No.

In the Supreme Court of the United States

STATES OF TEXAS, ALABAMA, ARIZONA, ARKANSAS, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, AND WEST VIRGINIA; NEILL HURLEY AND JOHN NANTZ,
Conditional Cross-Petitioners

v.

STATE OF CALIFORNIA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

CONDITIONAL CROSS-PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Congress passed the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), with the express goal of achieving near-universal health-insurance coverage. To achieve that goal, Congress found it was "essential" to require healthy Americans to ensure that they have what Congress considered minimum essential coverage. In 2012, this Court held that "[t]he Federal Government does not have the power to order people to buy health insurance." *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 567 U.S. 519, 575 (2012) (op. of Roberts, C.J.). The Court upheld the minimum-essential-coverage requirement, however, because it was "fairly possible" to construe the mandate as a tax. *Id.* at 574. In 2017, Congress eliminated that alternative construction by zeroing out any penalty. That legislative act rendered the individual mandate unconstitutional, as the court below correctly held.

The Court should deny the petitions in Nos. 19-840 and 19-841. But if it grants them, it should grant this conditional cross-petition, as well, which presents the following questions:

1. Whether the unconstitutional individual mandate to purchase minimum essential coverage is severable from the remainder of the ACA.

2. Whether the district court properly declared the ACA invalid in its entirety and unenforceable anywhere.

PARTIES TO THE PROCEEDING

Conditional cross-petitioners the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, as well as Neill Hurley and John Nantz are plaintiffs in the district court and appellees in the court of appeals.

Cross-respondents the States of California, Connecticut, Delaware, Hawaii, Illinois, Massachusetts, Minnesota (by and through the Department of Commerce), New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, Governor Andy Beshear of Kentucky, and the District of Columbia intervened as defendants in the district court and were appellants in the court of appeals. Cross-respondents the States of Colorado, Iowa, Michigan, and Nevada intervened as defendants-appellants in the court of appeals.

Cross-respondent the United States House of Representatives purported to intervene as defendant-appellant in the court of appeals. The Fifth Circuit, however, never ruled on the U.S. House's standing to do so.

Cross-respondents the United States of America, the United States Department of Health and Human Services, Alex Azar II, Secretary of the United States Department of Health and Human Services, the Internal Revenue Service, and Charles P. Rettig, the Commissioner of the Internal Revenue Service are defendants in the district court and filed a notice of appeal. Though designated as appellants in the court of appeals, they ultimately defended the district court's judgment and are

designated as respondents to the petitions for writs of certiorari filed in Nos. 19-840 and 19-841.

RELATED PROCEEDINGS

The proceedings directly related to this conditional cross-petition are:

California, et al. v. Texas, et al., No. 19-840, Supreme Court of the United States. Petition for writ of certiorari pending.

U.S. House of Representatives v. Texas, et al., No. 19-841, Supreme Court of the United States. Petition for writ of certiorari pending.

Texas, et al. v. United States, et al., No. 19-10011, United States Court of Appeals for the Fifth Circuit. Judgment entered December 18, 2019.

Texas, et al. v. United States, et al., No. 4:18-cv-167, United States District Court for the Northern District of Texas. Partial final judgment entered December 30, 2018.

TABLE OF CONTENTS

Page

Questions Presented I

Parties to the Proceeding II

Related Proceedings III

Table of Authorities V

Opinions Below 3

Jurisdiction 3

Constitutional and Statutory Provisions Involved 4

Statement 4

Reasons for Granting the Petition 9

I. Review of Either the Petitions or Conditional Cross-Petition Is Premature 9

II. If the Court Grants Either Petition, It Should Grant This Cross-Petition, Which Presents Complementary Questions That Allow the Court to Uphold the District Court's Judgment in Its Entirety 10

A. The district court correctly held that the individual mandate is not severable from the remainder of the ACA 11

B. The district court properly issued a declaratory judgment that was not limited by geography 18

Conclusion 22

Page(s)

Cases

Abbott v. Veasey,
137 S. Ct. 612 (2017) 9, 10

Alaska Airlines, Inc. v. Brock,
480 U.S. 678 (1987) 11, 12, 13, 16

Califano v. Yamasaki,
442 U.S. 682 (1979) 20

California v. Rooney,
483 U.S. 307 (1987) 10

Champlin Ref. Co. v. Corp. Comm'n of Okla.,
286 U.S. 210 (1932) 11

Combs v. Ryan's Coal Co.,
785 F.2d 970 (11th Cir. 1986) 19

Exec. Benefits Ins. Agency v. Arkinson,
573 U.S. 25 (2014) 13

Florida ex rel. Bondi v.
U.S. Dep't of Health and Human Servs.,
780 F. Supp. 2d 1307 (N.D. Fla. 2011) 18-19

Free Enter. Fund v. Pub. Co. Accounting
Oversight Bd.,
561 U.S. 477 (2010) 11

Genesis Healthcare Corp. v. Symczyk,
569 U.S. 66 (2013) 2

Gill v. Whitford,
138 S. Ct. 1916 (2018) 9

Page(s)

***Cases (continued)*:**

Halbig v. Burwell,
758 F.3d 390 (D.C. Cir. 2014) 4

Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.,
240 U.S. 251 (1916) 9

Hill v. Wallace,
259 U.S. 44 (1922) 13

Kontrick v. Ryan,
540 U.S. 443 (2004) 19

Madsen v. Women's Health Ctr., Inc.,
512 U.S. 753 (1994) 20

Microsoft v. Baker,
137 S. Ct. 1702 (2017) 19

Minnesota v.
Mille Lacs Band of Chippewa Indians,
526 U.S. 172 (1999) 13, 15

Murphy v. NCAA,
138 S. Ct. 1461 (2018) 11

Nat'l Fed'n of Indep. Bus. v. Sebelius,
567 U.S. 519 (2012) ..... *passim*

New York v. United States,
505 U.S. 144 (1992) 16

Pub. Serv. Comm'n of Utah v. Wycoff Co.,
344 U.S. 237 (1952) 18

Reno v. ACLU,
521 U.S. 844 (1997) 11

Page(s)

