severability “does not give the court power to amend the act”). Moreover, partial judicial “repeal” leaves in its wake a never-enacted law based on judicial speculation about counter-factual congressional desires. Particularly when Congress has omitted a severability clause—the traditional method of informing courts how it wants the judiciary to respond if part of a law is held unconstitutional—there is a grave danger that excising only part of the integrated whole will be based on mere guesswork, which may result in judicial creation of a law that Congress would not have enacted.

Indeed, such selective judicial deletion is virtually indistinguishable from improper judicial revision where the “line-drawing is inherently complex,” *Ayotte*, 546 U.S. at 330. This is especially true here because, as discussed below and as even the Government concedes, *some* constitutional parts of the Act *must* be excised once the mandate is invalidated. When some constitutional parts of a law must be severed, judicial selection of *which* parts of Congress’ permissible handiwork will remain is akin to judicial rewriting. *Selectively* deleting the remaining parts of the statute entails the same “blue pencil[ing]” as judicial rewriting. In both cases, the Court is not performing the straightforward judicial

function of striking unconstitutional statutory provisions, but also the quasi-legislative function of deciding which lawful provisions will survive, based on guesswork about which subset of the constitutional residue best serves Congress' policy goals.

Finally, these worries of judicial intrusion on legislative prerogative are particularly acute when the invalidated provision is part of a comprehensive, heavily negotiated package. Where legislation is born of compromise, severing an invalid provision threatens improperly to strip one side of the deal of its benefits in the "original legislative bargain." *Alaska Airlines*, 480 U.S. at 685. *See, e.g., Carter*, 298 U.S. at 316 (refusing to sever provisions that are "conditions, considerations, or compensations" for one another); *Allen v. Louisiana*, 103 U.S. 80, 84 (1881) (same); *see also Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 561-62 (2001) (Scalia, J., dissenting) (courts have "no authority" to "eliminate a significant *quid pro quo* of the legislative compromise"). It is no answer to say that Congress can simply repeal the remainder, given the inertial forces that check the legislative process. Imagine, for example, a law including some provisions demanded by each house of Congress, together reflecting a *quid pro quo*. If a court were to invalidate only one set of these, the result would be a law that never would have been enacted yet is unlikely to be repealed. Further, in a comprehensive legislative package, removal of any provision could impact the severability of every *other* provision, making the task all the more difficult and all the less appropriate for the judiciary.

The lesson is that this Court, “mindful that [its] constitutional mandate and institutional competence are limited,” *Ayotte*, 546 U.S. at 329, must be equally skeptical of severing either too much *or too little* of a law. At least absent a severability clause, severing a key provision from a hard-fought legislative deal should be viewed with special skepticism.

II. THE ACT’S INSURANCE REGULATIONS OPERATE IN TANDEM WITH, AND SO MUST FALL WITH, THE INDIVIDUAL MANDATE

The Act expressly states that the mandate is “essential to creating effective health insurance markets” because it was necessary to “lower health insurance premiums” that would be increased by the guaranteed-issue and community-rating provisions. 42 U.S.C.A. § 18091(a)(2)(I). That statutory finding—expressly linking the intended operation of the guaranteed-issue and community-rating provisions to the mandate—should be dispositive for severability purposes. But, in any event, further examination of the interrelationship of these provisions eliminates any conceivable doubt.

Even the Government agrees that the individual mandate is inextricably linked to the guaranteed-issue and community-rating requirements. The mandate was intended to be a direct subsidy to insurance companies, as compensation for requiring them (in the guaranteed-issue provision) to insure against “risks” that have already come to pass and forbidding them (in the community-rating provision) from using actuarially sound insurance premiums. The mandate thus works to counteract the powerful inflationary impacts of these other provisions, which would otherwise make premiums in the individual

insurance market prohibitively expensive, thereby frustrating Congress' goal of affordable health insurance. And Congress further viewed the mandate as necessary to prevent "adverse selection" to "game" the new insurance rules, which proponents warned would spark a "death spiral" in insurance.

The guaranteed-issue and community-rating requirements thus cannot operate without the mandate in the manner intended by Congress. Rather, "their associated force—not one or the other but both combined—was deemed by Congress to be necessary to achieve the end sought." *Carter*, 298 U.S. at 314. To strike the mandate alone would impermissibly eliminate a central *quid pro quo* of the Act. If the mandate falls, the guaranteed-issue and community-rating regulations must therefore fall with it, as the Government itself has conceded.

A. Congress Intended The Individual Mandate To Offset The New Burdens Imposed On Insurers By The Act's Insurance Regulations

The Act's guaranteed-issue and community-rating rules, both found in Subtitle C of Title I, prohibit the related "discriminatory" practices of denying coverage for a pre-existing condition or charging higher premiums to people who will require greater health-care expenditures because of risky conditions or habits. *Supra* at 10-11.

As Congress recognized, the unavoidable result of these measures would be a dramatic rise in premiums. The CBO estimated that they would cause a 30% increase in individual premiums. *Supra* at 11. Congress also believed that, because insurance companies would now be prohibited from "discriminating" against sick people, "many

individuals would wait to purchase health insurance until they needed care.” If the prediction of this type of “adverse selection” were accurate, it would reduce insurers’ revenues, and thus force them to increase the premiums charged to their diminishing number of customers. *Supra* at 15.

Congress was equally explicit that the individual mandate was its solution to these dual problems created by the guaranteed-issue and community-rating provisions. As the statutory findings expressly state, Congress believed the mandate was “essential” to mitigating increased premiums from these effects, and thus to “creating effective health insurance markets.” 42 U.S.C.A. § 18091(a)(2)(I). This was so for two reasons.

First, the individual mandate’s principal purpose and effect was to greatly offset the estimated 30% increase in premiums attributable to guaranteed-issue and community-rating. Specifically, the mandate was supposed to lower insurance premiums by 15-20%, or \$28 to \$39 billion annually, thus reducing nearly two-thirds of the premium increases caused by these insurance regulations. *Supra* at 14. It would do so by, in Congress’ words, “add[ing] millions of new consumers to the health insurance market,” 42 U.S.C.A. § 18091(a)(2), primarily healthy individuals whose premium payments far outweigh any reasonably foreseeable healthcare expenditures. This is why Congress emphasized that the individual mandate’s “broaden[ing] [of] the health insurance risk pool to include *healthy* individuals” would “lower health insurance premiums.” *Id.* (emphasis added).

A statute expected to increase premiums by some 30% would not have been acceptable to Congress, as it would have materially undermined the Act's stated goal of reducing costs to achieve "affordable care." The guaranteed-issue and community-rating rules would still dramatically drive up premiums, but without any countervailing effect. Absent the mandate, then, these insurance regulations plainly would not "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. They are legislation that Congress "never [would] have been willing by itself to enact." *Pollock*, 158 U.S. at 636. Nor could Congress have, without the vital support of the insurance industry, which found the insurance requirements palatable only as tempered by the mandate. *See supra* at 2, 12.

In short, the mandate is so closely tied to these provisions that its invalidation spells their demise. In concluding otherwise, the Eleventh Circuit simply failed to consider the adverse effect on premiums—and thus on the Act's express purposes—that the insurance regulations would have, if unmitigated by the mandate. *See* Pet.App. 180a-85a.

Second, Congress expressly stated its belief that the individual mandate was "essential" to eliminate the "adverse selection" enabled by guaranteed-issue and community-rating. 42 U.S.C.A. § 18091(a)(2)(I). To be sure, as the Eleventh Circuit explained, Congress greatly exaggerated this problem. *See supra* at 15, n18. Nevertheless, second-guessing Congress' judgments about how the individual mandate will actually operate should play no role in severability analysis. For severability, the question is whether *Congress* "would ... have been satisfied

with what remains” after the unconstitutional provision is invalidated, *Williams*, 278 U.S. at 242, not whether Congress *should* have been satisfied had it better understood the effect of its law.

In sum, because Congress thought the individual mandate was “essential” to cure dramatic premium increases and market distortions caused by the guaranteed-issue and community-ratings provisions, those provisions cannot, without the mandate, “function in the manner” Congress intended.

B. The Act’s Guaranteed-Issue And Community-Rating Provisions Are Indistinguishable From Its Other, Related Insurance Regulations

The Government has acknowledged that the mandate cannot be severed from the guaranteed-issue and community-rating provisions. Govt. Cert. Resp. 31-33 & n.13. But these provisions cannot be singled out from the Act’s restrictions on health-insurance products. *All* of these regulations, which appear together in Sections 1001 and 1201 of Title I of the Act, also must fall with the mandate—and for the same reasons.

