Selected docket entries for case 10−2347

Generated: 06/22/2013 14:30:24

Filed	Document Description	Page	Docket Text
02/27/2013	120 Supplemental Opening Brief on Remand	2	Supplemental BRIEF by Appellants Liberty University, Incorporated, Joanne V. Merrill and Michele G. Waddell in electronic and paper format. Type of Brief: Supplemental Opening. Method of Filing Paper Copies: courier. Date Paper Copies Mailed, Dispatched, or Delivered to Court: 02/27/2013. [999052894] [10−2347] Mary McAlister

APPEAL NO. 10-2347

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

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

PLAINTIFFS-APPELLANTS

v.

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

DEFENDANTS-APPELLEES.

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

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

Mathew D. Staver
Anita L. Staver
Liberty Counsel
1055 Maitland Ctr Commons
Second Floor
Maitland, FL 32751
(800) 671-1776 Telephone
(407) 875-0770 Facsimile
court@lc.org Email
Attorneys for Appellants

Stephen M. Crampton
Mary E. McAlister
Liberty Counsel
P.O. Box 11108
Lynchburg, VA 24506
(434) 592-7000 Telephone
(434) 592-7700 Facsimile
court@lc.org Email
Attorneys for Appellants

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

STATEMENT OF JURISDICTION 1

STATEMENT OF ISSUES PRESENTED FOR REVIEW 1

STATEMENT OF THE CASE 1

SUPPLEMENTAL STATEMENT OF FACTS 2

LEGAL ARGUMENT 14

I. THE ANTI-INJUNCTION ACT DOES NOT BAR THIS CHALLENGE TO THE EMPLOYER MANDATE. 15

II. THE EMPLOYER MANDATE EXCEEDS CONGRESS' ENUMERATED POWERS. 17

A. The Employer Mandate Exceeds Congress' Commerce Clause Authority 18

C. The Employer Mandate Is Not Authorized Under The Necessary And Proper Clause. 32

D. The Act Violates The Origination Clause. 33

III. THE MANDATES AND THEIR IMPLEMENTATION VIOLATE THE FREE EXERCISE OF RELIGION. 36

A. The Mandates Require That Employers Provide And Individuals Pay For Abortion Coverage In Violation of RFRA. 38

1. The Employer Mandate Violates RFRA. 38

2. The Individual Mandate Violates RFRA. 43

B. The Mandates Require That Employers Provide Abortifacients And Individuals Pay For Abortion Coverage In Violation Of The Free Exercise Clause. 47

1. The Employer Mandate Violates The Free Exercise Clause. 48

2. The Individual Mandate Violates the Free Exercise Clause. 52

C. The Act And Its Implementation Violates Equal Protection. 55

D. The Act And Its Implementation Violates The Establishment Clause. 59

IV. THE EMPLOYER MANDATE IS NOT SEVERABLE. 60

CONCLUSION.....62

TABLE OF AUTHORITIES

Cases

Adarand Constructors, Inc. v. Pena,
515 U.S. 200 (1995) 58

Alaska Airlines v. Brock,
480 U.S. 678 (1987) 61

Anderson v. Celebrezze,
460 U.S. 780 (1983) 43

Bailey v. Drexel Furniture (*Child Labor Tax Case*),
259 U.S. 20 (1922) 13-24, 24-26, 28-29

Black & Decker Disability Plan v. Nord,
538 U.S. 822 (2003) 21

Bob Jones University v. United States,
461 U.S. 574 (1983) 31

Braunfeld v. Brown,
366 U.S. 599 (1961) 51

Brecht v. Abrahamson,
507 U.S. 619 (1993) 15

Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah,
508 U.S. 520 (1993) ..... passim

City of Cleburne v. Cleburne Living Ctr.,
473 U.S. 432 (1985). 59

Employment Div. v. Smith,
494 U.S. 872 (1990) 40,47, 51

Everson v. Bd. of Educ.,
330 U.S. 1 (1947) 60

Gillette v. United States,
401 U.S. 437 (1971) 56, 60
Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal,
546 U.S. 418, 424 (2006) 40-42, 45

Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC,
132 S. Ct. 694 (2012)..... 50

Humana, Inc. v. Forsyth,
525 U.S. 299 (1999) 22

Kleinsasser v. United States,
522 F. Supp. 460 (D. Mont. 1981) 31

Larson v. Valente,
456 U.S. 228 (1982..... 59

Liberty University v. Geithner,
133 S.Ct. 679 (2012)..... 2

Liberty University v. Geithner,
671 F.3d 391 (4th Cir. 2011) ..... *passim*

Liberty University v. Geithner,
753 F.Supp.2d 611 (W.D. Va. 2010) ..... *passim*

Lockheed Corp. v. Spink,
517 U.S. 882 (1996) 21

Lynch v. Donnelly,
465 U.S. 668 (1984) 60

Nat'l Fed'n of Indep. Bus. v. Sebelius,
132 S. Ct. 2566 (2012)..... *passim*

Newland v. Sebelius,
881 F. Supp. 2d 1287 (D. Colo. 2012) 42

NLRB v. Jones & Laughlin Steel Corp.,
301 U.S. 1 (1937) 19, 20

Oklahoma Tax Comm'n v. Texas Co.,
336 U.S. 342 (1949)). 26

Olsen v. Comm'r,
709 F.2d 278 (4th Cir.1983) 56, 58

Plyler v. Doe,
457 U.S. 202 (1982) 59

Sherbert v. Verner,
374 U.S. 398 (1963) 42, 44-46, 52, 55

Thomas v. Review Bd. of Ind. Emp't Sec.,
450 U.S. 707 (1981) 39, 44

U.S. v. Khan,
461 F.3d 477 (4th Cir. 2006). 14

United States v. Booker,
543 U.S. 220 (2005) 60

United States v. Comstock,
130 S.Ct. 1949 (2010) 17, 33

United States v. Darby,
312 U.S. 100 (1941) 19, 20

United States v. Lopez,
514 U.S. 549 (1995) 19

United States v. Munoz-Flores,
495 U.S. 385(1990) 34, 35

United States v. South-Eastern Underwriters Association,
322 U.S. 533 (1944) 22

W. Va. State Bd. of Educ. v. Barnette,
319 U.S. 624 (1943) 50, 54

Wisconsin v. Yoder,
406 U.S. 205 (1972) 41, 50, 51

Wright v. West,
505 U.S. 277 (1992) 15

Constitutional Provisions

Const. art. I §7, cl. 1 34

Other Authorities

1 Timothy 5:18 40

111 Cong. Rec. S11607 (November 19, 2009) (Text of Amendment as introduced); PL 111-148, March 23, 2010, 124 Stat 119 36

American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG"), Comment to Docket No. FDA–2010–N–0001Advisory Committee for Reproductive Health Drugs; Notice of Meeting Ulipristal acetate tablets, (NDA) 22–474, Laboratoire HRA Pharma. (June 2, 2010).....4

Brief for American College of Pediatricians, et.al. as Amici Curiae Supporting Respondents, *United States Dep't. of Health and Human Services v. State of Florida*, decided *sub nom. NFIB v. Sebelius*, 132 S.Ct. 2566 (2012) (No. 11-398). 12

Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and A Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037 (1996). 19

Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (March 24, 2010) 11

FDA Office of Women's Health Birth Control Guide 4

HRSA, *Women's Preventive Services: Required Health Plan Coverage Guidelines,* 3

IOM (Institute of Medicine), Committee on Preventive Services for Women, Board on Population Health and Public Health Practice, *Clinical Preventive Services for Women Closing the Gaps* 2 (2011).....3

Jeremiah 22:13 40

Letter from Collegium Aesculapium Foundation, Inc. to Centers for Medicare & Medicaid Services Department of Health and Human Services (September 28, 2011) 7

Letter from General Counsel, U.S. Conference of Catholic Bishops to Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (August 31, 2011) 5

Letter from Richard Land, President, The Ethics and Religious Liberty Commission of the Southern Baptist Convention to Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (September 30, 2011) 7

Luke 10:7 40

Opening and Response Brief of Commonwealth of Virginia, *Commonwealth of Virginia v. Sebelius*, 656 F.3d 253 (4th Cir. 2011) (No. 11-1057) 23

Robin Fretwell Wilson, *The Calculus Of Accommodation: Contraception, Abortion, Same-Sex Marriage, And Other Clashes Between Religion and The State*, 53 B.C. L. REV. 1417, 1498-99 (2012), ...30

Statement of Cardinal Timothy Dolan, United States Conference of Catholic Bishops, *HHS Proposal Falls Short In Meeting Church Concerns; Bishops Look Forward To Addressing Issues With Administration* (February 7, 2013) 10

Regulations

45 CFR § 147.130 ..... *passim*

76 Fed. Reg. 46,621 ..... 4, 5, 42

78 Fed. Reg. 8,456 ..... 8, 38, 39, 42, 47

78 Fed. Reg. 8,474 ..... 47, 49, 57

Statutes

15 U.S.C. §§ 1011-1012 22

26 U.S.C. § 36B 26, 28, 29

26 U.S.C. §1402 53

26 U.S.C. §4959 35

26 U.S.C. §4980H ..... *passim*

26 U.S.C. § 4980I.....35

26 U.S.C. §5000A ..... *passim*

26 U.S.C. § 5000B 35

26 U.S.C. § 6033 49

26 U.S.C. §7421(a) 15

42 U.S.C. §300a-7 11

42 U.S.C. §300gg-13..... *passim*

42 U.S.C. §18011 41

42 U.S.C. §18022 ..... 2, 39, 44, 53

42 U.S.C. §18023 ..... 10, 12, 37, 38, 44

42 U.S.C. §18091 ..... 22, 61

Public L. No. 99-272, § 10001 (1986) 21

Public L. No. 111-8.....11

Virginia Health Care Freedom Act, Code of Virginia §38.2-3430.1:1 23

STATEMENT OF JURISDICTION

This Court has jurisdiction pursuant to 28 U.S.C. §1291.