***Cases (continued)*:**

Texas v. Hopwood,
518 U.S. 1033 (1996) 10

United Parcel Serv., Inc. v. Flores-Galarza,
318 F.3d 323 (1st Cir. 2003) 19

Va. House of Delegates v. Bethune-Hill,
139 S. Ct. 1945 (2019) 4

Va. Military Inst. v. United States,
508 U.S. 946 (1993) 9

Veasey v. Abbott,
888 F.3d 792 (5th Cir. 2018) 10

Whole Women's Health v. Hellerstedt,
136 S Ct. 2292 (2016) 11, 12

Williams v. Standard Oil Co. of La.,
278 U.S. 235 (1929) 17

Zobel v. Williams,
457 U.S. 55 (1982) 14

Statutes and Rules

26 U.S.C.
§ 36B 5
§ 4980H 5
§ 5000A(a) 5
§ 5000A(c) 5
§ 5000B 16
§ 6056 5

Page(s)

***Statutes and Rules (continued)*:**

28 U.S.C.
§ 1254 3
§ 1291 3

42 U.S.C.
§ 254b-2 20
§ 300gg 6
§§ 300gg to gg-4 6
§ 300gg-1 6
§ 300gg-4(a) 6
§ 300gg-15 5
§ 300u-11 20
§ 1396a(k)(1) 5
§ 1396u-7(b)(1) 5
§ 1396u-7(b)(5) 5
§ 18081 5
§ 18091(2)(F) 5
§ 18091(2)(H) 8
§ 18091(2)(I) 6, 12, 14
§ 18091(2)(J) 7

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) I
§ 9010(b) 16
§ 9010 15

Tax Cuts and Jobs Act of 2017, Pub. L. 115-97, § 11081, 131 Stat. 2054, 2092 (2017) 7

Page(s)

***Statutes and Rules (continued)*:**

Sup. Ct. R. 12.5 3

Sup. Ct. R. 13.1 3

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ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS (2012) 14

Br. for Defendants-Appellants United States et al., *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019) 19

Brief for Respondents (Severability), *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) 6, 7, 13, 14

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Robert L. Sterne, *When to Cross-Appeal or Cross-Petition—Certainty or Confusion?*, 87 HARV. L. REV. 763 (1974) 2

Samuel L. Bray, *The Myth of the Mild Declaratory Judgment*, 63 DUKE L.J. 1091 (2014) 19

STEPHEN M. SHAPIRO, ET AL., SUPREME COURT PRACTICE (10th ed. 2013) 2

Page(s)

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William J. Brennan, Jr., *Some Thoughts on the Supreme Court's Workload*, 66 JUDICATURE 230 (1983) 10

In the Supreme Court of the United States

No.

STATES OF TEXAS, ALABAMA, ARIZONA, ARKANSAS, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA; NEILL HURLEY AND JOHN NANTZ,
Conditional Cross-Petitioners,

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STATE OF CALIFORNIA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

CONDITIONAL CROSS-PETITION FOR A WRIT OF CERTIORARI

The petitions filed by the States (in No. 19-840) and the U.S. House of Representatives (in No. 19-841) should be denied. Those petitions seek review of the Fifth Circuit's decision that (1) conditional cross-petitioners have shown sufficient proof of standing to be entitled to partial summary judgment, (2) the ACA's minimum-essential-coverage requirement, also known as the "individual mandate," is unconstitutional, and (3) remand was appropriate for the district court to address questions of severability and remedy. The Fifth Circuit's decision is

not worthy for this Court's consideration at this time. The case is in an interlocutory posture, and none of the questions presented justify deviation from this Court's ordinary practice to grant review only after final judgment.

But if this Court were to grant either (or both) of the petitions, it should ensure that any writ of certiorari to the United States Court of Appeals for the Fifth Circuit encompasses whether the circuit court should have affirmed the district court's judgment in its entirety, including the district court's severability and remedial rulings.

This Court's rules are unclear on whether it is necessary for plaintiffs to separately cross-petition under these circumstances.[1] Indeed, the U.S. House has all but argued that this conditional cross-petition is unnecessary for the plaintiffs to preserve their right to argue for full affirmance of the district court. *See* House Mot. for Expedition Reply 10 (questioning whether this cross-petition is required and describing it as "at best a technical formality"). Nevertheless, out of an abundance of caution, and to avoid any accusation of waiver or forfeiture, cross-petitioners request that any Court order granting review permit them to argue that the district court's

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[1] STEPHEN M. SHAPIRO, ET AL., SUPREME COURT PRACTICE 491 n. 131 (10th ed. 2013) ("If the first petition asserts that a judgment for damages is too high, a cross-petition must be filed by a party who wishes to argue that the same amount is too low.") (citing Robert L. Sterne, *When to Cross-Appeal or Cross-Petition—Certainty or Confusion?*, 87 HARV. L. REV. 763, 767 (1974)); *cf. Genesis Healthcare Corp. v. Symczyk*, 569 U.S. 66, 82 n.1 (2013) (Kagan, J., dissenting).

ruling, including its holdings on severability and remedy, should have been affirmed in its entirety.

OPINIONS BELOW

The court of appeals has revised its opinion twice to correct technical errors. The operative version is published at 945 F.3d 355. As they do in their briefs in opposition, conditional cross-petitioners refer to the petitioners' appendix filed in *California v. Texas*, No. 19-840, to avoid confusion. The relevant orders of the district court are reported at 340 F. Supp. 3d 579 (App. 163a-231a) and 352 F. Supp. 3d 665 (App. 117a-162a).

JURISDICTION

The district court entered a partial final judgment on December 30, 2018. App.116a; *id.* 117a-162a.[2] The court of appeals had jurisdiction under 28 U.S.C. § 1291. The judgment of the court of appeals was entered on December 18, 2019. App. 1a.

This Court has certiorari jurisdiction under 28 U.S.C. § 1254 over (1) the petition filed by the States who intervened in the courts below, and (2) this conditional cross-petition, which was filed within 90 days of the circuit court's judgment. Sup. Ct. R. 13.1; *accord* Sup. Ct. R. 12.5 (allowing an additional 30 days for a conditional cross-petition).

The Court lacks jurisdiction over the petition filed by the U.S. House in No. 19-841. Though timely, as one chamber of a bicameral legislature, the U.S. House of Representatives lacks standing to separately petition in

[2] ROA refers to the record on appeal in *Texas v. United States*, 19-10011 (5th Cir.).

this Court on its own behalf to defend a legislative enactment. *Va. House of Delegates v. Bethune-Hill*, 139 S. Ct. 1945, 1953 (2019). And the U.S. House has no distinct injury of its own sufficient to support standing. *See id.*

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Certain pertinent constitutional and statutory provisions are reproduced at App. 232a-44a. Additional pertinent statutory provisions are reproduced at Cross-Pet. App. 1a-92a.