In addition to precluding insurers from setting premiums based on individualized factors, and from refusing to cover pre-existing conditions, the Act imposes closely related restrictions on insurance products. Many are designed to combat the *same* assertedly abusive or unfair insurance practices addressed by the guaranteed-issue and community-rating rules. For example, the Act forbids insurers to set limits on coverage, to exceed certain levels of cost-sharing, to refuse to cover various services, or to freely rescind or decline to renew coverage. *Supra* at

10-11. Like the guaranteed-issue and community-rating provisions, all of these are designed to protect health-insurance consumers—particularly unhealthy consumers most in need of open-ended, permanent coverage—from insurance practices that make coverage inadequate, expensive, or unavailable. By forcing insurers to offer policies on economically unfavorable terms, all of these provisions would drive up premiums. The individual mandate would offset many of those increased costs. The insurance regulations, together, thus comprise a package of restrictions that work in unison and are offset by the mandate. Absent the mandate, the *entire* set of insurance regulations must be invalidated.

The Government’s position, that this Court can strike the guaranteed-issue and community-rating provisions, but nonetheless retain the other insurance regulations, seems to rest on a policy determination that eliminating the former provisions, but no others, would sufficiently relax the burdens on insurance companies to make up for invalidation of the mandate’s subsidy. But that is precisely the type of responsive policy choice reserved to Congress. *See, e.g., Randall*, 548 U.S. at 262. For example, Congress could just as easily have decided to remedy the problem by retaining guaranteed-issue and community-rating but doing without the prohibition on coverage limits. For this Court to choose *which* of the Act’s insurance regulations to strike, in an effort to offset the effects of invalidating the mandate, would amount to nothing less than unauthorized “blue pencil[ing]” of the Act, *FEF*, 130 S. Ct. at 3162.

III. WITHOUT THE MANDATE AND INSURANCE REGULATIONS AT ITS HEART, THE ACT WOULD NOT OPERATE AS CONGRESS INTENDED

It is one thing to strike, from a major law, a minor or ancillary provision only tangentially related to its overarching purposes. But it is another thing entirely to displace a primary pillar of the legislative structure. When legislation is constructed around certain foundational provisions, striking them will almost inevitably topple the edifice as a whole.

The Act's pillars are the insurance regulations and the individual mandate. Indeed, the Act's full name is the *Patient Protection and Affordable Care Act*. By forcing insurance companies to forever extend equally priced coverage to all comers, the Act "protects patients" from market practices thought to be discriminatory. By forcing unwilling Americans to purchase insurance, the law subsidizes everyone else's premiums, ensuring "affordable care." These provisions are the heart of the legislation, and the foundation of the statute. None of the Act's other provisions can survive their excision; Congress would hardly have reached the same destination had it proceeded from an entirely different starting point.

Moreover, without the mandate and insurance regulations, the Act's other principal features would operate in dramatically different ways, shifting costs in unforeseen directions and allocating benefits and burdens inconsistent with the congressional scheme. Some of these provisions could perhaps continue to "function" without the mandate and insurance regulations, but not "in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685.

A. The Mandate And Insurance Regulations Are So Central To The Act's Principal Objectives That The Entire Act Must Be Invalidated

1. In determining whether partial invalidation would produce “legislation that Congress would not have enacted,” *Alaska Airlines*, 480 U.S. at 685, courts consider “the nature” of the stricken provision; its role “in the original legislative bargain,” *id.*; and the “historical context” of the legislation, *FEF*, 130 S. Ct. at 3162. These considerations establish a basic divide between run-of-the-mill provisions and legislative centerpieces. A statutory provision will likely be severable if it played only a minor role in the legislative debate; or if its effects are relatively small in the grand scheme; or if it simply added an additional frill to an otherwise-coherent regime. Conversely, if a provision was especially contentious; or if it constituted a core element of the legislation; or if it was a principal means of securing the law’s objects, severing it would likely be improper.

The caselaw bears out this distinction. For example, in *Alaska Airlines*, the record showed that Congress had “paid scant attention” to the unconstitutional provision of the statute at issue, while it had regarded another provision as “an important feature.” 480 U.S. at 691. During floor debate, “neither supporters nor opponents of the bill ever mentioned” the unconstitutional provision; it was, in fact, mentioned but once “during the entire deliberation on the Act”—and even then, only in general terms. *Id.* at 691-96. Faced with this history, the Court could not conclude that Congress “would have failed to enact” the law “if the [invalid provision] had not been included.” *Id.* at 697.

Similarly, in *Reagan v. Farmers' Loan & Trust Co.*, 154 U.S. 362 (1894), the invalidation of a provision giving conclusive effect to railroad rates set by an agency did not require striking the entire statute, which created the agency and gave it regulatory authority. Rather, “creation of a commission, with power to establish rules for the operation of railroads and to regulate rates, was the *prime object* of the legislation,” and that object could be “*fully accomplished*” regardless of “whether the rates shall be conclusive or simply *prima facie* evidence.” *Id.* at 395-96 (emphases added); *see also United States v. Jackson*, 390 U.S. 570, 586-91 (1968) (invalidating death-penalty provision but severing it from criminal prohibition, as “elimination [of death penalty] in no way alters the substantive reach of the statute and leaves completely unchanged its basic operation”).

By contrast, in *Mille Lacs Band*, the Court considered an executive order that (i) directed certain Indians to remove from territories they had ceded to the United States; and (ii) stripped those Indians of their treaty rights to hunt and fish on those lands. 526 U.S. at 179. After invalidating the former aspect of the order, the Court held it was not severable from the latter. Applying the “severability standard for statutes,” the Court concluded that the order had “to stand or fall as a whole,” because it “embodied a single, coherent policy,” and removal of the Indians from the lands was its “predominant purpose.” *Id.* at 191. Although the other portion of the order admittedly “perform[ed] an integral function in this policy,” it could not survive on its own after the primary function of the executive order had been so undermined. *Id.* at 192.

The severability principles applied in *Mille Lacs Band* have been settled for decades. For example, in *Alton*, the invalidation of central features of a compulsory pension scheme required the entire statute to be scrapped, because the unconstitutional provisions “so affect[ed] the dominant aim of the whole statute as to carry it down with them.” 295 U.S. at 361-62. Likewise, in *Williams*, this Court invalidated the substantive provisions of price-fixing legislation, 278 U.S. at 239-41, and then held that the law’s other provisions could not stand alone because they were “mere appendants in aid of the [statute’s] main purpose” or “mere aids to their effective execution.” *Id.* at 243-44. Although the new agency designated to fix prices could, in theory, still collect data, issue permits, and collect fees, it would have been “unreasonable to suppose” that the legislature would have wanted these mechanisms to keep operating once the most basic function of the law had been disabled. *Id.* at 244.

These cases make clear that severance is improper when the stricken provision is the heart of the legislative scheme—the principal effort toward its predominant purpose. In that context, it cannot fairly be surmised that Congress would have pushed ahead unperturbed, making no changes to the bill once its hallmark was stripped out. In such cases, the residue simply could not function in the manner that Congress intended. And it is not enough that Congress might have enacted “*some* form” of legislation without the invalid provision; severance is permissible only if Congress would have enacted “the same [provisions] currently found in the Act.” *Alaska Airlines*, 480 U.S. at 685 n.7.

2. The individual mandate, together with the insurance reforms, are the heart of the ACA, as demonstrated by their crucial significance in achieving its objectives and their central role in the legislative debate. The ACA cannot survive the elimination of these critically important provisions.

The overriding goals of the Act were to reduce premiums and the number of uninsured, without raising the deficit. *Supra* at 2-6; 42 U.S.C.A. § 18091(a)(2)(F). It is no surprise, then, that both the mandate and the insurance regulations appear in the Act's first title. These were considered indispensable to meeting the Act's core objectives. To expand coverage, the insurance regulations force insurers to provide coverage to the unhealthy on terms economically *unfavorable* to insurers. To keep premiums down, the mandate forces healthy people to buy insurance on terms economically *favorable* to insurers. And Congress thereby avoided the need to use direct spending to subsidize insurance companies (as well as the concomitant need to adopt a politically unpopular tax). The insurance regulations fundamentally transform the way health insurance may be sold in this country, and the mandate is expected to force some 16 million new consumers into the insurance market. By any fair measure, these provisions are the Act's centerpiece, and embody its "predominant purposes" or "dominant aims." Accordingly, once they are invalidated, the rest of the Act must fall. This is true even if its other parts can operate independently: Hunting and fishing rights in *Mille Lacs Band*, for example, could have been stripped independent of tribal removal, but because the latter was the "predominant purpose" of the executive order, its invalidity doomed the whole.