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Whether, in light of *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012), the Anti-Injunction Act, 26 U.S.C. §7421(a), bars this challenge to the Affordable Care Act's employer mandate, 26 U.S.C. §4980H;
2. Whether, in light of *NFIB*, the employer mandate exceeds Congress' powers under the Commerce, Necessary and Proper, and Taxing and Spending Clauses; and
3. Whether and how any developments since the previous briefing in this case may affect the constitutionality of the individual mandate, 26 U.S.C. §5000A, and the employer mandate under the Free Exercise, Establishment, and Equal Protection Clauses.

STATEMENT OF THE CASE

Plaintiffs' appeal is back before this Court following the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012) ("*NFIB*"). In *NFIB*, the Supreme Court held that the Anti-Injunction Act did not bar challenges to the individual mandate, abrogating this Court's decision in *Liberty University v. Geithner*, 671 F.3d 391, 450 (4th Cir. 2011).

On November 26, 2012, the Supreme Court granted Plaintiffs' Petition for Rehearing, vacated its prior denial of Plaintiffs' Petition for Certiorari, granted the Petition, and remanded the case to this Court for further consideration in light of *NFIB. Liberty University v. Geithner*, 133 S.Ct. 679 (2012). On January 17, 2013, this Court ordered supplemental briefing on the issues listed above.

SUPPLEMENTAL STATEMENT OF FACTS[1]

The Act requires that, with few exceptions, all individuals and employers of 50 or more people obtain and maintain government-defined "minimum essential coverage" for employees and dependents. 26 U.S.C. §§5000A, 4980H. Congress only generally defined "minimum essential coverage," stating that, at a minimum, it should include no-cost coverage for preventive care services, immunizations, and screenings for infants, children, adolescents and women as described in guidelines supported by the Health Resources and Services Administration ("HRSA"). 42 U.S.C. §300gg-13. The specifics of "minimum essential coverage," including preventive coverage, were left to the discretion of the Secretary of the Department of Health and Human Services ("HHS"). 42 U.S.C. §18022(b). HHS directed the Institute of Medicine ("IOM") to draft recommendations for the preventive

[1] Plaintiffs confine their Statement of Facts to the facts since the Opening Brief that are relevant to the questions presented.

coverage mandate.[2] "Preventive health services for women" were defined as measures "shown to improve wellbeing, and/or decrease the likelihood or delay the onset of a targeted disease or condition."[3] IOM recommended that these measures include free "contraceptive" coverage, testing for sexually transmitted diseases and screening and counseling for domestic violence.[4] "Contraceptive coverage" ("Preventive coverage" or "Preventive mandate") includes contraceptive medication, sterilization, abortion-inducing drugs (referred to herein as abortifacients, which include the so-called "emergency" or "morning after" drugs), and intra-uterine devices (IUDs). Abortifacients and IUDs often cause abortion and are not merely *contra*ceptives.

HRSA incorporated the IOM recommendations into its "comprehensive guidelines" on women's preventive coverage in 42 U.S.C. §300gg-13(4).[5] Those guidelines require that health insurance policies must include, *inter alia*, "the full range of Food and Drug Administration-approved contraceptive methods,

---

[2] IOM (Institute of Medicine), Committee on Preventive Services for Women, Board on Population Health and Public Health Practice, *Clinical Preventive Services for Women Closing the Gaps* 2 (2011), available at http://www.nap.edu/catalog.php?record_id=13181 (last visited February 22, 2013).

[3] *Id.* at 3.

[4] *Id.* at 10-12.

[5] HRSA, *Women's Preventive Services: Required Health Plan Coverage Guidelines*, available at http://www.hrsa.gov/womensguidelines (last visited February 22, 2013).

sterilization procedures, and patient education and counseling for women with reproductive capacity" in order to qualify as "minimum essential coverage" necessary to satisfy the individual and employer mandates.[6] FDA-approved "contraception" includes so-called "emergency contraception," Levonorgestrel, also known as "Plan B" or the "morning after pill," and Ulipristal acetate, also known as "Ella" or the "week after" pill,[7] both of which often act as abortifacients by terminating the life of a pre-born child.[8] During hearings regarding FDA approval for Ulipristal, medical professionals presented evidence that "Ulipristal acetate is an abortifacient of the same type as mifepristone ("RU-486") and that its approval as an emergency contraceptive raises serious health and ethical issues."[9]

> There is no doubt that Ulipristal acts as an abortifacient because the drug blocks progesterone receptors at three critical areas. These blocking capabilities form the basis of its embryocidal abortifacient mechanism. That mechanism is identical to the action of RU-486 in early pregnancy.[10]

---

[6] 45 CFR § 147.130, incorporating the guidelines at *id*. *See* 76 Fed. Reg. 46,626 (August 3, 2011).

[7] FDA Office of Women's Health Birth Control Guide, available at http://www.fda.gov/birthcontrol (last visited February 22, 2013).

[8] American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG"), Comment to Docket No. FDA–2010–N–0001Advisory Committee for Reproductive Health Drugs; Notice of Meeting Ulipristal acetate tablets, (NDA) 22–474, Laboratoire HRA Pharma. (June 2, 2010), available at http://www.aaplog.org/wp-content/uploads/2010/06/AAPLOG-Ulipristal-Comments_2010.pdf (last visited February 22, 2013).

[9] *Id*.

[10] *Id*.

The FDA guide to "contraceptives" states that "Plan B" and "Ella" prevent "attachment (implantation) [of the embryo] to the womb (uterus)."[11] FDA-approved "contraceptives" also include IUDs, which similarly prevent implantation of embryos and thereby terminate human life, and surgical sterilization.[12]

On August 3, 2011, the Administration issued amended interim final regulations in which it incorporated the HRSA guidelines into the definition of minimum essential coverage. 76 Fed. Reg. 46,621 (August 3, 2011). The Administration had issued interim final regulations on July 19, 2010, which stated that contraceptives would be part of the no-cost women's preventive care requirements. *Id.* at 46,623. In the interval between the interim final regulations and the amended interim final regulations, several commenters said that "requiring group health plans sponsored by religious employers to cover contraceptive services that their faith deems contrary to its religious tenets would impinge upon their religious freedom." *Id.*[13] The Administration responded by granting HRSA

---

[11] FDA Birth Control Guide at 16-17, http://www.fda.gov/birthcontrol (last visited February 22, 2013).

[12] *Id.* at 18-19.