STATEMENT

Conditional cross-petitioners have already provided a complete statement in their briefs in opposition in Nos. 19-840 and 19-841, filed February 3, 2020. Cross-petitioners incorporate that statement by reference and add the following information relevant to consideration of the questions presented in this conditional cross-petition.

1. In 2010, Congress sought to achieve near-universal health-insurance coverage by creating a complex latticework of "closely interrelated" provisions resting on three key features. *NFIB*, 567 U.S. at 691 (dissenting op.). Those features, which the D.C. Circuit referred to as a "three-legged stool," *Halbig v. Burwell*, 758 F.3d 390, 409 (D.C. Cir. 2014), *vacated on other grounds*, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014), were: (1) a requirement that Americans buy minimum essential health insurance, known as the "individual mandate"; (2) a guaranteed-issue provision; and (3) a community-rating provision. *Id.*

2. At the heart of the ACA is what is referred to as the individual mandate and its tax penalty enforceable

against those who do not comply. The text of the mandate provides: "An applicable individual shall . . . ensure that the individual . . . is covered under minimum essential coverage." 26 U.S.C. § 5000A(a). The statutory title of this subsection reiterates that it imposes a "requirement" on applicable individuals "to maintain minimum essential coverage." *Id.* (capitalization altered).

As discussed in greater detail in conditional cross-petitioners' briefs in opposition, Congress used several mechanisms to give the mandate teeth. Br. Opp. 4-5. As relevant here, Congress built numerous provisions of the ACA to effectuate the minimum-essential-coverage requirement. For example, Congress obligated States to provide what it defined as minimum essential care in their Medicaid programs, 42 U.S.C. § 1396a(k)(1) (incorporating standard through *id.* §§ 1396u-7(b)(1), (5)), and obligated employers to provide insurance to employees, 26 U.S.C. § 4980H. Congress used the minimum-essential-coverage requirement to define insurance companies' disclosure obligations to their customers, 42 U.S.C. § 300gg-15, and employers' disclosure obligations to the IRS, 26 U.S.C. § 6056. And it used the same requirement to trigger individuals' ability to access public insurance exchanges, 42 U.S.C. § 18081; their right to receive public subsidies to buy insurance, 26 U.S.C. § 36B; and their obligation to pay a tax penalty if they did not do so, *id.* § 5000A(c). In 2010, Congress found that the insurance "requirement, together with the[se] other provisions of the Act" would lead to universal healthcare coverage and lower health-insurance premiums. 42 U.S.C. § 18091(2)(F).

3. Statutory text insists that the mandate and its effectuating provisions are vital to the proper function of the ACA, which imposes voluminous regulations on health-insurance companies, with the most prominent being "guaranteed issue" and "community rating" requirements. *See id.* §§ 300gg to gg-4. The guaranteed-issue provision mandates that health-insurance companies "accept every employer and individual in the State that applies for . . . coverage," regardless of preexisting conditions. *Id.* § 300gg-1. The community-rating provision prohibits health insurers from charging higher rates to individuals within a given geographic area on the basis of their age, sex, health status, or other factors. *See id.* §§ 300gg, 300gg-4(a).

As the United States conceded in *NFIB* and again in this litigation, "the minimum[-]coverage provision is necessary to make effective the Act's guaranteed-issue and community-rating insurance market reforms." Brief for Respondents (Severability) 26, *NFIB*, 567 U.S. 519 ("*NFIB* Br."); ROA.1570. The government explained that "Congress's findings *expressly* state that enforcement of [community and guaranteed issue] without a minimum[-]coverage provision would *restrict* the availability of health insurance and make it *less* affordable—the opposite of Congress's goals in enacting the Affordable Care Act." *NFIB* Br. 44-45. This problem would result because, "in a market with guaranteed issue and community rating, but without a minimum[-]coverage provision, 'many individuals would wait to purchase health insurance until they needed care.'" *Id.* at 45 (quoting 42 U.S.C. § 18091(2)(I)).

This "adverse selection" problem would cause premiums to "go up, further impeding entry into the market by those currently without acute medical needs, risking a 'marketwide adverse-selection death spiral.'" *Id.* at 46 (quoting Alan C. Monheit, et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFFAIRS No. 4 at 167, 169 (July/Aug. 2004), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.4.167); *see* 42 U.S.C. § 18091(2)(J). This hazard is why Congress "twice described" minimum coverage "as 'essential'" to "the guaranteed-issue and community-rating reforms" in the ACA's text. *NFIB* Br. 46-47. In sum, "without a minimum[-]coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals." *Id.* at 26.

4. Neither this economic reality nor Congress's findings about the function of its own statute have changed since 2010. In 2017, Congress "eliminat[ed],"[3] this Court's statutory "basis to adopt such a saving construction," *NFIB*, 567 U.S. at 575 (Roberts, C.J.). Section 11081 of the Tax Cuts and Jobs Act ("TCJA") reduced the operative parts of section 5000A(c)'s tax penalty to "[z]ero percent" and "$0."

As petitioners acknowledge, the TCJA left "every other provision of the ACA in place," including the mandate and the inseverability clause that labels that mandate "essential." States Pet. 2; *see* House Pet. 31. Specifically, Congress preserved all of its earlier findings that

[3] Tax Cuts and Jobs Act of 2017, Pub. L. 115-97, § 11081, 131 Stat. 2054, 2092 (2017) (capitalization altered).

the individual mandate "is an essential part of [the government's] regulation of economic activity." 42 U.S.C. § 18091(2)(H).

5. Two individuals and eighteen States brought suit because the ACA, as amended, "forces an unconstitutional and irrational regime on the States and their citizens." ROA.504, 530-35. As the United States agrees that the minimum-essential-coverage requirement is unconstitutional, state petitioners intervened to defend the law. ROA.220-56, 946-52.