Further confirming this point, the mandate and insurance regulations were the clear focus of the debate surrounding the Act's negotiation and enactment. The President's 2010 State of the Union address, delivered while the Act was being debated in Congress, highlighted his desire to "protect every American from the worst practices of the insurance industry"—through the insurance regulations—and to give "uninsured Americans a chance to choose an *affordable* health care plan in a competitive market"—through the mandate. *Supra* at 3. Legislators emphasized that the insurance reforms would rein in practices condemned as odious and discriminatory. *Supra* at 4. Indeed, a major voting bloc was committed to going still further—through a public option designed to entirely eliminate the "profit motive" in insurance—but settled for the insurance regulations as a necessary compromise. *See supra* at 5-6. And numerous legislators highlighted how the mandate, together with guaranteed-issue and community-rating, would decrease the number of uninsured individuals in the country. *Supra* at 4-5; 42 U.S.C.A. § 18091(a)(2)(C) (finding that mandate "will increase the number and share of Americans who are insured"). What matters is not the accuracy of these claims, but that the Act is largely premised on them.

The contrast to *Alaska Airlines*—where the invalid provision had been referenced only a single time during extensive debate, 480 U.S. at 691—could not be starker. Congress' sustained attention to the mandate and insurance reforms reflects their singular importance to the overall legislative bargain.

B. Invalidating Only The Mandate And Insurance Regulations Would Disturb The Allocation Of “Shared Responsibility” Intended By Congress

Analysis of the Act’s other notable provisions reinforces that the mandate and insurance regulations were its foundational premises. Without them, the operation of the Act’s other features would be significantly undermined. And, if an unconstitutional provision “is of such import that the other sections without it would cause results not contemplated or desired by the legislature, then the entire statute must be held inoperative.” *Connolly v. Union Sewer Pipe Co.*, 184 U.S. 540, 565 (1902).

Most obviously, elimination of the mandate and insurance regulations would displace Congress’ effort to allocate the costs of the Nation’s health insurance. President Obama argued that “[i]mproving our health care system only works if everybody does their part.” *Remarks to Congress, supra*. “Shared Responsibility for Health Care” (ACA Title I, Subtitle F) is thus the Act’s theme; Congress sought to distribute the costs of near-universal coverage across individuals, employers, insurers, participants in the healthcare industry, States, and the Federal Government itself. As explained below, without the mandate and insurance regulations, individuals and insurers will be freed of the major burdens that the Act imposed on them—and other stakeholders will, to a degree not intended, be left to pick up the slack.

Pollock is instructive as to the implications of those redistributive impacts. In that case, this Court invalidated a general income tax as applied to income from real or personal property. 158 U.S. at

637. Then, it held that the tax could not survive subject to those exclusions, because revenues from property “formed a vital part of the scheme,” and striking it “would leave the burden of the tax to be borne by professions, trades, employments, or vocations.” *Id.* at 636-37. Eliminating the invalid provisions thus would shift tax burdens “in a direction which could not have been contemplated.” *Id.* at 637. “[W]hat was intended as a tax on capital would remain in substance a tax on occupations and labor,” and the scheme, “considered as a whole,” was not intended to function as such. *Id.*

Here, striking only the mandate and insurance regulations would similarly disturb the allocation of costs and shared responsibility under the Act.

1. Title I of the Act includes not only the mandate and insurance regulations, but also subsidies to help individuals with lower incomes to buy insurance. The subsidies grant refundable tax credits tied to the lesser of (i) the premiums paid by those individuals, or (ii) the community-rated cost of the second-cheapest “silver” plan for the individual’s geographic “rating area.” *Supra* at 19-20.

If, per the Eleventh Circuit, this Court were to sever only the mandate, the anticipated cost to the Government would skyrocket. As explained above, in that circumstance, premiums in the individual market would rise by some 30%. *Supra* at 11. And, because the subsidies are calculated based on actual premium costs, the Government would be on the hook for these costs. Congress intended for the Government to subsidize premiums, but on the assumption that they would be relatively low, given the mandate’s subsidy.

Even if the insurance regulations are properly invalidated along with the mandate, the subsidies would not operate as intended. The subsidy amounts are effectively capped by the community-rated premiums for the applicable geographic “rating area,” *see* 26 U.S.C.A. § 36B(b)(3)(C); 42 U.S.C.A. § 300gg(a)(2), which of course exist only by virtue of the insurance regulations. And if that now-inoperative cap were simply set aside, and the subsidies calculated by reference only to actual premiums paid, the effects would be unacceptable: Absent the insurance regulations, insurers would return to the individualized pricing that Congress found discriminatory, with higher premiums for the elderly and those with pre-existing conditions. Yet the Government, paying subsidies tied to actual premiums, would simply be footing the bill for *private insurers* to charge these *unrestricted* prices. Rather than *ban* the insurer practices that Congress condemned, the Act would actually *pay for them* with federal money. The Congress that enacted the ACA could not possibly have intended that result.

Nor would Congress have been willing to pay the whole bill for universal coverage. Congress required healthy people, through the mandate, to provide an annual \$30 billion subsidy to defray premiums for the sick—Congress simply could not afford, and never intended, for the Government to pay the entire amount. Moreover, if the Federal Government really wanted to shoulder the entire cost of healthcare for Americans who cannot afford it, it would likely have done so through a public program like Medicaid—not by simply accepting, and paying, “discriminatory” prices charged by private insurance companies.

2. A cousin to the individual mandate, the employer “responsibility” assessment, encourages certain employers to sponsor health plans for their employees. Specifically, it imposes an exaction on covered employers if one of their employees obtains a federal subsidy to help pay for insurance purchased elsewhere. *Supra* at 21.

This assessment—labeled “shared responsibility for employers regarding health coverage,” 26 U.S.C.A. § 4980H—was one plank of a multi-part effort to spread health-care costs across *multiple* actors. For that reason alone, it cannot stand once individuals, insurers, and the Federal Government are all let off the hook. *Pollock*, 158 U.S. at 636-37.

Further, the exaction is inextricably intertwined with the subsidies described above. Indeed, if those subsidies are invalidated, no employee will ever receive one—and so the employer exaction will never be triggered. The employer exaction is thus simply “incapable of functioning independently” of the subsidies. *Alaska Airlines*, 480 U.S. at 684.

3. The Act also creates new health-insurance “exchanges,” marketplaces where individuals and small businesses can buy the Act’s new insurance products. The Federal Government only subsidizes coverage purchased within an exchange, thus giving insurance companies a reason to sell there despite the distinct regulatory burdens imposed on plans offered through the exchanges. *Supra* at 19-20.

The exchanges cannot be severed from the provisions already addressed. Without the subsidies driving demand within the exchanges, insurance companies would have absolutely no reason to offer their products through exchanges, where they are

subject to far greater restrictions. Premised on the mandate, the insurance regulations, and the subsidies, the insurance exchanges cannot operate as intended by Congress absent those provisions.

4. Another part of the Act requires that States substantially relax the eligibility criteria for Medicaid. *Supra* at 21-22. But, as the Government explained below, Congress intended for the additional Medicaid spending required of the States to be “offset” by other “cost-saving provisions.” RE 1024. For example, Congress believed the insurance regulations would prevent individuals with pre-existing conditions from being driven onto Medicaid rolls, or into state-funded high-risk pools, by the uninsurable cost of their care. *See* RE 1023; 42 U.S.C.A. § 18091(a)(2)(G) (finding that “62 percent of all personal bankruptcies are caused in part by medical expenses”). Congress further believed the States would also, in light of the mandate and premium subsidies, save money on uncompensated care. *See* RE 1023. If the States need no longer worry about picking up the tab for uninsurable sick people (because private insurers will now be forced to), or for cost-shifting by the uninsured (because the mandate will force them to buy insurance), then they can devote more resources to the poor. Absent the mandate, insurance regulations, and subsidies, this premise would no longer be true, and the States would be forced to bear additional costs far greater than those intended by Congress.²⁹

²⁹ Of course, if the Medicaid expansion is independently unconstitutional, as the State Petitioners contend, then the severability analysis must take their invalidity as a given.

5. Another major component of the Act is a set of new taxes, most of which are found in Subtitle A of Title IX (“Revenue Offset Provisions”), and a set of spending cuts to public programs like Medicare.

Many of these affect insurance companies and healthcare providers but, like the insurance regulations, were offset by the substantial benefits conferred by the mandate. *Supra* at 22. Without the mandate’s subsidy, these taxes and cuts would saddle insurance companies and providers with far greater net burdens than did the original legislative bargain. *See Pollock*, 158 U.S. at 636-37.