[13] *See, e.g.*, Letter from General Counsel, U.S. Conference of Catholic Bishops to Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (August 31, 2011), stating that the proposal violates the First Amendment and RFRA, available at http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08-2.pdf (last visited on February 25, 2013).

discretion to consider a religious employer exemption, saying "it is appropriate that HRSA, in issuing these Guidelines, takes into account the effect on the religious beliefs of certain religious employers if coverage of contraceptive services were required in the group health plans in which employees in certain religious positions participate." *Id.* The Administration specified that it only wanted "to provide for a religious accommodation that respects the unique relationship between *a house of worship and its employees in ministerial positions*." *Id.* (emphasis added). Therefore, the amendment provided only that HRSA "*may* establish exemptions" from the contraceptive mandate for "religious employers." *Id.* at 46,626. "Religious employers" was initially defined as those whom HRSA determined met *all* of the following criteria: (1) The inculcation of religious values is the purpose of the organization; (2) The organization primarily employs persons who share the religious tenets of the organization; (3) The organization serves primarily persons who share the religious tenets of the organization; and (4) The organization is a non-profit church, integrated auxiliary, convention or association of churches or a religious order. *Id.*

Faith-based organizations complained that the August 2011 exemption did not resolve the violations of right of conscience contained within the Preventive

mandate.[14] In response, the Administration postponed implementation of the Preventive mandate by creating a narrowly defined one-year "temporary enforcement safe harbor" for non-profit organizations that had religious objections to contraceptives and abortifacients but did not fall within the "religious employer" exemption. 77 Fed. Reg. 8,725, 8,728 (February 15, 2012). The Administration represented that the safe harbor would be used to develop alternative accommodations for non-profit organizations that do not meet the religious employer exemption and object to providing Preventive mandate services. *Id.* at 8,728. Meanwhile, President Obama emphasized that any new accommodation must retain the provision of free contraceptives (and abortifacients), and that insurance companies would be required to cover contraceptives (and abortifacients) if the religious organization objected.[15]

On February 1, 2013, the Administration issued a Notice of Proposed Rulemaking ("NPRM") to address the accommodation referenced in the February

---

[14] *See e.g.*, Letter from Richard Land, President, The Ethics and Religious Liberty Commission of the Southern Baptist Convention to Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services (September 30, 2011), available at http://www.regulations.gov/#!documentDetail; D=HHS-OS-2011-0023-77408 (last visited February 25, 2013). Letter from Collegium Aesculapium Foundation, Inc. to Centers for Medicare & Medicaid Services Department of Health and Human Services (September 28, 2011), available at http://www.regulations.gov/#!documentDetail; D=HHS-OS-2011-0023-60660 (last visited February 25, 2013).

[15] *Id.*

15, 2012 regulation. 78 Fed. Reg. 8,456 (February 6, 2013). The NPRM proposes to modify the "religious employer" exemption to remove the first three requirements so that an exemption is available to "a non-profit church, integrated auxiliary, convention or association of churches or a religious order." *Id.* at 8,474. No further exemptions would be available, but the proposal suggests adding an "accommodation" for "eligible organizations." *Id.* An "eligible organization" is defined as a non-profit organization that "holds itself out as a religious organization" and opposes providing some or all of the services under the Preventive mandate. *Id.* Organizations covered by an insurance carrier would allegedly not have to directly pay for the objectionable products. *Id.* at 8,475. The organization would notify its insurance carrier that it objects to paying for certain contraceptive or abortifacient coverage. *Id.* The insurer would then be required to "automatically provide health insurance coverage" for the objectionable services through a separate insurance policy without cost to employees. *Id.* According to the proposal, the issuer of the separate policy could not directly or indirectly charge a fee or premium to the non-profit organization for the objectionable contraceptive or abortifacient services. *Id.* For these organizations which are not self-insured, the NPRM proposes that the cost of the separate

contraceptive/abortifacient policy would be paid for through reductions in the fees the insurer would pay to government insurance exchanges. *Id.*

The Administration did not offer a final proposal for self-insured organizations, such as Liberty University, regarding how the third party coverage would be funded. *Id.* at 8,474. Instead, the Administration offered possible scenarios, each involving some sort of federal fee offset for a third party administrator providing separate contraceptive or abortifacient coverage, and asked for public comments for other approaches. *Id.* at 8,463-8,464. The Administration had no proposal for how self-insured non-profit organizations without third party administrators will be able to comply with providing free contraceptives or abortifacients without incurring costs themselves. *Id.* at 8,464. The contraceptives and abortifacients cost something, and someone has to pay. The Administration says that the person receiving the drugs is not to pay, but also says that the employer who objects to providing such products will "not be required to contract, arrange, pay, or refer for contraceptive coverage." *Id.*at 8,463. As the Administration admits in the NPRM, self-insured organizations such as Liberty University are the only funding source for insurance coverage. There is no way Liberty University can avoid paying for Preventive coverage, including abortifacients. *Id.* at 8,463-8,464. As the United States Conference of Catholic

Bishops remarked, the gaps in the funding mechanism in the NPRM indicates that objecting employers such as Liberty University will have to be involved in paying for or facilitating for payment of the contraceptives/abortifacients.

> [I]t appears that the government would require all employees in our "accommodated" ministries to have the illicit coverage—they may not opt out, nor even opt out for their children—under a separate policy. In part because of gaps in the proposed regulations, it is still unclear how directly these separate policies would be funded by objecting ministries, and what precise role those ministries would have in arranging for these separate policies. Thus, there remains the possibility that ministries may yet be forced to fund and facilitate such morally illicit activities.[16]

The Administration's implementation of the "minimum essential coverage" definition to include abortifacients is significant in light of the language in the Act and accompanying Executive Order, which stated that "abortion" would not be a required coverage and that rights of conscience would be protected, language upon which the district court and Judge Davis relied when analyzing Plaintiffs' religious liberty claims. *Liberty University v. Geithner*, 753 F.Supp.2d 611, 642-643 (W.D. Va. 2010); *Liberty University v. Geithner*, 671 F.3d 391, 450 (4th Cir. 2011) (Davis, J., dissenting). The Act provides that no health plan shall be required to include "abortion" as an essential health benefit. 42 U.S.C. §18023(b)(1). On

[16] Statement of Cardinal Timothy Dolan, United States Conference of Catholic Bishops, *HHS Proposal Falls Short In Meeting Church Concerns; Bishops Look Forward To Addressing Issues With Administration* (February 7, 2013), available at http://www.usccb.org/news/2013/13-037.cfm (last visited February 22, 2013).

March 24, 2010, President Obama signed an Executive Order that reiterated that "abortion coverage" would not be required under the Act. Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (March 24, 2010). President Obama said that the Act "maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges." *Id.* President Obama said that "longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8), remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions." *Id.* Subsequent acts by the Administration reveal that protection of the religious rights of those who object to abortion was not as inclusive as presented, but apparently only applied to surgical abortions, not chemical abortions or abortions caused by IUDs.

The representation that conscience rights against paying for abortion is also not accurate in light of the Act's provision that health insurers *shall* collect directly from each enrollee (without regard to the enrollee's age, sex, or family status) a separate payment of no less than $1 per month for separate coverage of elective

abortions. 42 U.S.C. §§ 18023(b)(2) (B)-(b)(2)(D).[17] While one section of the Act provides that no health plan will be required to provide abortion services, another requires that abortion services be funded through direct payments by insureds. *Id.* Regulations implementing the Act require that all private health insurance plans include free abortifacient drugs and devices. *See* 45 CFR § 147.130. This significant factual development warrants re-examination of Plaintiffs' allegations that the Act's mandates violate religious liberty under the First Amendment and the Religious Freedom Restoration Act ("RFRA").

The Supreme Court ruled that the individual mandate is invalid under the Commerce Clause and the Anti-Injunction Act (AIA) did not bar suit against the Act. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012). While the Court upheld the individual mandate under the Taxing and Spending Clause, it did so based upon a finding that the tax was not punitive. Here, the penalty imposed on employers is punitive, thus triggering the Court's warning that Congress cannot use its taxing authority to destroy. *Id.* at 2600.

[17] For a detailed discussion of this "abortion premium mandate," *see* Brief for American College of Pediatricians, et.al. as Amici Curiae Supporting Respondents, *United States Dep't. of Health and Human Services v. State of Florida*, decided *sub nom. NFIB v. Sebelius*, 132 S.Ct. 2566 (2012) (No. 11-398).

SUMMARY OF ARGUMENT

The Supreme Court's determination that the AIA does not bar challenges to the individual mandate applies equally to the employer mandate, and this Court should proceed to analyze Plaintiffs' challenges on the merits. That analysis will reveal that, as is true with the individual mandate, the employer mandate is not a valid exercise of Congress' Commerce Clause powers. Congress' present regulation of employers who voluntarily provide employee benefits and who can discontinue providing those benefits is not analogous to the intrusive employer mandate that compels unwilling employers into the health insurance market and then holds them hostage with cumulative, multi-million penalties that prevent them from leaving the market, even when providing health insurance coverage will violate sincerely held religious beliefs.

The very reason that led the Supreme Court to find that the individual mandate is a valid exercise of Congress' authority under the Taxing and Spending Clause in *NFIB* must lead this Court to find that employer mandate exceeds that power and transforms it into the power to destroy. The *NFIB* court found that the penalty assessed under the individual mandate does not resemble the punitive assessment imposed in *Bailey v. Drexel Furniture* (*Child Labor Tax Case*), 259 U.S. 20, 36 (1922), and therefore could be regarded as a valid tax. *NFIB*, 132 S.Ct.

at 2596. By contrast, the potentially multi-million dollar penalties assessed under the employer mandate are as punitive or more punitive than those in *Drexel Furniture*, and therefore exceed Congress' Taxing and Spending authority.