In December 2018, the district court granted a declaratory judgment on the first of cross-petitioners' five claims: that the individual mandate is unconstitutional. App. 163a-231a. As to remedy, the court noted that respondents (individual, state, and federal) "agree[d] … that the guaranteed-issue and community-rating provisions … are inseverable" from the individual mandate. *Id.* 204a. Indeed, federal respondents requested that the district court "enter[] a declaratory judgment" to that effect. ROA.1581. The district court declared that the remainder of the ACA was inseverable from the requirement as well. *Id.* 204a-05a. It was the understanding of all parties that the declaration would apply nationwide. *See* Oral Argument at 7:31-8:35, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019) (No.19-10011), www.ca5.uscourts.gov/OralArgRecordings/19/19-10011_7-9-2019.mp3 (premising state conditional cross-respondents' appellate standing on nationwide impact of declaration); *id.* at 49:25-50:19. At the request of state petitioners (ROA.2674-706), the district court entered a partial final judgment to allow immediate appeal. App. 117a-62a.

The Fifth Circuit affirmed on almost everything except remedy. On the issues of severability and remedy, the court noted that the United States "ha[d] shifted [its] position on appeal more than once." *Id.* 13a. At oral argument before the Fifth Circuit, the United States argued that under *Gill v. Whitford*, 138 S. Ct. 1916 (2018), remand was necessary because the remedy "should only reach ACA provisions that injure the plaintiffs." App. 71a. Because this remedial argument "came as a surprise" to conditional cross-petitioners, the Fifth Circuit ordered the district court to consider this new argument—including whether it was "timely raised"—in the first instance. *Id.*

REASONS FOR GRANTING THE PETITION

I. Review of Either the Petitions or Conditional Cross-Petition Is Premature.

For the reasons conditional cross-petitioners explain in their briefs in opposition, the petitions should be denied. This case comes to this Court in an interlocutory posture in which the lower courts have not yet determined the scope of the relief to which conditional cross-petitioners are entitled. The proper procedure in those circumstances is to deny review. *E.g.*, *Abbott v. Veasey*, 137 S. Ct. 612, 613 (2017) (Roberts, C.J., respecting the denial of certiorari); *Va. Military Inst. v. United States*, 508 U.S. 946, 946 (1993) (Scalia, J., respecting the denial of certiorari); *accord Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916).

This practice preserves this Court's resources and prevents it from becoming prematurely involved in disputes that may fundamentally change over the course of

subsequent litigation. William J. Brennan, Jr., *Some Thoughts on the Supreme Court's Workload*, 66 JUDICATURE 230, 231-32 (1983); *compare Abbott*, 137 S. Ct. at 613 (Roberts, C.J.) (declining certiorari because no remedy had been awarded), *with Veasey v. Abbott*, 888 F.3d 792, 795 (5th Cir. 2018) (holding that no remedy was necessary in light of legislative action taken during remand). The petitioners' asserted and unspecified desire for "certainty" in the health-insurance market does not overcome this rule. *See* Br. Opp. 16-35.

In short, this Court "reviews judgments, not opinions," even when those opinions address "an issue of great national importance." *Texas v. Hopwood*, 518 U.S. 1033, 1033 (1996) (Ginsburg, J., respecting the denial of certiorari). This Court has said many times before that parties may not appeal to press disagreements with a lower court's abstract legal conclusions, divorced from any remedial consequences. *See, e.g.*, *California v. Rooney*, 483 U.S. 307, 311 (1987) (per curiam). As conditional cross-petitioners have explained in their briefs in opposition, that is effectively all the petitioners seek to do here.

II. If the Court Grants Either Petition, It Should Grant This Cross-Petition, Which Presents Complementary Questions That Allow the Court to Uphold the District Court's Judgment in Its Entirety.

If this Court nonetheless decides to grant review as to either petition, it should also grant this conditional cross-petition and conclude that the district court's severability and remedy rulings were correct. The questions

are complementary to the third question presented in Nos. 19-840 and 19-841. *See* House Mot. for Expedition Reply 10 (questioning whether this conditional cross-petition is necessary and labeling it "at best, a technical formality"). Granting this conditional cross-petition would thus allow the Court to fully analyze those questions and to hold that the district court's partial final judgment should have been affirmed in its entirety.

A. The district court correctly held that the individual mandate is not severable from the remainder of the ACA.

As petitioners explain, severability is a question of statutory interpretation. Though courts will avoid invalidating more of an act than necessary to remedy a constitutional defect, this principle does not allow the Court to "substitute the judicial for the legislative department of the government." *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292, 2319 (2016) (quoting *Reno v. ACLU*, 521 U.S. 844, 884-85 n.49 (1997)). Because severance is ultimately a question of legislative intent, *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010), courts will not attempt to salvage pieces of a legislative scheme where it is "evident that [Congress] would not have enacted those provisions which are within its power, independently of [that] which [is] not," *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (quoting *Alaska Airlines, Inc. v. Brock,* 480 U.S. 678, 684 (1987)). *See also Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234-35 (1932). The district court correctly relied on the operative statutory text to hold that

the ACA's remaining provisions are inseverable from the unconstitutional mandate.

1. As in all issues of statutory interpretation, the first question is whether Congress expressly addressed severability in the statutory text. While not an "inexorable command," the presence of a severability—or inseverability—clause is evidence of the legislature's preferred remedy in the event that a portion of the statute is determined to be unconstitutional. *Hellerstedt*, 136 S. Ct. at 2319.

In this instance, Congress included an inseverability clause when it passed the ACA in 2010. It states that "[t]he requirement [to buy health insurance] 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." 42 U.S.C. § 18091(2)(I). The 2017 Congress evidently agreed, as it left in place both the mandate and the inseverability clause.

There can be no clearer statement of Congress's view that the mandate is not severable from the rest of the ACA. That is what the district court concluded. So, too, should this Court.

2. This conclusion is confirmed by looking to the broader statutory language. The Court looks to two inquiries to determine if an unconstitutional provision is inseverable. *First*, provisions are inseverable if they would not "function in a *manner* consistent with the intent of Congress" absent the unconstitutional provision. *Alaska Airlines*, 480 U.S. at 684. If the operation of the unconstitutional provision is "so interwoven with" the intended operation of other provisions "that they cannot be

separated," none will stand. *Hill v. Wallace*, 259 U.S. 44, 70 (1922).

Second, provisions are inseverable if "the Legislature would not have enacted [them] . . . independently of" the provisions found unconstitutional, even if those provisions operated in some otherwise meaningful way. *Alaska Airlines*, 480 U.S. at 684. In examining this question, the Court looks not (as petitioners would ask) to isolated floor statements by individual members of Congress. Instead, it looks to whether the statute at issue "embodie[s] a single, coherent policy" or a "predominant purpose," and whether the unconstitutional provisions are necessary to that purpose. *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999).