Moreover, these provisions satisfied (as the heading of the revenue Subtitle indicates) the Act’s overriding political constraint—that it not add to the federal deficit. *Supra* at 6. Given the new *liabilities* adopted by the Government—notably, the subsidies for low-income Americans—Congress had to include new *revenues* to “offset” them. The Act’s revenue-raising and spending cuts were thus premised on the funds being used to expand coverage and hold down the cost of health insurance.

But, as shown, the subsidies cannot survive without the mandate and insurance regulations. And there is no reason to think that Congress would have imposed this hodge-podge of taxes and cuts for its own sake, without furthering the twin goals of the Act. Accordingly, these “offset” provisions, too, must fall. *Williams*, 278 U.S. at 244 (holding “taxes” that were enacted to “defra[y] the expenses” of an invalid provision to be non-severable). Nor could this Court restore budget neutrality by “blue pencil[ing]” the Act, *FEF*, 130 S. Ct. at 3162, in determining which of the new taxes to strike. *Randall*, 548 U.S. at 262.

* * *

In sum, Congress designed the Act to spread the costs of expanded insurance coverage among individuals (the mandate), insurers (the insurance regulations), employers (the “responsibility” assessment), the Federal Government (the premium subsidies), the States (the Medicaid expansion), and other actors (the “offset” taxes and spending cuts). Eliminating the mandate and insurance reforms would have major ripple effects, twisting Congress’ reticulated scheme of “shared responsibility” beyond repair. Accordingly, the Act must be invalidated *in toto*.

C. Retaining Only The Act’s Miscellaneous Tag-Along Provisions Would Fundamentally Change The Statute That Congress Enacted

To be sure, the discussion above does not address *every* provision of the 2700-page Act. As the Eleventh Circuit observed, within the law’s countless provisions can be identified various obscure measures that appear independent of its major planks. The Act, for example, requires employers to provide “reasonable break time for nursing mothers” and restores “funding for abstinence education.” Pet.App. 174a-175a. For three reasons, however, the existence of these peripheral provisions does not affect the conclusion of wholesale non-severability.

First, the mandate cannot be severed from the Act’s *major* components. As explained above, a law’s central pillars cannot be removed without toppling the statute as a whole, and the mandate and insurance regulations together plainly qualify as such pillars. *Supra* Part III.A. *A fortiori*, so too does the combination of the mandate, insurance

regulations, subsidies, health exchanges, employer assessment, Medicaid expansion, and taxes. Once all of these are stricken, what is left would bear no resemblance to the statute Congress enacted.

Whereas severability analysis normally removes a small discrete part to preserve a larger coherent whole, the issue here is removing a large coherent whole to preserve small discrete parts. We are aware of no precedent that has allowed severance in remotely similar circumstances. And for good reason: It is inconceivable that Congress, trying to adopt a comprehensive solution to a perceived crisis, would “have been satisfied” with the menagerie of tag-along provisions that remain after a statute’s pillars are removed. *Williams*, 278 U.S. at 242.

Second, if the severability analysis really must proceed provision-by-provision, courts would be faced with the impractical, unrealistic task of proceeding through the Act’s “hundreds of new laws about hundreds of different areas of health insurance and health care,” Pet.App. 21a, and evaluating each provision’s relationship to the others and to the whole. There are simply too many provisions to engage in such granular inquiries, particularly because the severance of each provision could alter the calculus and call into question earlier decisions about other provisions. Once numerous, substantial pieces of the legislation cannot operate as intended, this Court should invalidate the whole statute.

Third, even if it were somehow practical to consider every provision on its own, the difficulty of analysis required would be far beyond the judicial ken. In an act this complex and interrelated, courts cannot confidently deem individual provisions to be

operationally independent. Once a number of major provisions are stricken, the only responsible course for a court—“mindful that [its] constitutional mandate and institutional competence are limited,” *Ayotte*, 546 U.S. at 329—is to declare the entire Act non-severable, and let Congress handle rebuilding.

IV. THE ACT WOULD NOT, AND COULD NOT, HAVE BEEN ENACTED WITHOUT THE MANDATE AND INSURANCE REGULATIONS

Another way of framing the severability inquiry is to ask whether the valid portions would have been enacted independently of the invalid ones. *FEF*, 130 S. Ct. at 3161. Here, even apart from the centrality of the mandate and insurance regulations to the functioning of the whole, the unusual legislative proceedings further confirm that, absent those provisions, the Act would not have been enacted in anything even resembling its current form. The Act emerged only after extended, hard-fought, legislative negotiation. Every vote was crucial to its passage, and the vote-trading and log-rolling that developed as a result make this “sweeping and comprehensive Act” (Pet.App. 4a) an unusually unstable grand bargain. Moreover, the shift in the composition of the Senate that preceded the Act’s final passage made it *certain* that the bill *could not* have passed without the mandate.

A. The Act Was A Grand Bargain, With Nearly Every Provision Crucial To Its Success

In an oft-cited analysis, Chief Justice Shaw of the Supreme Judicial Court of Massachusetts reasoned that, while “the same act of legislation may be unconstitutional in some of its provisions, and yet constitutional in others,” the proposition “must be

taken with this limitation”: If the parts “are so mutually connected with and dependent on each other, as *conditions, considerations or compensations* for each other,” then the statute must fall as a whole. *Warren v. Charlestown*, 68 Mass. 84, 98-99 (1854) (emphasis added). This Court long ago adopted that test, directing courts to inquire whether, if “while the bill was pending in Congress a motion to strike out the [invalid] provisions had prevailed,” Congress would still have enacted the bill. *Carter*, 298 U.S. at 313, 316; *see also Alaska Airlines*, 480 U.S. at 685 (considering role of invalid provision in “original legislative bargain”). Here, the nature of the debate that produced the bill, and the indications from its drafting history, confirm that the answer is “no.”

1. The Act ultimately passed, in both the House and the Senate, by the closest of margins. In the Senate, every affirmative vote was necessary for passage, making every Senator in the majority a swing vote. And the uncertain outcome of the votes shaped negotiations over the bill throughout the legislative process. Dispositive blocs of votes demanded a wide-ranging set of provisions—from the Act’s treatment of abortion to its exclusion of the so-called “public” option. Yet other votes were extended in exchange for particular, parochial benefits, such as a Medicaid subsidy for Louisiana; a pilot program for a group of people exposed to asbestos in Montana; and grants to particular, but unnamed, hospitals and universities in other states. *See supra* at 23-25.

This historical context provides strong additional evidence that, if “while the bill was pending in Congress a motion to strike out the [mandate and insurance reforms] had prevailed,” *Carter*, 298 U.S.

at 313, the delicate compromises embodied in the Act would have blown up, and there is little chance that Congress would nonetheless have proceeded, unfazed, to enact the remainder of the law.

Separation-of-powers concerns about the judicial displacement of legislative bargains are especially grave in this context. Granted, every statute represents some compromise, but this Act's inherent "conditions, considerations [and] compensations," *Warren*, 68 Mass. at 98-99, are unusually complex and were unusually important to its passage. As the Senate Majority Leader acknowledged, there are more *quid pro quos* in this Act than anyone even knows. *See supra* at 25. For this Court to slice up the legislation in unforeseen, un contemplated ways—invalidating *quids* and retaining *quos*, likely without even realizing it—would raise profound separation-of-powers concerns regarding the judicial creation of a statute so substantially different, politically as well as operationally, from the one that Congress enacted.

2. Textual confirmation that Congress intended the Act to operate as a package deal can be found in its drafting history—namely, *removal* of an express severability clause. If a law simply *omits* such a clause, its silence "does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686. But here, Congress *removed* a severability clause that *had* been included in an earlier iteration of the bill. H.R. 3962, § 255 (Oct. 29, 2009). While not dispositive, this fact "does suggest that Congress intended to have the various components of the [legislative] package operate together or not at all." *Gubiensio-Ortiz*, 857 F.2d at 1267.

The Eleventh Circuit entirely discounted this drafting history, pointing out that “both the Senate and House legislative drafting manuals state that ... severability clauses are unnecessary.” Pet.App. 175a. That may have explained a failure to include a severability clause *at all*, but it hardly explains why Congress went to the effort of *deleting* a clause it had earlier found important enough to include. And, despite the drafting manuals, the very same Congress included—in its other showcase piece of complex legislation, enacted just weeks after the Act—an apparently “unnecessary” severability clause. *See* Dodd-Frank Wall Street Reform and Consumer Protection Act, § 3, Pub. L. No. 111-203 (2010). That fundamental difference between these two landmark statutes is highly probative of congressional intent.