Both the individual and employer mandates, as fully defined through the regulations enacted by the Administration, violate Plaintiffs' religious liberties under RFRA, the Free Exercise Clause, Equal Protection and the Establishment Clause. Regulations requiring that individuals and employers purchase or provide coverage for abortifacient drugs contradict representations in the Act and Executive Order that conscience rights would be protected. Both the district court and this Court relied upon those representations when they analyzed and initially dismissed Plaintiffs' religious liberties challenges, and the change in circumstances requires reconsideration of those challenges. The Administration's piecemeal attempts to feign protection of conscience rights while ensuring that free abortifacients are provided to policyholders demonstrate that the individual and employer mandates cannot withstand strict scrutiny analysis and must be declared unconstitutional.

LEGAL ARGUMENT

Plaintiffs' constitutional challenges to the Act are subject to de novo review. *U.S. v. Khan*, 461 F.3d 477, 492 (4th Cir. 2006). Questions of law or mixed

questions of law and fact are reviewed de novo. *Wright v. West*, 505 U.S. 277, 299-202 (1992) (O'Connor, J. concurring). De novo review is particularly appropriate since a court's decision that substantially burdens fundamental rights should not be accorded deference. *Brecht v. Abrahamson*, 507 U.S. 619, 642 (1993) (Stevens, J. concurring).

I. THE ANTI-INJUNCTION ACT DOES NOT BAR THIS CHALLENGE TO THE EMPLOYER MANDATE.

As is true with the individual mandate, the Anti-Injunction Act ("AIA"), 26 U.S.C. §7421(a), does not bar Plaintiffs' challenges to the employer mandate. The Supreme Court determined the "Affordable Care Act does not require that the penalty for failing to comply with the individual mandate be treated as a tax for purposes of the Anti–Injunction Act." *NFIB v. Sebelius*, 132 S.Ct. 2566, 2584 (2012). The virtually identical language describing the penalties for employers requires the same conclusion.

Regarding the AIA and the individual mandate, the Supreme Court focused particularly on language regarding collection and enforcement of the penalty imposed for non-compliance. *Id.* at 2583. Congress directed that "the penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68 [26 U.S.C.

§6671(a)]," *i.e.* in the same manner as taxes. 26 U.S.C. §5000A(g)(1). The Supreme Court stated:

> Section 5000A(g)(1)'s command that the penalty be "assessed and collected in the same manner" as taxes is best read as referring to those chapters and giving the Secretary the same authority and guidance with respect to the penalty. That interpretation is consistent with the remainder of § 5000A(g), which instructs the Secretary on the tools he may use to collect the penalty. The Anti–Injunction Act, by contrast, says nothing about the procedures to be used in assessing and collecting taxes. The Affordable Care Act does not require that the penalty for failing to comply with the individual mandate be treated as a tax for purposes of the Anti–Injunction Act.

Id. at 2484.

The employer mandate contains the same language upon which the Supreme Court relied for its conclusion that the AIA did not apply to the individual mandate, *i.e.*, "[a]ny 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." 26 U.S.C. §4980H(d)(1). The balance of §4980H(d) like the balance of §5000A(g), addresses the timing and procedures for collection of the penalty. As was true with the individual mandate penalty, the employer mandate penalty should not be treated as a tax for purposes of the AIA. *See NFIB*, 132 S.Ct. at 2484. Moreover, unlike the individual mandate penalty, the employer mandate penalty cannot be

characterized as a tax for purposes of the Taxing and Spending Clause. *See infra*, Argument II.B.

As the Supreme Court said in *NFIB*, "[t]he Anti–Injunction Act therefore does not apply to this suit," and this Court should proceed to the merits. *Id.*

II. THE EMPLOYER MANDATE EXCEEDS CONGRESS' ENUMERATED POWERS.

The Supreme Court warned that Congress' enumerated powers must be read carefully "to avoid creating a general federal authority akin to the police power." *NFIB*, 132 S.Ct. at 2578. The Court found the individual mandate exceeded Congress' authority under the Commerce and Necessary and Proper clauses, *id.* at 2593. This Court should conclude that the employer mandate exceeds Congress' authority under the Commerce Clause for the same reasons. However, significant differences between the penalties assessed in the individual and employer mandates mean that, under *NFIB*'s Taxing and Spending Clause analysis, the employer mandate is "so punitive that the taxing power does not authorize it." *See id.* at 2600. Also, if it is regarded as a taxing measure, then it violates the Origination Clause. Since the mandate is not premised upon Congress' other enumerated powers, it is not authorized under the Necessary and Proper Clause. *United States v. Comstock*, 130 S.Ct. 1949, 1970 (2010) (Alito, J., concurring).

A. The Employer Mandate Exceeds Congress' Commerce Clause Authority.

Congress' Commerce Clause power does not extend to the point of compelling citizens to act as the government would have them act. *NFIB v. Sebelius*, 132 S.Ct. at 2589. The Court has "always recognized that the power to regulate commerce, though broad indeed, has limits." *Id.* The individual mandate exceeded those limits because "Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product." *Id.* at 2586. "The Framers gave Congress the power to regulate commerce, not to compel it, and for over 200 years both our decisions and Congress' actions have reflected this understanding. There is no reason to depart from that understanding now." *Id*. at 2589. The individual mandate is unconstitutional if characterized as a command under the Commerce Clause because the federal government "does not have the power to order people to buy health insurance." *Id.* at 2601.

Neither does Congress have the power to order employers to provide government-defined health insurance to their employees. Mandating that employers provide particular government-defined benefits to all employees is not analogous to minimum wage and hour laws. Regulating employee benefit plans that employers voluntarily provide and can discontinue does not give Congress the authority to mandate that employers provide health insurance, dictate what the

insurance policies must include and then effectively prohibit employers from opting out of coverage by imposing debilitating penalties on those that do.

While Congress has offered incentives for employers that voluntarily provide health benefits, until now there has been no statutory mandate requiring employers to provide health insurance.[18] While legislative novelty is not necessarily determinative, sometimes "the most telling indication of [a] severe constitutional problem ... is the lack of historical precedent for Congress's action." *NFIB*, 132 S.Ct. at 2586. "At the very least, we should 'pause to consider the implications of the Government's arguments' when confronted with such new conceptions of federal power." *Id.* (citing *United States v. Lopez*, 514 U.S. 549, 564 (1995)). As in *NFIB*, the implications here are far-reaching and potentially destructive of the constitutional limits placed upon congressional power. 132 S.Ct. at 2587.

Allowing Congress to mandate that employers provide health insurance and dictate the type of coverage goes far beyond regulations of wages and hours upheld under the Commerce Clause. *United States v. Darby*, 312 U.S. 100 (1941); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937). In *Darby* and *Jones*, the

[18] Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and A Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1042 (1996).

Supreme Court carefully discussed the interplay between the challenged provisions and interstate commerce. *Darby*, 312 U.S. at 115; *Jones & Laughlin*, 301 U.S. at 31. The Court was concerned about the effects of strikes on the movement of goods and services and the effects of underpaying workers on competition, and on those bases found that the wage and hour laws comported with the Commerce Clause. *Jones & Laughlin*, 301 U.S. at 31; *Darby*, 312 U.S. at 115. But the Court expressly noted that the "act does not compel agreements between employers and employees. It does not compel any agreement whatever." *Jones & Laughlin*, 301 U.S. at 45. "The act does not interfere with the normal exercise of the right of the employer to select its employees or to discharge them." *Id.* Similarly, the laws under review in *Darby* did not intrude into all aspects of the employment relationship nor dictate what benefits must be provided to employees. *Darby*, 312 U.S. at 115. The challenged provisions were carefully worded to prohibit only the shipment of goods in interstate commerce that were produced by workers who were not paid at least a minimum wage and were required to work more than a maximum number of permitted hours per week. *Id.* at 110.

The employer mandate also goes beyond employee benefit regulations such as ERISA and COBRA, which only apply if employers have voluntarily agreed to provide employee benefits. "In contrast to the obligatory, nationwide Social

Security program, '[n]othing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.'" *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) (citing *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996)). Similarly, under COBRA, employers retain their freedom not to offer or to discontinue offering employee health insurance benefits. Public L. No. 99-272, § 10001 (1986), 100 Stat. 82. But, if the employer mandate is upheld, employers will no longer have the freedom to determine whether they will provide employee benefit plans, and if they do provide them, what they will include. Instead, employers must either: (1) provide a government-defined health insurance plan that includes, *inter alia*, free abortifacient drugs and devices, or (2) pay debilitating penalties of $2,000 to $3,000 per employee. 26 U.S.C. §4980H. The excessive penalties leave employers with no choice, much like the individual mandate, which forces an unwilling individual to buy an unwanted product. Unlike ERISA and COBRA, under the mandate employers will not be able to discontinue offering benefits to employees and escape regulation . *Id.* Employers will always be subject to the mandate, either through providing the required coverage or being penalized excessively for failing to do so. *Id.* Being unable to opt-out is particularly problematic for faith-based employers such as Liberty University that

have sincerely held religious beliefs against facilitating or paying for abortions. (JA 0029). These faith-based employers will have to either violate their religious beliefs by providing abortion coverage or pay exorbitant penalties, thus substantially burdening those who choose to exercise their right of conscience. 26 U.S.C. §4980H.