To sever the "essential" individual mandate from the rest of the ACA, both tests must be satisfied. *NFIB*, 567 U.S. at 692-94 (dissenting op.). The ACA satisfies neither. To see why the individual mandate is inextricably intertwined with the remainder of the ACA, it is easiest to divide the 900-page statute into three tranches: (1) the community-rating and guaranteed-issue provisions, (2) remaining major provisions, and (3) minor or ancillary provisions. *See generally id.* at 697-706.

a. The United States has conceded for nearly a decade—across two different presidential administrations—that the community-rating and guaranteed-issue provisions are "so interwoven" with the mandate "that they cannot be separated." *Hill*, 259 U.S. at 70. As a result, "[n]one of them can stand." *Id.*; *see NFIB* Br. 26; ROA.1570. This concession alone provides reason to declare those provisions inseverable. *Exec. Benefits Ins. Agency v. Arkinson*, 573 U.S. 25, 36-37 (2014); *accord*

Zobel v. Williams, 457 U.S. 55, 65 (1982) (remanding severability of state statute). Congress had firm empirical evidence that "in a market with guaranteed issue and community rating, but without a minimum[-]coverage provision, 'many individuals would wait to purchase health insurance until they needed care.'" *NFIB* Br. 45 (quoting 42 U.S.C. § 18091(2)(I)); *id.* at 47; *cf. NFIB*, 567 U.S. at 694-96 (dissenting op.).

Amici assert that, notwithstanding Congress's decision to retain these express findings, the findings simply were no longer true by 2017. In particular, amici point to economic studies suggesting that subsidies have been the real driving factor for the increase in the rates of insured persons seen since 2010. *E.g.*, *Nat'l Hosp. Ass'n* Br. 8-10. This argument is circular. Subsidies are one of several mechanisms that Congress used to effectuate the mandate that Americans buy minimum essential coverage. CONGRESSIONAL BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 50-53 (Dec. 2008), https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf. Moreover, neither petitioners nor amici cite evidence that Congress adopted this view beyond isolated floor statements by particular members of Congress. Such statements of individual legislators cannot change the meaning of the text adopted by both chambers of Congress and signed by the President. ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 369-90 (2012) (discussing "[t]he false notion" that "floor speeches are worthwhile aids in statutory construction").

b. The remaining major provisions are similarly inseverable because they effectuate the near-universal healthcare coverage that the mandate requires. These provisions are predominantly located in Title I of the ACA and are identified in detail in the *NFIB* dissent. 567 U.S. at 691-703. They include insurance regulations and taxes; changes to the Medicaid program (*e.g.*, reducing hospital reimbursements); health-insurance exchanges and their federal subsidies; employer responsibility payments; and tax benefits to individuals. *Id.* Though highly varied, each of these provisions works to meet the "single, coherent policy" that all Americans have minimum-essential-healthcare coverage. *Mille Lacs Band*, 526 U.S. at 191.

To take an example of why they are inseverable from the individual mandate, consider the health-insurance provider fee contained in section 9010 of the ACA. This fee is an assessment imposed upon health-insurance providers on the theory that they will receive a windfall of new subscribers as a result of the mandate. Robert Book, *The Strange Effects of The Health Insurance 'Annual Fee' Tax*, Forbes.com, Feb. 20, 2014, https://www.forbes.com/sites/theapothecary/2014/02/20/the-strange-effects-of-the-health-insurance-annual-fee-tax/#70027bf45cdf. If the mandate is declared unconstitutional, any chance of such a windfall would evaporate. The tax would, however, remain unchanged due to the way the tax is calculated. Generally speaking, corporate income tax is assessed by multiplying a tax rate by the company's earnings. The ACA's health-insurance-provider fee, by contrast, is assessed by multiplying the insurer's market share by a total amount levied against the

industry. ACA § 9010(b). Without the increase in customers caused by the mandate, insurers would have to increase their premiums on existing customers to meet the fee—which was the exact opposite of Congress's intent. *Cf. NFIB*, 567 U.S. at 699 (dissenting op.).

Because this provision would not "function in a manner consistent with the intent of Congress" without the mandate, it is inseverable from that mandate. *Alaska Airlines*, 480 U.S. at 685; *see also NFIB*, 567 U.S. at 692-93 (dissenting op.).

The same is true of all of the major provisions of the ACA. These provisions include "mandates and other requirements; comprehensive regulation and penalties; some undoubted taxes; and increases in some governmental expenditures, decreases in others." *NFIB*, 567 U.S. at 694 (dissenting op.). As the *NFIB* dissent noted, these provisions work "to balance the costs and benefits affecting each set of regulated parties." *Id.* Because that balance would be fundamentally altered by removing the individual mandate, the ACA's remaining major provisions are inseverable from that individual mandate. *Cf. Alaska Airlines*, 480 U.S. at 685; *New York v. United States*, 505 U.S. 144, 187 (1992).

c. Finally, the ACA's minor provisions are inseverable for similar reasons. These provisions included, among other things, a number of minor taxes, *e.g.*, 26 U.S.C. §5000B, and "a number of provisions that provided benefits to the State of a particular legislator." *NFIB*, 567 U.S. at 704 (dissenting op.). Without the main provisions, these minor provisions make little sense. For example, the "tax increases no longer operate to offset costs" as part of "the Act's scheme of 'shared

responsibility.'" *Id.* at 705. Moreover, as a whole, "[t]here is no reason to believe that Congress would have enacted them independently" of the mandate, community-rating provision, and guaranteed-issue requirement. *Id.*; *see also Williams v. Standard Oil Co. of La.*, 278 U.S. 235, 243 (1929).

Petitioners and their amici counter by pointing to ancillary provisions that, in their view, Congress included in the ACA for convenience. For example, the ACA reauthorized the Indian Health Service, which has existed since long before the ACA. Economic Scholars Am. Br. 22. If anything, however, highlighting these examples demonstrates why this case is not yet ripe for review. This entire appeal originated from the federal government's request that the district court treat a request for a preliminary injunction as a motion for summary judgment. ROA.1563. Like most requests for preliminary relief, the original motion was drafted and briefed in broad strokes. ROA.572-633. The Fifth Circuit "direct[ed] the district court to employ a finer-toothed comb on remand" before entering final judgment. App. 68a. The Court should allow the lower courts to conduct that analysis in the first instance. But if it chooses to hear the case now, it should allow conditional cross-petitioners to argue that the district court was correct that Congress would *not* have passed the ACA absent the mandate.