B. Under Congress’ Procedural Rules, The Act Could Not Have Been Enacted Without the Individual Mandate

In many cases, determining whether Congress would have enacted the legislation absent its invalid provision may be an “elusive” inquiry. *Chadha*, 462 U.S. at 932. Not so here. The unique procedures by which the Act was passed, following an unexpected change in the political composition of the Senate, provides the plainest evidence imaginable that this bill not only *would not*, but *could not* have been enacted without the mandate.

On December 24, 2009, the Senate passed a health-insurance reform bill with exactly the sixty votes needed to overcome a filibuster the day prior. *Supra* at 8. But when Senator Scott Brown, a staunch opponent of the legislative efforts, was

elected soon thereafter, the balance of power shifted, and the Act's proponents could no longer retain its fundamental structure and yet avoid a filibuster. *Supra* at 9. Accordingly, the House of Representatives had no choice but to pass the bill in the *exact* form in which it had already passed the Senate, since a *different* bill emerging from a bicameral conference committee, reconciling the two houses' versions, could not then pass in the Senate. To satisfy the Constitution's requirement that a bill pass both houses in the same form, the House was bound (if it wanted *any* bill remotely resembling the pending one) to pass the Senate's version—which included the mandate and insurance regulations. *Id.*

Thus, the *only* way for Congress to make changes to the bill as passed by the Senate was through the budget reconciliation process, but that process allowed only for *budgetary* provisions. *Id.* Congress therefore was precluded from making any *non-budgetary* amendments to the version of the Act passed by the Senate. In other words, the large parts of the Act that did not affect the budget—*i.e.*, everything aside from the Act's taxes, subsidies, and changes to public programs like Medicare—were unalterable, and thus *essential* to the Act's successful enactment. The point is further confirmed by the rule that the House adopted to govern its consideration of the Senate bill: It allowed for no amendments, requiring instead an all-or-nothing vote on the entire package. *See supra* at 9-10.

This history confirms that the Act, without the mandate or insurance regulations, could not have been enacted. The latter have no direct budgetary impact, and so any attempt to amend them out of the

Act through reconciliation would have failed. The whole statute is thus procedurally—not just operationally—intertwined with the mandate and insurance regulations. It therefore would be doubly inappropriate for this Court to substitute for the Act a law that Congress would not, and could not, have enacted.

CONCLUSION

This Court should hold that the ACA is entirely non-severable from the individual mandate and reverse in relevant part the judgment below.

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**TITLE I—QUALITY, AFFORDABLE HEALTH
CARE FOR ALL AMERICANS**

**Subtitle A—Immediate Improvements in Health
Care Coverage for All Americans**

**SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH
SERVICE ACT.**

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

**“PART A—INDIVIDUAL AND GROUP
MARKET REFORMS”;**

(2) by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) by inserting after section 2702, the following:

“Subpart II—Improving Coverage

“SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

“(a) PROHIBITION.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

“(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

“(B) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

“(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term ‘restricted annual limit’ for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

“(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.

“SEC. 2712. PROHIBITION ON RESCISSIONS.

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be

cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

“SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

“(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force;

“(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

“(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

“(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

“(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be

considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

“(b) Interval.—

“(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

“(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

“(c) Value-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

“SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

“(b) REGULATIONS.—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

“(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the definition of ‘dependent’ as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

“SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

“(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholder or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

“(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

“(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

“(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

“(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes—

“(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

“(B) a description of the coverage, including cost sharing for—

“(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

“(ii) other benefits, as identified by the Secretary;

“(C) the exceptions, reductions, and limitations on coverage;

“(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

“(E) the renewability and continuation of coverage provisions;

“(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

“(G) a statement of whether the plan or coverage—

“(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

“(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

“(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

“(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

“(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

“(d) REQUIREMENT TO PROVIDE.—

“(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits

and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

“(A) an applicant at the time of application;

“(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

“(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

“(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

“(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

“(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

“(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

“(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60

days prior to the date on which such modification will become effective.

“(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

“(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

“(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

“(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

“(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

“(3) **MEDICAL TERMS.**—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

“SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

“(a) **IN GENERAL.**— A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

“(b) **RULES AND DEFINITIONS.**—For purposes of this section—

“(1) **CERTAIN RULES TO APPLY.**—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

“(2) **HIGHLY COMPENSATED INDIVIDUAL.**—The term ‘highly compensated individual’ has the meaning given such term by section 105(h)(5) of such Code.

“SEC. 2717. ENSURING THE QUALITY OF CARE.

“(a) **QUALITY REPORTING.**—

“(1) **IN GENERAL.**—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and

stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

“(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

“(B) implement 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) implement 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; and

“(D) implement wellness and health promotion activities.

“(2) REPORTING REQUIREMENTS.—

“(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to

enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

“(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

“(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

“(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

“(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

“(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program’s participants, and which may include the following wellness and prevention efforts:

“(1) Smoking cessation.

“(2) Weight management.

“(3) Stress management.

“(4) Physical fitness.

“(5) Nutrition.

“(6) Heart disease prevention.

“(7) Healthy lifestyle support.

“(8) Diabetes prevention.

“(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—

“(1) WELLNESS AND PREVENTION PROGRAMS.— A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

“(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

“(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

“(2) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

“(A) the lawful ownership or possession of a firearm or ammunition;

“(B) the lawful use of a firearm or ammunition; or

“(C) the lawful storage of a firearm or ammunition.

“(3) LIMITATION ON DATABASES OR DATA BANKS.— None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be

construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

“(A) the lawful ownership or possession of a firearm or ammunition; or

“(B) the lawful use or storage of a firearm or ammunition.

(5) LIMITATION ON DATA COLLECTION REQUIREMENT FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

“(A) the lawful ownership or possession of a firearm or ammunition; or

“(B) the lawful use, possession, or storage of a firearm or ammunition.

“(d) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

“(e) **STUDY AND REPORT.**—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

“(a) **CLEAR ACCOUNTING FOR COSTS.**—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

“(1) on reimbursement for clinical services provided to enrollees under such coverage;

“(2) for activities that improve health care quality; and

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

“(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

“(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if that ratio of the amount that is equal to the amount by which premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

“(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

“(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of 80 percent may

destabilize the individual market in such State.

“(B) REBATE AMOUNT.—

“(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

“(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

“(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

“(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

“(2) CONSIDERATION IN SETTING PERCENTAGES.— In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

“(3) ENFORCEMENT.—The provisions Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

“(c) DEFINITIONS.— Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

“(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

“(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

“SEC. 2719. APPEALS PROCESS.

“(a) INTERNAL CLAIMS APPEALS.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals

of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

“(A) have in effect an internal claims appeal process;

“(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

“(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

“(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

“(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

“(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures

set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

“(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

“(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

“(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

“(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

“(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

“(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

“SEC. 2719A PATIENT PROTECTIONS.

“(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

“(b) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.— If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

“(A) without the need for any prior authorization determination;

“(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

“(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

“(i) by a nonparticipating health care provider with or without prior authorization; or

“(ii)(I) such 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;

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

“(2) DEFINITIONS.—In this subsection:

“(A) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(B) EMERGENCY SERVICES.—The term ‘emergency services’ means, with respect to an emergency medical condition—

“(i) a medical screening examination (as required under section 1867 of the Social

Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

“(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

“(C) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

“(c) ACCESS TO PEDIATRIC CARE.—

“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

“(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

“(1) GENERAL RIGHTS.—

“(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

“(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage,

described in this paragraph is a group health plan or coverage that—

“(A) provides coverage for obstetric or gynecologic care; and

“(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

“(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

“(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

“(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.”.

SEC. 1003 ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

“SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

“(a) INITIAL PREMIUM REVIEW PROCESS.—

“(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

“(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

“(b) CONTINUING PREMIUM REVIEW PROCESS.—

“(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

“(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

“(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

“(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

“(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

“(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

“(c) GRANTS IN SUPPORT OF PROCESS.—

“(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—

The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

“(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage;

“(B) in providing information and recommendations to the Secretary under subsection (b)(1); and

“(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.

“(2) FUNDING.—

“(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary \$250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

“(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

“(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

“(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

“(ii) no State qualifying for a grant under paragraph (1) shall receive less than \$1,000,000, or more than \$5,000,000 for a grant year.”

“(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

“(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

“(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

“(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

“(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

“(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

“(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

“(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such bylaws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care

services based on the center's analysis of health care costs.

“(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.”.