The Act claims Congress has power under the Commerce Clause to enact the individual and employer mandates because "[i]n *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." 42 U.S.C. §18091(3). However, shortly after *South-Eastern Underwriters,* Congress passed the McCarran-Ferguson Act, which clarified that Congress cannot exercise its Commerce Clause power in a way that supersedes, invalidates or impairs state lawmaking and administrative regulation of insurance. 15 U.S.C. §§ 1011-1012; *See Humana, Inc. v. Forsyth*, 525 U.S. 299, 309-10 (1999) (explaining the interaction between federal and state regulation of insurance under McCarran-Ferguson).

Responding to the Supreme Court's sweeping pronouncement in *South-Eastern Underwriters*, Congress clarified that federal regulation of insurance is only permissible when it does not directly conflict with state regulation, and when

application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime. *Id.* at 310. That is not the case here, where Congress is not merely seeking to regulate insurance alongside the states, but seeking to compel the citizens of the various states who are not part of the regulated industry to become part of it, something which the Commerce Clause does not permit. *NFIB v. Sebelius*, 132 S.Ct. at 2589. Several states, including the Commonwealth of Virginia, have enacted laws which provide that residents cannot be compelled to purchase insurance nor penalized for failing to comply. *See* Virginia Health Care Freedom Act, Code of Virginia §38.2-3430.1:1.[19] The employer mandate directly conflicts with these statutes in a way that is prohibited under McCarran-Ferguson.

Upholding the employer mandate "would open a new and potentially vast domain to congressional authority" under the Commerce Clause. *NFIB v. Sebelius*, 132 S.Ct. at 2587. This would empower Congress to "reach beyond the natural extent of its authority, 'everywhere extending the sphere of its activity and drawing all power into its impetuous vortex.'" *Id.* (citing THE FEDERALIST No. 48, at 309

[19] For further discussion of the Virginia statute, *see* Opening and Response Brief of Commonwealth of Virginia, *Commonwealth of Virginia v. Sebelius,* 656 F.3d 253 (4th Cir. 2011) (No. 11-1057).

(James Madison)). The employer mandate exceeds Congress' Commerce Clause authority.

B. The Employer Mandate Is Punitive And Not A Permissible Tax Under The Taxing And Spending Clause.

Although the Supreme Court found that the individual mandate "would be unconstitutional if read as a command" under the Commerce Clause, it concluded that it could be upheld under the Taxing and Spending power. *NFIB,* 132 S.Ct. at 2601. The Court ruled that while Congress cannot command that individuals purchase an unwanted product, it can tax individuals who choose not to purchase the product. *Id.* The assessment imposed under 26 U.S.C. §5000A did not cross the line between a permissible tax and impermissible punitive penalty as described in *Bailey v. Drexel Furniture,* 259 U.S. 20 (1922). *Id.* at 2596. "The reasons the Court in *Drexel Furniture* held that what was called a 'tax' there was a penalty support the conclusion that what is called a 'penalty' here may be viewed as a tax." *Id.* Those same reasons, when applied to the employer mandate, 26 U.S.C. § 4980H, yield the opposite conclusion, *i.e.*, that the mandate contains a prohibitive penalty similar to the one struck down in *Drexel Furniture*.

Critical to the Court's conclusion that the individual mandate was a permissible tax was the fact that the assessment for non-compliance did not cross the line from a reasonable payment in lieu of health insurance to a prohibitive,

potentially destructive penalty. *NFIB,* 132 S.Ct. at 2595-2596. By contrast, the various penalties assessed under the employer mandate do cross that line, as did the penalties found impermissible in *Drexel Furniture.* The *NFIB* court found that the penalty imposed for noncompliance with the individual mandate could be seen as a reasonable financial trade-off for individuals who chose not to purchase health insurance. *NFIB,* 132 S.Ct. at 2595-2596. "First, for most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more." *Id. See* 26 U.S.C. §5000A(c). "It may often be a reasonable financial decision to make the payment rather than purchase insurance…." *Id.* at 2596. By contrast, in *Drexel Furniture,* an employer which failed to comply with a complicated and detailed regulatory scheme regarding child labor was assessed a penalty of 10 percent of its net income for an entire year. *Drexel Furniture*, 259 U.S. at 36. "The amount is not to be proportioned in any degree to the extent or frequency of the departures, but is to be paid by the employer in full measure whether he employs 500 children for a year, or employs only one for a day." *Id.* *Drexel Furniture* called the penalty "a heavy exaction for a departure from a detailed and specified course of conduct in business." *Id.* The *NFIB* court agreed, and also characterized the assessment in *Drexel Furniture* as a "prohibitory financial punishment" that was unlike the individual mandate penalty which is

capped at the cost of the insurance policy that the individual failed to purchase. *NFIB*, 132 S.Ct. at 2596. Unlike the impermissible penalty in *Drexel Furniture*, "the shared responsibility payment merely imposes a tax citizens may lawfully choose to pay in lieu of buying health insurance." *Id.* at 2597. However, there is still a line Congress cannot cross. *Id.* at 2600. "[W]e need not here decide the precise point at which an exaction becomes so punitive that the taxing power does not authorize it." *Id.* It remains true that the "'power to tax is not the power to destroy while this Court sits.'" *Id.* (citing *Oklahoma Tax Comm'n v. Texas Co.*, 336 U.S. 342, 364 (1949)).

With the employer mandate penalty, that line has been crossed. Unlike the individual mandate penalty, the penalties imposed for noncompliance with the employer mandate have the prohibitory, punitive nature found impermissible in *Drexel Furniture* and therefore cross the line. *Id.* As was true in *Drexel Furniture*, the employer mandate imposes a complex regulatory scheme upon employers and exacts a heavy toll on those who depart from *any* of the rules. Employers of more than 50 "full time equivalent" employees must provide government-defined "minimum essential coverage," offering at least "minimum value" of costs and benefits, at a price that is "affordable." 26 U.S.C. §§36B, 4980H, 5000A. Employers who fail to comply with *any* requirement, as to even *one* employee,

face penalties that are themselves complex formulas not tied to or capped at the cost of health care coverage (as is the penalty under the individual mandate). 26 U.S.C. §4980H.

Two levels of penalties are imposed upon employers, one for employers that do not offer "minimum essential coverage," and one for employers that do offer such coverage but which the Administration determines does not meet "affordability" standards. 26 U.S.C. §4980H(a),(b). If an employer fails to offer what the Administration defines as "minimum essential coverage" for any month, then it will be assessed a penalty of $166.67 (1/12 of $2,000) multiplied by the number of full-time equivalent employees for that month. 26 U.S.C. §§4980H(a),(c)(1). That penalty would be applied not merely if employers fail to provide any coverage, but if they provide coverage that does not include all of the features dictated by the government, including those that violate their religious beliefs. *Id.* Consequently, if Liberty University continued to provide health insurance to its employees but refused to provide free abortifacients, then it would pay $2,000 per employee per year for not having "minimum essential coverage," and would also still be paying the premiums for its employees. *Id.* If Liberty University cancelled all employee health insurance policies, then it would still pay $2,000 per employee per year for not offering coverage, *id*.

The punitive nature of the penalties is particularly apparent in the second level of penalty imposed against employers that provide "minimum essential coverage" the Administration deems is "unaffordable." 26 U.S.C. §§4980H(b), 36B. These employers are forced to pay for "minimum essential coverage," but the Administration will still penalize them if even one of perhaps thousands of employees seeks a tax credit or subsidy because the employee portion of the premium is more than 9.5 percent of the employee's household income (the Administration's definition of "affordable"). 26 U.S.C. §§36B, 4980H(b). The penalty for "unaffordable" coverage begins in 2014 at $250 per month (1/12 of $3,000) multiplied by the number of full-time equivalent employees. 26 U.S.C. §§36B, 4980H(b), and is adjusted for inflation. 26 U.S.C. §§4980H(c)(5). As was true with the penalty in *Drexel Furniture*, the penalty here is "not to be proportioned in any degree to the extent or frequency of the departures, but is to be paid by the employer in full measure"[20] if even one of thousands of employees seeks help for payment of health insurance premiums. 26 U.S.C. §§36B, 4980H(b).