3. The district court faithfully applied the above principles—including the statutory inseverability clause—to reach the correct conclusion: No portion of the ACA is severable from the mandate. The Fifth Circuit should have affirmed that judgment. Instead, it vacated the district court's judgment and instructed that court to redo

its analysis in light of authorities and arguments the federal government raised for the first time on appeal.

B. The district court properly issued a declaratory judgment that was not limited by geography.

If the Court grants review, it should also hold that the district court's remedy was correct. The district court declared the individual mandate unconstitutional and inseverable from the remainder of the ACA. App. 231a. Consistent with the conditional cross-petitioners' request for relief, that declaratory judgment carried nationwide effect. The Fifth Circuit should have affirmed that judgment in its entirety.

Instead, the Fifth Circuit vacated the district court's remedial determination based in part on a new argument that the federal government raised for the first time on appeal. In its district court papers, the federal government expressly argued that the injunctive relief that conditional cross-petitioners had requested was not warranted because such a declaration "would be adequate relief against the government," ROA.1581, and that "a declaratory judgment is the functional equivalent of an injunction against the federal government," ROA.2722. At oral argument before the district court, the federal government again insisted that it would treat its declaration *like* the nationwide injunction that conditional cross-petitioners had requested. *Cf.* Oral Argument 50:25-38 (describing oral concession to the district court). That concession is consistent with how courts and commentators have viewed declarations when government actors are involved. *Cf. Pub. Serv. Comm'n of Utah v. Wycoff Co.*, 344 U.S. 237, 247 (1952); *Florida ex rel.*

Bondi v. U.S. Dep't of Health and Human Servs., 780 F. Supp. 2d 1307, 1315-16 (N.D. Fla. 2011); Samuel L. Bray, *The Myth of the Mild Declaratory Judgment*, 63 DUKE L.J. 1091, 1093 & n.9 (2014) (citing *inter alia* PETER H. SCHUCK, SUING GOVERNMENT: CITIZEN REMEDIES FOR OFFICIAL WRONGS 14-15 (1983)).

But on appeal, the federal government changed its position and argued for a narrower remedy. *See* Br. for Defendants-Appellants United States et al. 26-29 *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019). The Fifth Circuit remanded in part to allow the district court to address this new argument in the first instance. App. 70a-72a. But there was no need to do so. Arguments raised for the first time on appeal are not properly before the appellate court. *See* DOUGLAS LAYCOCK, ET AL., MODERN AMERICAN REMEDIES: CASES AND MATERIALS 955 (4th ed. 2010) ("[T]he court and the other litigants relied by continuing to litigate; courts will not retry a case to correct an error that could have been corrected when it was made.") (citing *Kontrick v. Ryan*, 540 U.S. 443, 458 n.13 (2004)); *accord United Parcel Serv., Inc. v. Flores-Galarza*, 318 F.3d 323, 338 (1st Cir. 2003); *Combs v. Ryan's Coal Co.*, 785 F.2d 970, 979 (11th Cir. 1986). Moreover, as Justice Thomas recently recognized in a different context, "it has long been the rule that a party may not appeal" from the conclusion of a district court if "the party consented to the judgment against it." *Microsoft v. Baker*, 137 S. Ct. 1702, 1717 (2017) (Thomas, J., concurring) (collecting cases). The Fifth Circuit should have affirmed the district court's remedial order, rather than remanding to allow the United States to raise

arguments that it could have raised—but did not raise—in district court.

Furthermore, the district court was correct to declare the entire ACA unconstitutional and unenforceable nationwide: Such a declaration is both equitable and necessary to "provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979); *see also Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994). Invalidating the ACA in a more limited geographic area would force citizens of the cross-petitioning States to heavily subsidize other States with their general tax dollars. For example, citizens of and entities located in the cross-petitioning States would have their tax dollars collected and spent in accordance with ACA programs such as the Prevention and Public Health Fund, *see* 42 U.S.C. § 300u-11, and the Community Health Center Fund, *see id.* § 254b-2. Yet none of those funds would be spent in the cross-petitioning States. A less-than-nationwide injunction would effectively allow a transfer of hundreds of millions of dollars from the prevailing States to either conditional-cross-respondent or non-party States. Far from redressing conditional cross-petitioners' injuries, such an injunction would *exacerbate* their injuries by forcing them to pay for programs and services they no longer receive because they prevailed in showing those programs and services to be inseverable from the unconstitutional individual mandate. Such a result is plainly inequitable.

The district court therefore properly invalidated the ACA nationwide. In the event it grants either or both petitions, the Court should affirm the district court's

remedial order in its entirety consistent with the federal government's representations in district court.

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CONCLUSION

The petitions for writs of certiorari filed in Nos. 19-840 and 19-841 should be denied. But if the Court decides to grant either, it should grant this conditional cross-petition as well, which presents complementary questions of whether the Fifth Circuit should have affirmed the district court's judgment in its entirety.

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Appendix

TABLE OF CONTENTS

Page

Appendix A – 26 U.S.C. § 36B 1a
Appendix B – 26 U.S.C. § 4980H 17a
Appendix C – 26 U.S.C. § 6056 .....23a
Appendix D – 42 U.S.C. § 300gg 26a
Appendix E – 42 U.S.C. § 300gg-1 .....28a
Appendix F – 42 U.S.C. § 300gg-2 .....31a
Appendix G – 42 U.S.C. § 300gg-3 .....35a
Appendix H – 42 U.S.C. § 300gg-4 .....50a
Appendix I – 42 U.S.C. § 300gg-15 .....63a
Appendix J – 42 U.S.C. § 1396a(k) 68a
Appendix K – 42 U.S.C. § 1396u-7(b) 70a
Appendix L – 42 U.S.C. § 18081 .....74a
Appendix M – 42 U.S.C. § 18091 .....89a

APPENDIX A

26 U.S.C. § 36B

Effective: December 22, 2017

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

(ii) Indexing.--

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

calendar year over the rate of income growth for the preceding calendar year.

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

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

[**(iii) Repealed.** Pub.L. 111-152, Title I, § 1001(a)(1)(B), Mar. 30, 2010, 124 Stat. 1031]

(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) Repealed.** Pub.L. 112-10, Div. B, Title VIII,

§ 1858(b)(1), Apr. 15, 2011, 125 Stat. 168]

(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.