**Subtitle C—Quality Health Insurance Coverage for
All Americans**

**PART 1—HEALTH INSURANCE MARKET
REFORMS**

**SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH
SERVICE ACT.**

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

“Subpart I—General Reform”;

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

**“SEC. 2704. PROHIBITION OF PREEXISTING CONDITION
EXCLUSIONS OR OTHER DISCRIMINATION BASED ON
HEALTH STATUS.**

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg–1)—

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)—

(I) by striking “health insurance issuer offering health insurance coverage in connection with a group health plan” each place that such appears and inserting “health

insurance issuer offering group or individual health insurance coverage”; and

(II) in paragraph (2)(A)—

(aa) by inserting “or individual” after “employer”; and

(bb) by inserting “or individual health coverage, as the case may be” before the semicolon; and

(iii) in subsection (e)—

(I) by striking “(a)(1)(F)” and inserting “(a)(6)”;

(II) by striking “2701” and inserting “2704”;

and
(III) by striking “2721(a)” and inserting “2735(a)”;

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

“SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

“(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

“(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

“(A) such rate shall vary with respect to the particular plan or coverage involved only by—

“(i) whether such plan or coverage covers an individual or family;

“(ii) rating area, as established in accordance with paragraph (2);

“(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

“(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

“(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

“(2) RATING AREA.—

“(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

“(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

“(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

“(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

“(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

“SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

“(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

“(b) ENROLLMENT.—

“(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

“(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

“(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

“SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

“(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

“SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

“(1) Health status.

“(2) Medical condition (including both physical and mental illnesses).

“(3) Claims experience.

“(4) Receipt of health care.

“(5) Medical history.

“(6) Genetic information.

“(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(8) Disability.

“(9) Any other health status-related factor determined appropriate by the Secretary.

“(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

“(1) GENERAL PROVISIONS.—

“(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

“(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

“(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

“(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does

not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

“(A) A program that reimburses all or part of the cost for memberships in a fitness center.

“(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

“(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

“(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

“(E) A program that provides a reward to individuals for attending a periodic health education seminar.

“(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

“(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

“(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease

in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

“(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

“(D) The full reward under the wellness program shall be made available to all similarly situated individuals.

For such purpose, among other things:

“(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

“(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

“(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

“(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual’s physician, that a health status factor makes it unreasonably difficult or medically inadvisable

for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

“(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

“(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

“(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

“(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

“(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand

such demonstration project to include additional participating States.

“(3) REQUIREMENTS.—

“(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State’s project is designed in a manner that—

“(i) will not result in any decrease in coverage; and

“(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

“(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

“(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

“(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

“(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

“(I) do not create undue burdens for individuals insured in the individual market;

“(II) do not lead to cost shifting; and

“(III) are not a subterfuge for discrimination;

“(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

“(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

“(m) REPORT.—

“(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

“(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

“(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

“(C) the impact of premium-based and cost-sharing incentives on participant behavior and

the role of such programs in changing behavior;
and

“(D) the effectiveness of different types of rewards.

“(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

“(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

“SEC. 2706. 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 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance

issuer offering group or individual health insurance coverage.

“SEC. 2707. 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 1302(a) of the Patient Protection and Affordable Care Act.

“(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 1302(c).

“(c) **CHILD-ONLY PLANS.**—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, 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 1302(d)(2)(B)(ii)(I).

“SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

“A group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.’

“SEC. 2709 COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

“(a) **COVERAGE.**—

“(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

“(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

“(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

“(C) may not discriminate against the individual on the basis of the individual’s participation in such trial.

“(2) ROUTINE PATIENT COSTS.—

“(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

“(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

“(i) the investigational item, device, or service,
itself;

“(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

“(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

“(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

“(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ‘qualified individual’ means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

“(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

“(2) Either—

“(A) the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

“(B) the participant or beneficiary provides medical and scientific information establishing

that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

“(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

“(d) APPROVED CLINICAL TRIAL DEFINED.—

“(1) IN GENERAL.—In this section, the term ‘approved clinical trial’ means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

“(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

“(i) The National Institutes of Health.

“(ii) The Centers for Disease Control and Prevention.

“(iii) The Agency for Health Care Research and Quality.

“(iv) The Centers for Medicare & Medicaid Services.

“(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or

the Department of Defense or the Department of Veterans Affairs.

“(vi) A qualified non-governmental research entity

identified in the guidelines issued by the National Institutes of Health for center support grants.

“(vii) Any of the following if the conditions described in paragraph (2) are met:

“(I) The Department of Veterans Affairs.

“(II) The Department of Defense.

“(III) The Department of Energy.

“(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

“(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

“(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

“(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

“(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

“(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term ‘life-threatening condition’ means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan’s or issuer’s coverage with respect to clinical trials.

“(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

“(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.”.

**Subtitle D—Available Coverage Choices for All
Americans
PART 1—ESTABLISHMENT OF QUALIFIED
HEALTH PLANS**

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) **QUALIFIED HEALTH PLAN.**—In this title:

(1) **IN GENERAL.**—The term “qualified health plan” means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and

such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term “health plan” means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple

employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) **ESSENTIAL HEALTH BENEFITS PACKAGE.**—In this title, 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 1311(b)(2)(B)(ii) (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 title 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 2713 of the Public Health Service Act.

(3) COST-SHARING.—In this title—

(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 title, 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 title, 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 2713); 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 title 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 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) 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

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under section 1902(bb) of such Act (42 U.S.C.
1396a(bb)) for such item or service.

**Subtitle E—Affordable Coverage Choices for All
Americans**

**PART I—PREMIUM TAX CREDITS AND COST-
SHARING REDUCTIONS**

**Subpart A—Premium Tax Credits and Cost-sharing
Reductions**

**SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING
PREMIUM ASSISTANCE FOR COVERAGE UNDER A
QUALIFIED HEALTH PLAN.**

(a) **IN GENERAL.**—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

**“SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE
UNDER A QUALIFIED HEALTH PLAN.**

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

“(b) **PREMIUM ASSISTANCE CREDIT AMOUNT.**—For purposes of this section—

“(1) **IN GENERAL.**—The term ‘premium assistance credit amount’ means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

“(2) **PREMIUM ASSISTANCE AMOUNT.**—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

“(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover

the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

“(B) the excess (if any) of—

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

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

“(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

“(A) APPLICABLE PERCENTAGE.—

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

“In the case of The initial The final
household income premium premium
(expressed as a percentage is— percentage
percent of poverty is—
line) with the
following income tier

| | | |
|-----------------|-------|-------|
| Up to 133% | 2.0% | 2.0% |
| 133% up to 150% | 3.0% | 4.0% |
| 150% up to 200% | 4.0% | 6.3% |
| 200% up to 250% | 6.3% | 8.05% |
| 250% up to 300% | 8.05% | 9.5% |
| 300% up to 400% | 9.5% | 9.5% |

“(ii) INDEXING.—

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

“(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

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

“(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

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

“(ii) provides—

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

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

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

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

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

“(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

“(D) ADDITIONAL BENEFITS.—If—

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

“(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover

benefits in addition to the essential health benefits required to be provided by the plan, the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

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

“(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

“(1) APPLICABLE TAXPAYER.—

“(A) IN GENERAL.—The term ‘applicable taxpayer’ means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

“(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS
LAWFULLY PRESENT IN THE UNITED STATES.—If—

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

“(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status, the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

“(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer’s spouse file a joint return for the taxable year.

“(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(2) COVERAGE MONTH.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘coverage month’ means, with respect to an applicable taxpayer, any month if—

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

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

“(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

“(i) IN GENERAL.—The term ‘coverage month’ shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

“(ii) MINIMUM ESSENTIAL COVERAGE.—The term ‘minimum essential coverage’ has the meaning given such term by section 5000A(f).

“(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

“(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

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

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

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

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

“(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

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

(D) EXCEPTIONS FOR INDIVIDUALS RECEIVING FREE CHOICE VOUCHERS.—The term ‘coverage month’ shall not include any month in which such individual has a free choice voucher

provided under section 10108 of the Patient Protection and Affordable Care Act.

“(3) DEFINITIONS AND OTHER RULES.—

“(A) QUALIFIED HEALTH PLAN.—The term ‘qualified health plan’ has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

“(B) GRANDFATHERED HEALTH PLAN.—The term ‘grandfathered health plan’ has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

“(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

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

“(2) HOUSEHOLD INCOME.—

“(A) HOUSEHOLD INCOME.—The term ‘household income’ means, with respect to any taxpayer, an amount equal to the sum of—

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

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

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

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

“(B) MODIFIED ADJUSTED GROSS INCOME.—The term ‘modified adjusted gross income’ means adjusted gross income increased by—

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

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

“(3) POVERTY LINE.—

“(A) IN GENERAL.—The term ‘poverty line’ has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

“(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

“(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

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

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

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

“(i) A method under which—

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

“(II) the taxpayer’s household income is equal to the product of the taxpayer’s household income (determined without regard to this subsection) and a fraction—

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

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

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

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

“(3) **SECRETARIAL AUTHORITY.**—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size

and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

“(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

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

“(2) EXCESS ADVANCE PAYMENTS.—

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

“(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

“(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed \$400 (\$250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

“(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

“(I) such dollar amount, multiplied by

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

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

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

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

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

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

“(E) Any information provided to the Exchange, including any change of

circumstances, necessary to determine eligibility for, and the amount of, such credit.