The penalties imposed under the employer mandate go beyond a payment in lieu of providing health insurance coverage, as could be said about the individual mandate payment, to punishing employers for not offering what the government

[20] *Drexel Furniture*, 259 U.S. at 36.

has defined as "minimum essential coverage," or even for offering that coverage but not ensuring that it is what the government deems is "affordable" for employees at *all* salary levels. *Id.* Liberty University will face millions of dollars of penalties for offering coverage if the employee's share for even *one* employee or "full time equivalent" is greater than 9.5 percent of the employee's *household* income. 26 U.S.C. §§36B, 4980H, 5000A. A "full time equivalent" is someone working 30 hours per week.[21]

As was true with the penalty in *Drexel Furniture*, the penalty is not proportional in that if *only one* employee seeks a federal subsidy because his share of the premium for coverage is "unaffordable" at the lowest salary level, the employer will be penalized more than if it had denied *all* employees coverage. *Id.*

[21] A 30-hour "full time equivalent" employee earning $16,000 whose insurance cost more than $1,520 annually will mean the entire employer coverage (even if it otherwise meets every demand of the Act) is "unaffordable" and subject to the $3,000 penalty per employee per year. An employee can work 10 hours through the fall, spring and winter but 30 hours in the summer and may qualify as a "full time equivalent" employee. Moreover, the Act speaks of "household income," meaning a family of four with a single income-earner will easily make the entire coverage "unaffordable" because the single income for the household will be the comparison number for the cost of the entire household. If each person's health insurance cost only $2,500, then the single income-earner will need to make over $100,000 to maintain an "affordable" plan.

The penalties quickly become "massive," even destructive.[22] For the 2012 period, Liberty University employed 6,900 people. The University's net claims were $14,214,000. Liberty University will be fined $20,700,000 ($3,000 x 6,900) if only *one* employee meets the 9.5 percent "unaffordable" criteria. That penalty will be imposed on top of what Liberty University will have to pay for providing coverage that excludes abortifacients. That additional penalty of $2,000 per employee amounts to $13,800,000, for a combined penalty of $34,500,000![23] If

---

[22] Robin Fretwell Wilson, *The Calculus Of Accommodation: Contraception, Abortion, Same-Sex Marriage, And Other Clashes Between Religion and The State*, 53 B.C. L. REV. 1417, 1498-99 (2012), listing examples such as the University of Notre Dame, with 16,445 employees, which would face an annual penalty of $32.8 million if it were determined to not offer "minimum essential coverage" and $49.3 million if it offers coverage deemed unaffordable.

[23] This $34,500,000 is on top of the $14,214,000 Liberty University paid in net claims during the 2012 coverage period. The penalty for providing insurance that does not meet the "minimum essential coverage" (such one that excludes Preventive coverage) and the penalty for providing insurance which is deemed not "affordable" (the 9.5 percent formula) are cumulative. The penalty per employee per year for not providing any coverage is $2,000; for providing "affordable" coverage that meets the "minimum essential coverage" but where one employee seeks a subsidy outside the coverage (such as when the employer refuses to cover contraceptive, sterilization or abortifacient drugs or devices), is $2,000; and for providing the "minimum essential coverage" but where one employee meets the 9.5 percent formula and the coverage deemed "unaffordable" is $3,000. These penalties will increase for 2013 because the number of projected employees is 7,610. The penalties will be $15,227,610 for providing insurance without the Preventive mandate, and $22,830.000 for providing insurance which is not deemed "affordable."

Liberty University decided not to offer any coverage, it would pay $13,800,000 for 2012 and $15,227,000 for 2013.

Unlike the individual mandate penalty that cannot be more than the cost of an insurance policy for the individual, these multi-million dollar penalties go beyond being a financial incentive to being "so punitive that the taxing power does not authorize it." *NFIB*, 132 S.Ct. at 2600. In enacting the employer mandate, Congress transformed the power to tax into the power to destroy. *Id.* It cannot be upheld as a permissible exercise of Congress' power under the Taxing and Spending Clause.

The employer mandate also cannot be upheld as a permissible tax as applied to non-profit organizations such as Liberty University, which is designated as a tax-exempt organization under 26 U.S.C. §501(c)(3) (JA 0026). The federal government has determined that Liberty University shall not be subject to taxation, and cannot now renege upon that promise in order to shore up the unconstitutional employer mandate. *See Bob Jones University v. United States*, 461 U.S. 574, 589-91(1983) (discussing history and intent of tax exemptions for charitable organizations). *See also, Kleinsasser v. United States,* 522 F. Supp. 460, 462 (D. Mont. 1981), *aff'd sub nom., Kleinsasser on Behalf of Kleinsasser v. United States,* 707 F.2d 1024 (9th Cir. 1983) (stating that once the government accepts an

organization as tax exempt it cannot change that status to suit its necessity or its convenience). The tax-exempt status of Liberty University is further evidence that the employer mandate cannot be upheld under the Taxing and Spending Clause.

C. The Employer Mandate Is Not Authorized Under The Necessary And Proper Clause.

Although the *NFIB* court found that the individual mandate was authorized under the Taxing and Spending Clause, it nonetheless found that it represented a "great substantive and independent power" that could not be sustained under the Necessary and Proper Clause. *NFIB*, 132 S.Ct. at 2592-2593. Laws have been upheld as necessary and proper only when they "involved exercises of authority derivative of, and in service to, a granted power." *Id.* Rather than being a law that is narrow in scope or incidental to the exercise of an enumerated power, the individual mandate is a substantial expansion of federal authority. *Id.* Even if the individual mandate could be said to be "necessary" to the Act's insurance reforms, it is not a "proper" means for making those reforms effective. *Id.*

The same is true of the employer mandate, which, unlike the individual mandate, cannot even be said to be a proper exercise of Congress' Taxing and Spending authority. The employer mandate is an exercise of a "great substantive and independent power" that is not authorized by the Constitution. *See id.* at 2593.

The Necessary and Proper Clause "does not give Congress carte blanche" to create such new power, but must be premised upon an existing enumerated power. *United States v. Comstock*, 130 S.Ct. 1949, 1970 (2010) (Alito, J., concurring). The employer mandate, like the individual mandate, is not a permissible exercise of Congress' power under the Necessary and Proper Clause.

D. The Act Violates The Origination Clause.

As this Court acknowledged in its Supplemental Briefing Order, the Supreme Court's determination that the individual mandate is constitutional as a tax requires analysis of whether the employer mandate can be upheld as a valid exercise of Congress' taxing power. From the outset, Plaintiffs have argued that Congress exceeded its enumerated powers when it enacted the mandates. (JA0033-0035). The district court determined that the mandates were permissible exercises of Congress' Commerce Clause authority and did not reach the question of whether it was valid under other enumerated powers. *Liberty University v. Geithner*, 753 F.Supp.2d at 630. Plaintiffs argued that the employer mandate was not a permissible taxing measure. (Dkt. 10, pp. 40-44). Defendants relied primarily upon the Commerce Clause in their argument, and argued as an aside that it would also be a valid exercise of Congress' authority under the Taxing and Spending Clause. (Dkt. 34, pp. 54-59). This Court did not reach the issue, but dismissed the

case on jurisdictional grounds after finding that it was barred by the AIA. *Liberty University v. Geithner*, 671 F.3d at 414-15.

Inherent in Plaintiffs' *ultra vires* challenge to the mandates is that they exceed Congress' authority under the Constitution, including the power to tax and spend. Congress' power to tax and spend, in turn, is governed by constitutional requirements regarding the relative powers of the House of Representatives and the Senate. Const. art. I §7, cl. 1. The Origination Clause states that: "All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may propose or concur with Amendments as on other Bills." Const. art. I §7, cl. 1. Though denominated with a House bill number, the Act actually originated in the Senate, and therefore violates the Origination Clause.

NFIB held that the individual mandate penalty "yields the essential feature of any tax: it produces at least some revenue for the Government." *NFIB*, 132 S.Ct. at 2594. "Indeed, the payment is expected to raise about $4 billion per year by 2017." *Id.* If, as *NFIB* stated, the Act is a bill raising revenue, then it can be upheld only if it originated in the House of Representatives. *United States v. Munoz-Flores*, 495 U.S. 385, 400 (1990).