(4) Special rules for qualified small employer health reimbursement arrangements.--

(A) In general.--The term "coverage month" shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.

(B) Denial of double benefit.--In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

(C) Affordable coverage.--For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if--

(i) the excess of--

(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

(II) $^1/_{12}$ of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed--

(ii) $^1/_{12}$ of 9.5 percent of the employee's household income.

(D) Qualified small employer health reimbursement arrangement.--For purposes of this paragraph, the term "qualified small employer health reimbursement arrangement" has the meaning given such term by section 9831(d)(2).

(E) Coverage for less than entire year.--In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting "the number of months during the year for which such arrangement was provided" for "12".

(F) Indexing.--In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

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

(1) Family size.--The family size involved with respect to any taxpayer shall be equal to the number of

individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) Household income.--

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

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

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

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

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

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

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

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

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

(3) Poverty line.--

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

(B) Poverty line used.--In the case of any qualified

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

(e) Rules for individuals not lawfully present.--

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

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

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

(i) A method under which--

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

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

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

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

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

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

(3) Secretarial authority.--The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Reconciliation of credit and advance credit.--

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

(2) Excess advance payments.--

(A) In general.--If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without

regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) Limitation on increase.--

(i) In general.--In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

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

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

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for "calendar year 2016" in subparagraph (A)(ii)

thereof.

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B

26 U.S.C. § 4980H

Effective: March 23, 2018

(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) Repealed.** Pub.L. 112-10, Div. B, Title VIII, § 1858(b)(4), Apr. 15, 2011, 125 Stat. 169]

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

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

(2) Applicable large employer.--

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

(B) Exemption for certain employers.--

(i) In general.--An employer shall not be

considered to employ more than 50 full-time employees if--

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Exemption for health coverage under TRICARE or the Department of Veterans Affairs.--Solely for purposes of determining whether an employer is an applicable large employer under this paragraph for any month, an individual shall not be taken into account as an employee for such month if such individual has medical coverage for such month under–

(i) chapter 55 of title 10, United States Code,

including coverage under the TRICARE program, or

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

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

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

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

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

(4) Full-time employee.--

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

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

(5) Inflation adjustment.--

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

(i) such dollar amount, and

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

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

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

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

(d) Administration and procedure.--

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

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

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

APPENDIX C

26 U.S.C. § 6056

(a) In general.--Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

(b) Form and manner of return.--A return is described in this subsection if such return--

(1) is in such form as the Secretary may prescribe, and

(2) contains--

(A) the name, date, and employer identification number of the employer,

(B) a certification as to whether the 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)),

(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll--

(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,

(ii) the months during the calendar year for which coverage under the plan was available,

(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and

(iv) the employer's share of the total allowed costs of benefits provided under the plan,

[**(v)** Repealed. Pub.L. 112-10, Div. B, Title VIII, § 1858(b)(5)(B)(iv), Apr. 15, 2011, 125 Stat. 169]

(D) the number of full-time employees for each month during the calendar year,

(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and

(F) such other information as the Secretary may require.

The Secretary shall have the authority to review the accuracy of the information provided under this subsection, including the applicable large employer's share under paragraph (2)(C)(iv).

(c) Statements to be furnished to individuals with respect to whom information is reported.--

(1) In general.--Every person required to make a return under subsection (a) shall furnish to each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing--

(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

(B) the information required to be shown on the return with respect to such individual.

(2) Time for furnishing statements.--The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(d) Coordination with other requirements.--To the maximum extent feasible, the Secretary may provide that--

(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.

(e) Coverage provided by governmental units.--In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

(f) Definitions.--For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.

APPENDIX D

42 U.S.C. § 300gg

(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 300gg-6(c) of this title); 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 subchapter.

(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 subchapter. 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 18032(f)(2)(B) of this title), 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.

APPENDIX E

42 U.S.C. § 300gg-1

§ 300gg-1. 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 1163 of Title 29).

(3) Regulations

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

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may--

(A) limit the employers that may apply for such

coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that--

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that--

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

APPENDIX F

42 U.S.C. § 300gg-2

(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.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums

The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud

The plan sponsor, or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rates

In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.

(4) Termination of coverage

The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

(5) Movement outside service area

In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).

(6) Association membership ceases

In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for uniform termination of coverage

(1) Particular type of coverage not offered

In any case in which an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if--

(A) the issuer provides notice to each plan sponsor or individual, as applicable, provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor or individual, as applicable, provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of all coverage

(A) In general

In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group market, or all markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if--

(i) the issuer provides notice to the applicable State authority and to each plan sponsor or individual, as applicable, (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health

insurance coverage in such market (or markets) is not renewed.

(B) Prohibition on market reentry

In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for uniform modification of coverage

At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan--

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(e) Application to coverage offered only through associations

In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

APPENDIX G

42 U.S.C. § 300gg-3

(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.

(b) Definitions

For purposes of this part--

(1) Preexisting condition exclusion

(A) In general

The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term "late enrollee" means, with respect to coverage under a group health plan, a participant or

beneficiary who enrolls under the plan other than during--

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) Waiting period

The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act.

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

(E) Chapter 55 of Title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of Title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of Title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg-91(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before January 1, 2014--

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for

purposes of section 7527 of Title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 300bb-5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall--

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the individual or group group [sic] market, the issuer--

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted

children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)--

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of--

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a

certification of coverage of the individual under paragraph (1)--

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the

employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)--

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries

(A) In general

If--

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of--

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective--

(i) in the case of marriage, not later than the first

day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for

assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under Title XIX of the Social Security Act, or child health assistance under a State child health plan under Title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 1181(f)(3)(B)(i)(II) of Title 29.

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of Title 29.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the

State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if--

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

APPENDIX H

42 U.S.C. § 300gg-4

(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.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-

related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed--

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease

or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing

(1) Limitation on requesting or requiring genetic testing

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment

(A) In general

Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) Limitation

For purposes of subparagraph (A), a group health

plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that--

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 300gg-91 of this title).

(2) Prohibition on collection of genetic information prior to enrollment

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans

The provisions of subsections (a)(6), (b)(3), (c), and (d) and subsection (b)(1) and section 300gg-3 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to

section 300gg-21(a) of this title.

(f) Genetic information of a fetus or embryo

Any reference in this part to genetic information concerning an individual or family member of an individual shall-

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(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 March 23, 2010, 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 Title 26 or cost-sharing assistance under section 18071 of this title.