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

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.

“(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

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

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

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.”.

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on

the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term “appropriate committees of Congress” means the Committee on Ways and

Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting “36B,” after “36A,”.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

“Sec. 36B. Refundable credit for coverage under a qualified health plan.”.

(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting “36B,” after “36A,”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

**Subtitle F—Shared Responsibility for Health Care
PART I—INDIVIDUAL RESPONSIBILITY**

**SEC. 1501. 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.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

“CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

“Sec. 5000A. Requirement to maintain minimum essential coverage.

“SEC. 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 taxpayers 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 \$750.

“(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$325 for 2015.

“(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

“(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

“(i) \$695, multiplied by

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

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

“(4) TERMS RELATING TO INCOME AND FAMILIES.—
For purposes of this section—

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

“(B) HOUSEHOLD INCOME.—The term ‘household income’ means, with respect to any

taxpayer for any taxable year, an amount equal to the sum of—

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

“(ii) the aggregate modified *adjusted* gross incomes of all other individuals who—

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

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

“(C) MODIFIED ADJUSTED GROSS INCOME.—The term ‘modified adjusted gross income’ means adjusted gross income increased by—

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

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

“(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

“(1) IN GENERAL.—The term ‘applicable individual’ means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

“(2) RELIGIOUS EXEMPTIONS.—

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

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

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

“(B) HEALTH CARE SHARING MINISTRY.—

“(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

“(ii) HEALTH CARE SHARING MINISTRY.—The term ‘health care sharing ministry’ means an organization—

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

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

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

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

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

“(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

“(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

“(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

“(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

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

“(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term ‘required contribution’ means—

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

through salary reduction or otherwise) for self-only coverage, or

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

“(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to 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 6102(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.

“(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) the TRICARE for Life program,

“(v) the veteran’s health care program under chapter 17 of title 38, United States Code, or

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

“(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.”.

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

“CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“SEC. 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 \$2000.

“(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 fulltime 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).

“(e) 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.”.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

“Sec. 4980H. Shared responsibility for employers regarding health coverage.”.

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS’ WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees’ wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001- EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

“SEC. 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.

“(b) EXCESS BENEFIT.—For purposes of this section—

“(1) IN GENERAL.—The term ‘excess benefit’ means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

“(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

“(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

“(B) an amount equal to 1/12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

“(3) ANNUAL LIMITATION.—For purposes of this subsection—

“(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

“(B) APPLICABLE ANNUAL LIMITATION.—

“(i) IN GENERAL.—Except as provided in clause (ii) the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

“(ii) MULTIMEMPLOYER PLAN COVERAGE.—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.

“(C) APPLICABLE DOLLAR LIMIT—Except as provided in subparagraph (D)—

“(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—

“(I) in the case of an employee with self-only coverage, \$10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage), and

“(II) in the case of an employee with coverage other than self-only coverage, \$27,500 multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage).

“(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the

health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

“(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

“(II) 55 percent.

“(iii) AGE AND GENDER ADJUSTMENT. —

“(I) IN GENERAL.— The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

“(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—

“(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual’s employer, over

“(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

“(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.— In the case of an individual who is a qualified

retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

“(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

“(II) the dollar amount in clause (i)(II) shall be increased by \$3,450.

“(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

“(I) such amount as so in effect, multiplied by

“(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for ‘1992’ in subparagraph (B) thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

“(c) LIABILITY TO PAY TAX.—

“(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

“(2) COVERAGE PROVIDER.—For purposes of this subsection, the term ‘coverage provider’ means each of the following:

“(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

“(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

“(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

“(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

“(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

“(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

“(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

“(A) IN GENERAL.—Each employer shall—

“(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable

share of such excess benefit for each coverage provider, and

“(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

“(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

“(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

“(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

“(A) IN GENERAL.—The term ‘applicable employer-sponsored coverage’ means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

“(B) EXCEPTIONS.—The term ‘applicable employer-sponsored coverage’ shall not include—

“(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care, or

“(ii) any policy under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are

for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or

“(iii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

“(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

“(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

“(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

“(2) DETERMINATION OF COST.—

“(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax

imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

“(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

“(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

“(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

“(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

“(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable

period on such basis as the Secretary may prescribe.

“3) EMPLOYEE.—The term ‘employee’ includes any former employee, surviving spouse, or other primary insured individual.

“(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

“(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

“(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

“(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

“(2) LIMITATIONS ON PENALTY.—

“(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable

diligence would have known, that such failure existed.

“(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

“(i) such failure was due to reasonable cause and not to willful neglect, and

“(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

“(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

“(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

“(1) COVERAGE DETERMINATIONS.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

“(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least

one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

“(2) QUALIFIED RETIREE.—The term ‘qualified retiree’ means any individual who—

“(A) is receiving coverage by reason of being a retiree,

“(B) has attained age 55, and

“(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

“(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term ‘employees engaged in a high-risk profession’ means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such

sentence for a period of not less than 20 years during the employee's employment.

“(4) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning given such term by section 5000(b)(1).

“(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

“(A) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

“(B) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given such term by section 9832(b)(2).

“(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term ‘person that administers the plan benefits’ shall include the plan sponsor if the plan sponsor administers benefits under the plan.

“(7) PLAN SPONSOR.—The term ‘plan sponsor’ has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

“(8) TAXABLE PERIOD.—The term ‘taxable period’ means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

“(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

“(10) DENIAL OF DEDUCTION.—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).

“(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.”.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by section 1513, is amended by adding at the end the following new item:

“Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W-2.

(a) **IN GENERAL.**—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “, and”, and by adding after paragraph (13) the following new paragraph:

“(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

“(A) coverage to which paragraphs (11) and (12) apply, or

“(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: “Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: “Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “15 percent” and inserting “20 percent”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATIONS ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

“(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

“(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

“(2) ADJUSTMENT FOR INFLATION.— In the case of any taxable year beginning after December 31, 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(A) such amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) **IN GENERAL.**—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

“(h) **APPLICATION TO CORPORATIONS.**—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term ‘person’ includes any corporation that is not an organization exempt from tax under section 501(a).

“(i) **REGULATIONS.**—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.”.

(b) **PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.**—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting “amounts in consideration for property,” after “wages,”

(2) by inserting “gross proceeds,” after “emoluments, or other”, and

(3) by inserting “gross proceeds,” after “setting forth the amount of such”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

“(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

“(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

“(A) meets the community health needs assessment requirements described in paragraph (3),

“(B) meets the financial assistance policy requirements described in paragraph (4),

“(C) meets the requirements on charges described in paragraph (5), and

“(D) meets the billing and collection requirement described in paragraph (6).

“(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

“(A) IN GENERAL.—This subsection shall apply to—

“(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

“(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or

purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

“(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

“(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

“(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

“(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

“(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

“(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

“(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

“(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

“(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

“(ii) is made widely available to the public.

“(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

“(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

“(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

“(ii) the basis for calculating amounts charged to patients,

“(iii) the method for applying for financial assistance,

“(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies, and

“(v) measures to widely publicize the policy within the community to be served by the organization.

“(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

“(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

“(A) limits amounts charged for emergency or other medically necessary care provided to

individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the amounts generally billed to individuals who have insurance covering such care, and

“(B) prohibits the use of gross charges.

“(6) BILLING AND COLLECTION REQUIREMENTS.—

An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

“(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).”.

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

“SEC. 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.”.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

“Sec. 4959. Taxes on failures by hospital organizations.”.

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary’s delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking “and” at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

“(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

“(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

“(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in

a consolidated financial statement with other organizations, such consolidated financial statement).”.

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking “and” at the end of subparagraph (B), by inserting “and” at the end of subparagraph (C), and by adding at the end the following new subparagraph:

“(D) section 4959 (relating to taxes on failures by hospital organizations),”.