A bill is regarded as a "revenue bill" if it raises revenue to support government generally, as opposed to establishing a discrete governmental program

and funding for that program. *Id.* at 398. The penalties imposed under the individual mandate are reported on standard income tax returns and collected by the IRS as part of its regular tax collecting duties. *NFIB*, 132 S.Ct. at 2594. The penalties imposed for noncompliance with the employer mandate are reported to and collected by the IRS and are not designated for any particular program or fund. 26 U.S.C. §4980H. The same is true of other excise taxes enacted as part of the Act. *See e.g.*, 26 U.S.C. § 4980I (a) ("excise tax" on high cost employer-sponsored health coverage); 26 U.S.C. §4959 ("excise tax" on failure to meet hospital exemption requirements); 26 U.S.C. § 5000B ("excise tax" on indoor tanning services). The Act does not create a special fund for health insurance coverage or other specialized services as did the crime victims assistance act in *Munoz-Flores*, 495 U.S. at 398. Therefore, unlike the bill in *Munoz-Flores*, the Act is a revenue raising bill subject to the Origination Clause. *See id.*

Although denominated as "HR 3590," the Act as signed by President Obama originated in the Senate, not the House. HR 3590 as originally approved in the House was entitled, ''An Act to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed

Forces and certain other Federal employees, and for other purposes."[24] On November 19, 2009, Sen. Harry Reid (D-NV) introduced an "amendment" *which struck all of the language after the enacting clause and inserted language that became the 2,000+ pages of the Act* adopted by the Senate on December 24, 2009 and signed by President Obama on March 23, 2010.[25] The Senate attempted to disguise its action as merely an amendment of an existing revenue bill originating in the House, when in fact it was drafting wholly unrelated *entirely new legislation* that is expected to raise billions of dollars in revenue. *See NFIB*, 132 S.Ct. at 2594. This Court should look beyond the label and determine that the Act violates the Origination Clause. If the mandates are taxes designed to raise revenue, they are unconstitutional because revenue bills must originate in the House, and the Act originated in the Senate. The entire Act is therefore invalid.

III. THE MANDATES AND THEIR IMPLEMENTATION VIOLATE THE FREE EXERCISE OF RELIGION.

The Act and its implementation of the "minimum essential coverage" requirement underscore how the Act undermines the most fundamental rights protected by the Bill of Rights—the free exercise of religion−as well as statutory

[24] Title of HB 3590 as adopted by House of Representatives October 8, 2009, available at http://thomas.loc.gov/home/gpoxmlc111/h3590_eh.xml (last visited February 14, 2013).

[25] 111 Cong. Rec. S11607 (November 19, 2009) (Text of Amendment as introduced); PL 111-148, March 23, 2010, 124 Stat 119 (Text of Bill as signed).

protections against substantial government burdens upon religious exercise. Even before the Administration promulgated regulations requiring that all insurance policies cover abortifacient drugs and devices, the Act conflicted with Plaintiffs' free exercise of religion by requiring that individuals and employers pay at least one dollar per person per month directly into an account to cover elective abortions. *See* 42 U.S.C. §18023(b)(2) (JA0029). The subsequent determination that "minimum essential coverage" must include, *inter alia*, free abortifacient drugs and devices, increased the direct collision with Plaintiffs' free exercise of religion. To Plaintiffs, abortion violates their sincerely-held religious beliefs that God is the Author of life and abortion is murder and a sin against God. (JA 0029). Liberty University and Miss Waddell and Mrs. Merrill will be required to choose between (1) exercising their free exercise rights and paying exorbitant penalties, or (2) abandoning sincerely held religious beliefs in order to avoid governmental sanctions.

Both the district court and Judge Davis of this Court pointed to 42 U.S.C. §18023 and the accompanying Executive Order that rights of conscience would be protected against compelled payment for abortions when they concluded that Plaintiffs had failed to state a claim for violation of RFRA and First Amendment Free Exercise rights. *Liberty University v. Geithner*, 753 F.Supp.2d at 642-643;

Liberty University v. Geithner, 671 F.3d at 450 (Davis, J., dissenting). Judge Davis added, "[i]f appellants had plead[ed] sufficient facts to demonstrate a substantial burden to their exercise of religion, I would be forced to consider the relevance of the RFRA to a subsequent act of Congress." *Id.* at 451. The Act and its implementation demonstrate that the mandates impose a substantial burden upon Plaintiffs' exercise of religion. This Court should reconsider Plaintiffs' constitutional and statutory challenges to the mandates.

A. The Mandates Require That Employers Provide And Individuals Pay For Abortion Coverage In Violation of RFRA.

The Act's requirement that individuals and employers pay directly into an account to cover elective abortions signaled that the mandates would pose a threat to religious freedom. 42 U.S.C. §18023(b)(2). That threat was fully realized with the promulgation of regulations requiring that all insurance policies must provide coverage for abortifacients, at no cost to policyholders. 45 CFR § 147.130; 78 Fed. Reg. 8,456. These latest developments undermine the assumptions upon which the Plaintiffs' RFRA claim was dismissed.

1. The Employer Mandate Violates RFRA.

Defining the "minimum essential coverage" that all employers must provide to include abortion-inducing drugs and devices places a substantial burden upon Liberty University's free exercise of religion. From its initial regulations defining

"minimum essential coverage" through the most recent NPRM, the Administration has made it clear that, regardless of religious beliefs to the contrary, faith-based employers (with only narrow exceptions that are themselves constitutionally suspect), are required to provide abortifacients or pay crippling penalties.

Liberty University is on a collision course with the Act, because under force of penalty, the Act mandates that the University violate its religious beliefs and obey the law or adhere to its beliefs and violate the Act. 42 U.S.C. §§ 300gg, 18022; 45 CFR § 147.130. The penalty for violating the Act is crippling. 45 CFR § 147.130; 78 Fed. Reg. 8,456. The Act places an impermissible burden upon religious exercise. *Thomas v. Review Bd. of Ind. Emp't Sec*., 450 U.S. 707, 717-18 (1981).

> Where the state conditions receipt of an important benefit upon conduct proscribed by a religious faith, or where it denies such a benefit because of conduct mandated by religious belief, thereby putting substantial pressure on an adherent to modify his behavior and to violate his beliefs, a burden upon religion exists. While the compulsion may be indirect, the infringement upon free exercise is nonetheless substantial.

Id. Here, the burden involves much more than merely being denied a government benefit. It is an imposition of punishment. For refusing to provide abortifacient drugs or devices, Liberty University will be penalized at the rate of $2,000 per employee per year, or between $13.8 and $15.2 million. 26 U.S.C. §4980H. If it

provides coverage which is deemed unaffordable, it will be fined an additional $20.7 to $22.8 million. If Liberty University stops providing any insurance coverage, it will be fined between $13.8 and $15.2 million. The latter option is no option at all in that it collides with basic religious beliefs that an employer should treat its employees with Christian charity and pay them what they are worth.[26] Both options collide with the free exercise of religion. This is precisely the kind of coercive burden that RFRA was designed to remedy. *See Thomas*, 450 U.S at 718; *See also, Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 424 (2006).

Congress enacted a more stringent version of the compelling interest test under RFRA than is employed under the First Amendment since *Employment Div. v. Smith*, 494 U.S. 872 (1990). *O Centro Espirita*, 546 U.S. at 438. Under RFRA, the government must demonstrate it has a compelling interest and that such interest be applied to the *particular party* whose sincere exercise of religion is being substantially burdened. *Id.* at 430-31 (citing 42 U.S.C. § 2000bb-1(b)). The Administration cannot merely assert an interest in uniform application of laws such as the Controlled Substances Act, which was at issue in *O Centro Espirita*,

[26] *See, e.g.*, Jeremiah 22:13 (Shallum built injustice into the walls of the buildings he constructed by refusing to pay his laborers a fair wage); Luke 10:7 (a laborer is worthy of his wages); 1 Timothy 5:18 (same).

compulsory education, which was at issue in *Wisconsin v. Yoder*, 406 U.S. 205 (1972), or the abortifacient mandate at issue here. *See O Centro Espirita*, 546 U.S. at 431-32.

The Administration must demonstrate that granting a religious exemption to *Liberty University* will seriously compromise its ability to administer the program of providing Preventive coverage. *See id.* at 435.[27] The Administration cannot meet this high standard in light of the substantial exemptions it has already granted for the mandate in general and Preventive coverage in particular. *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547 (1993). "[A] law cannot be regarded as protecting an interest of the highest order when it leaves appreciable damage to that supposedly vital interest unprohibited." *Id.* Congress created exemptions for small employers and grandfathered health plans. 26 U.S.C. § 4980H(c)(2) (exempting from health care provision requirement employers of less than 50 full-time employees); 42 U.S.C. § 18011 (grandfathering of existing health care plans).