(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 March 23, 2010, 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.

APPENDIX I

42 U.S.C. § 300gg-15

(a) In general

Not later than 12 months after March 23, 2010, 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 policyholders 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 18022(b)(1) of this title; 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 Title 26); 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 March 23, 2010, 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 1002(16) of Title 29).

(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 1022 of Title 29) 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).

APPENDIX J

42 U.S.C. § 1396a(k)

§ 1396a. State plans for medical assistance

Effective: October 1, 2019

(k)Minimum coverage for individuals with income at or below 133 percent of the poverty line

(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1396u-7(b)(1) of this title or benchmark equivalent coverage described in section 1396u-7(b)(2) of this title. Such medical assistance shall be provided subject to the requirements of section 1396u-7 of this title, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1396u-7(a)(2) of this title, the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1396u-7 of this title or benchmark equivalent coverage described in subsection (b)(2) of that section.

(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based

on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1396u-1 of this title.

APPENDIX K

42 U.S.C. § 1396u-7(b)

§ 1396u-7. State flexibility in benefit packages

Effective: January 1, 2014

(b) Benchmark benefit packages

(1) In general

For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-equivalent health insurance coverage

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of Title 5.

(B) State employee coverage

A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(C) Coverage offered through HMO

The health insurance coverage plan that--

(i) is offered by a health maintenance organization (as defined in section 300gg-91(b)(3) of this title), and

(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(D) Secretary-approved coverage

Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be

provided such coverage.

(2) Benchmark-equivalent coverage

For purposes of subsection (a)(1), subject to paragraphs (5) and (6) coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the following categories of basic services:

(i) Inpatient and outpatient hospital services.

(ii) Physicians' surgical and medical services.

(iii) Laboratory and x-ray services.

(iv) Coverage of prescription drugs.

(v) Mental health services.

(vi) Well-baby and well-child care, including age-appropriate immunizations.

(vii) Other appropriate preventive services, as designated by the Secretary.

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

(C) Substantial actuarial value for additional services included in benchmark package

With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such

package:

(i) Vision services.

(ii) Hearing services.

(3) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

(A) by an individual who is a member of the American Academy of Actuaries;

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of the population involved;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this subchapter that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(4) Coverage of rural health clinic and FQHC services

Notwithstanding the previous provisions of this section,

a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless--

(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1396d(a)(2) of this title; and

(B) payment for such services is made in accordance with the requirements of section 1396a(bb) of this title.

(5) Minimum standards

Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 18022(b) of this title.

APPENDIX L

42 U.S.C. § 18081

§ 18081. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions

Effective: December 13, 2016

(a) Establishment of program

The Secretary shall establish a program meeting the requirements of this section for determining--

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 18032(f)(3), 18071(e), and 18082(d) of this title and section 36B(e) of Title 26 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of Title 26 or section 18071 of this title--

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2) of Title 26; and

(4) whether to grant a certification under section 18031(d)(4)(H) of this title attesting that, for purposes

of the individual responsibility requirement under section 5000A of Title 26, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) Information required to be provided by applicants

(1) In general

An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide--

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an "enrollee"); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) Citizenship or immigration status

The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) Eligibility and amount of tax credit or reduced cost-sharing

In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of Title 26 or section 18071 of this title is being

claimed, the following information:

(A) Information regarding income and family size

The information described in section 6103(l)(21) of Title 26 for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) Certain individual health insurance policies obtained through small employers

The amount of the enrollee's permitted benefit (as defined in section 9831(d)(3)(C) of Title 26) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such title).

(C) Changes in circumstances

The information described in section 18082(b)(2) of this title, including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) Employer-sponsored coverage

In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of Title 26 or cost-sharing reduction under section 18071 of this title is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of Title 26 as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time

employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of Title 26) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) Exemptions from individual responsibility requirements

In the case of an individual who is seeking an exemption certificate under section 18031(d)(4)(H) of this title from any requirement or penalty imposed by section 5000A of Title 26, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the

individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) Verification of information contained in records of specific Federal officials

(1) Information transferred to Secretary

An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) Citizenship or immigration status

(A) Commissioner of Social Security

The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) Secretary of Homeland Security

(i) In general

In the case of an individual--

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with

information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) Information

The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) Eligibility for tax credit and cost-sharing reduction

The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) Methods

(A) In general

The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done--

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) Flexibility

The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of Title 26 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) Verification by Secretary

In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) Actions relating to verification

(1) In general

Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) Verification

(A) Eligibility for enrollment and premium tax credits and cost-sharing reductions

If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)--

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 18082(c) of this title of the amount of any advance payment to be made.

(B) Exemption from individual responsibility

If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 18031(d)(4)(H) of this title.

(3) Inconsistencies involving attestation of citizenship or lawful presence

If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the

records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1396a(ee) of this title (as in effect on January 1, 2010).

(4) Inconsistencies involving other information

(A) In general

If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) Reasonable effort

The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) Notice and opportunity to correct

In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall--

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during

the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) Specific actions not involving citizenship or lawful presence

(i) In general

Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) Eligibility or amount of credit or reduction

If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) Employer affordability

If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of Title 26 or cost-sharing reduction under section 18071 of this title because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that

coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of Title 26 .

(iv) Exemption

In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such title will be issued.

(C) Appeals process

The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) Appeals and redeterminations

(1) In general

The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers--

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) Employer liability

(A) In general

The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax

imposed by section 4980H of Title 26 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to--

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such title.

(B) Confidentiality

Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of Title 26, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of Title 26 with respect to the employee, except that--

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in

such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) Confidentiality of applicant information

(1) In general

An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) Receipt of information

Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall--

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) Penalties

(1) False or fraudulent information

(A) Civil penalty

(i) In general

If--

(I) any person fails to provides correct information under subsection (b); and

(II) such failure is attributable to negligence or

disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms "negligence" and "disregard" shall have the same meanings as when used in section 6662 of Title 26.

(ii) Reasonable cause exception

No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) Knowing and willful violations

Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $250,000.

(2) Improper use or disclosure of information

Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(3) Limitations on liens and levies

The Secretary (or, if applicable, the Attorney General of the United States) shall not--

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty

imposed by this subsection; or

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

(i) Study of administration of employer responsibility

(1) In general

The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of Title 26 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) Report

Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

APPENDIX M

42 U.S.C. § 18091

§ 18091. Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this section 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.