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity’s branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

| | |
|--|--|
| With respect to a covered entity’s branded | The percentage of such aggregate sales taken into account prescription is: |
|--|--|

drug sales during the calendar year that are:

| | |
|--|--------------|
| Not more than \$5,000,000 | 0 percent |
| More than \$5,000,000 but not more than \$125,000,000. | 10 percent |
| More than \$125,000,000 but not more than \$225,000,000. | 40 percent |
| More than \$225,000,000 but not more than \$400,000,000. | 75 percent |
| More than \$400,000,000..... | 100 percent. |

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity’s branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(4) APPLICABLE AMOUNT.—For purposes of paragraph (1), the applicable amount shall be determined in accordance with the following table:

| Calendar year | Applicable amount |
|---------------|-------------------|
| 2011..... | \$2,500,000,000 |
| 2012..... | \$2,800,000,000 |
| 2013..... | \$2,800,000,000 |
| 2014..... | \$3,000,000,000 |
| 2015..... | \$3,000,000,000 |

| | |
|--------------------------|-----------------|
| 2016..... | \$3,000,000,000 |
| 2017..... | \$4,000,000,000 |
| 2018..... | \$4,100,000,000 |
| 2019 and thereafter..... | \$2,800,000,000 |

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(3) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (2), all such persons shall be jointly and severally liable for payment of such fee.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term “branded prescription drug sales” means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term “branded prescription drug” means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term “prescription drug” means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term “branded prescription drug sales” shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare

disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term “specified government program” means—

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

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

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

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENTS OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such

manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—The Secretary of Defense shall report, for each covered entity and for each branded

prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term “Secretary” includes the Secretary’s delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) EFFECTIVE DATE.—This section shall apply to calendar years beginning after December 31, 2010.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting “or section 9008(c) of the Patient Protection and Affordable Care Act of 2009” after “this part”.

SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

Subchapter E—Medical Devices

“Sec. 4191. Medical devices.

“SEC. 4191. MEDICAL DEVICES.

“(a) *IN GENERAL.*—*There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax equal to 2.3 percent of the price for which so sold.*

“(b) *TAXABLE MEDICAL DEVICE.*—*For purposes of this section—*

“(1) *IN GENERAL.*—*The term ‘taxable medical device’ means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.*

“(2) *EXEMPTIONS.*—*Such term shall not include— ‘*

“(A) *eyeglasses,*

“(B) *contact lenses,*

“(C) *hearing aids, and*

“(D) *any other medical device determined by the Secretary to be of a type which is generally purchased by the general public at retail for individual use.’, and*

(2) by INSERTING after the item relating to subchapter D in the table of subchapters for such chapter the following new item:

“SUBCHAPTER E. MEDICAL DEVICES”.

(b) Certain Exemptions Not to Apply.—

(1) Section 4221(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: “In the case of the tax imposed by section 4191, paragraphs (3), (4), (5), and (6) shall not apply.”.

(2) Section 6416(b)(2) of such Code is amended by adding at the end the following: “In the case of the

tax imposed by section 4191, subparagraphs (B), (C), (D), and (E) shall not apply.”

(c) Effective Date.—The amendments made by this section shall apply to sales after December 31, 2012.

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS**(a) IMPOSITION OF FEE.—**

(1) **IN GENERAL.**—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b).

(2) **ANNUAL PAYMENT DATE.**—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) **IN GENERAL.**—With respect to each covered entity under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(2) **AMOUNTS TAKEN INTO ACCOUNT.**—For purposes of paragraph (1),

(A) **IN GENERAL.** .—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

| | |
|---|--|
| <p>With respect to a covered entity's net premiums written during the calendar year are:</p> <p>Not more than \$25,000,000</p> <p>More than \$25,000,000 but not more than \$50,000,000.</p> <p>More than \$50,000,000.....</p> | <p>The percentage of net premiums written that are taken into account is:</p> <p>0 percent</p> <p>50 percent</p> <p>100 percent.</p> |
|---|--|

(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees’ health risks,

(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(C) any entity—

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except to the extent as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and (iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity provides (other than by an employer

or employers) for purposes of providing health insurance coverage through the community health insurance option under section 1323).care benefits.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

If any entity described in subparagraph (C) or (D) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.

(4) JOINT AND SEVERAL LIABILITY.— If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term “United States health risk” means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1)—

(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

| Calendar year | Applicable amount |
|---------------|-------------------|
| 2014..... | \$8,000,000,000 |
| 2015..... | \$11,300,000,000 |
| 2016..... | \$11,300,000,000 |
| 2017..... | \$13,900,000,000 |
| 2018..... | \$14,300,000,000 |

(2) Years after 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) \$10,000, plus

(ii) the lesser of—

(I) an amount equal to \$1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(3) ACCURACY-RELATED PENALTY.—

(A) IN GENERAL.— In the case of any understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

(i) the amount of the covered entity's fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such understatement, over

(ii) the amount of such fee the Secretary determined based on such understatement.

(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net premiums written as reported on the return filed by the covered entity under paragraph (1) and the amount of such net premiums written that should have been reported on such return.

(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

(4) TREATMENT OF INFORMATION.— Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate.

(2) UNITED STATES.—The term “United States” means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term “health insurance” shall not include—

(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

(B) any insurance for long-term care, or

(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2).

(j) EFFECTIVE DATE.—This section shall apply to calendar year beginning after December 31, 2013.

**SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES
ALLOCABLE TO MEDICARE PART D SUBSIDY.**

(a) **IN GENERAL.**—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) **IN GENERAL.**—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking “7.5 percent” and inserting “10 percent”.

(b) **TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.**—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(f) **SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.**—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting ‘7.5 percent’ for ‘10 percent’ if such taxpayer or such taxpayer’s spouse has attained age 65 before the close of such taxable year.”.

(c) **CONFORMING AMENDMENT.**—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking “by substituting ‘10 percent’ for ‘7.5 percent’” and inserting “without regard to subsection (f) of such section”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

“(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—

“(A) IN GENERAL.—No deduction shall be allowed under this chapter—

“(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds \$500,000, or

“(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds \$500,000 reduced (but not below zero) by the sum of—

“(I) the applicable individual remuneration for such disqualified taxable year, plus

“(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were

applied by substituting ‘December 31, 2009’ for ‘December 31, 2012’ in the matter preceding subclause (I).

“(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term ‘disqualified taxable year’ means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

“(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—

“(i) IN GENERAL.—The term ‘covered health insurance provider’ means—

“(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

“(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

“(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for

purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

“(D) APPLICABLE INDIVIDUAL REMUNERATION.— For purposes of this paragraph, the term ‘applicable individual remuneration’ means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

“(E) DEFERRED DEDUCTION REMUNERATION.— For purposes of this paragraph, the term ‘deferred deduction remuneration’ means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

“(F) APPLICABLE INDIVIDUAL.— For purposes of this paragraph, the term ‘applicable individual’ means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

“(i) who is an officer, director, or employee in such taxable year, or

“(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

“(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

“(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—

(1) IN GENERAL.—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking “In addition” and inserting the following:

“(1) IN GENERAL.—In addition”,

(B) by striking “the following percentages of the” and inserting “1.45 percent of the”,

(C) by striking “(as defined in section 3121(b))—” and all that follows and inserting “(as defined in section 3121(b)).”, and

(D) by adding at the end the following new paragraph:

“(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.9 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

“(A) in the case of a joint return, \$250,000,

“(B) in the case of a married taxpayer (as defined in section 7703) filing a separate return, 1/2 of the dollar amount determined under subparagraph (A), and

“(C) in any other case, \$200,000.”.

(2) COLLECTION OF TAX.—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(f) SPECIAL RULES FOR ADDITIONAL TAX.—

“(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of \$200,000, and the employer may disregard the amount of wages received by such taxpayer’s spouse.

“(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

“(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.”.

(b) SECA.—

(1) IN GENERAL.—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking “In addition” and inserting the following:

“(1) IN GENERAL.—In addition”, and

(B) by adding at the end the following new paragraph:

“(2) ADDITIONAL TAX.—

“(A) IN GENERAL.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31,

2012, a tax equal to 0.9 percent of the self-employment income for such taxable year which is in excess of—

“(i) in the case of a joint return, \$250,000,

“(ii) in the case of a married taxpayer (as defined in section 7703) filing a separate return, 1/2 of the dollar amount determined under clause (i), and

“(iii) in any other case, \$200,000.

“(B) COORDINATION WITH FICA.—The amounts under clauses (i), (ii), or (iii) (whichever is applicable) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.”.

(2) NO DEDUCTION FOR ADDITIONAL TAX.—

(A) IN GENERAL.—Section 164(f) of such Code is amended by inserting “(other than the taxes imposed by section 1401(b)(2))” after “section 1401”.

(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting “(determined without regard to the rate imposed under paragraph (2) of section 1401(b))” after “for such year”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS.

(a) **IN GENERAL.**—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(5) **NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.**—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization’s percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.