More notably, the Administration's creation of a "religious employer" exemption and now a proposed "accommodation" itself demonstrates that

[27] The same is true of the individual Plaintiffs with respect to their similar objection to the individual mandate that requires them to violate their religious beliefs regarding abortion.

excluding certain employers from the mandate does not threaten the integrity of the Act. 76 Fed.Reg. 46,621, 46,626; 78 Fed. Reg. 8,456. As was true with the exemption for sacramental use of illegal drugs for Native American religious adherents and the government's claim that it could not exempt similar use by the O Centro Espirita Church, the Administration's creation of a partial exemption for certain religious employers and Congress' exemption of small employers and grandfathered plans belies any claim that there is a compelling interest in denying exemptions for Liberty University. *See O Centro Espirita*, 546 U.S. at 436-37. As the Colorado District Court said in granting a preliminary injunction against the Preventive mandate, "[t]he government has exempted over 190 million health plan participants and beneficiaries from the preventive care coverage mandate; this massive exemption completely undermines any compelling interest in applying the preventive care coverage mandate to Plaintiffs." *Newland v. Sebelius*, 881 F. Supp. 2d 1287, 1297-98 (D. Colo. 2012).

The Administration's piecemeal "religious employer" exemption to the Preventive mandate also demonstrates that the mandate is not the least restrictive means for accomplishing a compelling interest. *Sherbert v. Verner*, 374 U.S. 398, 407 (1963). To show that the mandate is the "least restrictive means" available, the Administration must "demonstrate that no alternative forms of regulation would

[serve its interest] without infringing First Amendment rights." *Id.* If the government "has open to it a less drastic way of satisfying its legitimate interests, it may not choose a [regulatory] scheme that broadly stifles the exercise of fundamental personal liberties." *Anderson v. Celebrezze*, 460 U.S. 780, 806 (1983).

That is precisely what the Administration has done in enacting the Preventive mandate. The very act of drafting a narrow "religious employer" exemption and then an additional "accommodation" demonstrates that there was and is a less drastic way to provide the kind of Preventive coverage the Administration claims is necessary, even if Preventive coverage were a compelling government interest (which it is not). In light of the substantial evidence provided to the Administration regarding the adverse effects that Preventive coverage mandate will cause to religious beliefs,[28] it can be assumed that the Administration knew that its proposal would stifle the fundamental rights of employers (and their employees), but chose that avenue anyway. The Administration cannot establish that it has chosen the least restrictive means to implement its purported interest. *Celebrezze*, 460 U.S. at 806.

2. The Individual Mandate Violates RFRA.

The Act and its implementation respecting abortion violate RFRA. Section 5000A of the Internal Revenue Code, like Section 4980H, requires that individuals,

[28] *See* references in notes 13 and 14.

with few exceptions, must demonstrate that they have "minimum essential coverage" as defined under 42 U.S.C. §§300gg, 18022, and now implemented under 45 CFR § 147.130. As is true with the employer mandate, the requirement that "minimum essential coverage" include contraceptives and abortifacients leaves individuals such as Plaintiffs Waddell and Merrill with a Hobson's choice. They must either violate their sincerely held religious beliefs by purchasing insurance that requires payments of at least one dollar per month for the "abortion premium" under 42 U.S.C. §18023(b)(2) and covers abortifacients under 45 CFR §147.130, or pay a tax for refusing to violate their beliefs. 26 U.S.C. §5000A. Prior to the Act, individuals could exercise their sincerely held religious beliefs by either not purchasing health insurance and financing care on their own, or purchasing health insurance that did not pay for abortions or abortifacients. Those choices are no longer available, as individuals must either violate their sincerely held religious beliefs or pay the tax penalty described in Section 5000A.

The choice posed by the individual mandate is similar to choices found impermissible under *Thomas*, 450 U.S. at 717-18, and *Sherbert*, 374 U.S. at 404. In *Thomas*, the Court found that requiring the plaintiff to choose between violating his religious beliefs by producing implements of war or lose his job constituted a substantial infringement of religious exercise. *Thomas*, 450 U.S. at 718. In

Sherbert, the Court found that denying unemployment benefits because the plaintiff refused to work on her Sabbath forced her to choose between following the precepts of her religion and forfeiting benefits or abandoning one of the precepts of her religion in order to accept work. *Sherbert*, 374 U.S. at 404. The Court compared the governmental imposition of such a choice to putting the same kind of burden upon the free exercise of religion as would a fine imposed against the employee for her Saturday worship. *Id.* That is precisely the burden imposed upon individuals by the Act and the regulations. Individuals are given a choice of violating their religious beliefs by buying insurance that pays for abortion services or paying a fine in order to abide by their beliefs.

The Administration cannot satisfy the more stringent compelling interest test under RFRA. *O Centro Espirita,* 546 U.S. at 435. The exemptions granted to participants in "health care sharing ministries," members of "recognized religious sects," Indian tribes, and those who cannot afford coverage, 26 U.S.C. §§5000A(d),(e), like the exemptions granted to "religious employers" under Section 4980H, show that the Administration cannot establish that respecting individuals' religious rights will seriously compromise its ability to administer the Preventive coverage program. *See id.* Since members of exempted organizations and Indian tribes as well as individuals who cannot afford coverage are not

required to carry insurance that pays for Preventive coverage, Plaintiffs Waddell and Merrill should not be forced to pay for abortion coverage or pay a penalty for refusing to obtain coverage. *Church of the Lukumi Babalu Aye,* 508 U.S. at 547.

Likewise, the Administration cannot establish that the individual mandate and its requirement for abortion coverage is the least restrictive means of accomplishing its asserted interests. *Sherbert,* 374 U.S. at 407. Congress and the Administration have already determined that their interests can be effectuated without the participation of those who are part of health sharing ministries, certain religious sects and Indian tribes, as well as those who cannot afford coverage. 26 U.S.C. §§5000A(d),(e). By exempting these groups from participation in the individual mandate in its entirety, the government has shown that there are ways to serve its interest without requiring that individuals to pay for abortion and thus be forced to choose between violating their religious beliefs and government sanction. The Preventive mandate that requires an abortion payment is not the least restrictive means. *Sherbert,* 374 U.S. at 407.

Regardless of whether the individual abortion payment can be viewed as a permissible exercise of Congress' Taxing and Spending power, it cannot infringe upon individual rights protected by RFRA. The forced abortion payment violates RFRA and must be stricken.

B. The Mandates Require That Employers Provide Abortifacients And Individuals Pay For Abortion Coverage In Violation Of The Free Exercise Clause.

The Act and its implementation regarding abortion and abortifacients is not a neutral, generally applicable law. *Employment Div. v. Smith*, 494 U.S. 872, 878 (1990). The history of the Administration's rulemaking, from the initial regulations that included a narrowly defined "religious employers" exemption (45 CFR §147.130), to the most recent proposal of a "religious employers" exemption and "accommodations" for non-profit but not for-profit faith based organizations (78 Fed. Reg. 8,456, 8,474), illustrates that the mandates contain individualized exemptions so that strict scrutiny is required. *Id.* at 884. The exemptions/proposed accommodations contained within the Preventive coverage mandate consist of religious gerrymanders that do not "protect religious observers against unequal treatment," and cannot survive strict scrutiny review under the Free Exercise Clause. *Church of the Lukumi Babalu Aye*, 508 U.S. at 531.

The Administration's rulemaking undermines the entire basis for the district court's rejection of Plaintiffs' First Amendment challenge. *See Liberty University v. Geithner*, 753 F.Supp.2d at 642-643; *Liberty University v. Geithner*, 671 F.3d at 450 (Davis, J., dissenting). The employer and individual mandates violate the Free Exercise Clause.

1. The Employer Mandate Violates The Free Exercise Clause.

Even before the Administration included free abortifacient drugs in the definition for "minimum essential" coverage, the employer mandate contained individualized exemptions that undermined the Administration's claim that the law was generally applicable. Both in the text of the statute, *See* 26 U.S.C. §4980H (c)(2)(A), and in practice, the Administration granted waivers of certain provisions of the Act to more than 1,000 companies, covering millions of employees.[29] The Administration's recent attempt to craft a "religious employer" exemption and an "accommodation" for non-profit but not for-profit companies offers even more evidence that the employer mandate is neither neutral nor generally applicable. The most recent actions create a differential hierarchy of who will be regarded as "religious enough" to warrant an exemption from the Preventive coverage mandate, thereby creating the kind of unequal treatment that violates the First Amendment. *Church of the Lukumi Babalu Aye*, 508 U.S. at 542.

Under the regulations, only employers that fulfill all of the following are considered "religious" enough to be exempt from providing free contraceptives to their employees. The organization must (1) inculcate religious values as part of its

[29] As of January 6, 2012, the Department of Health and Human Services reported that it had granted waivers of various provisions of the Act to 1,231 companies.http://cciio.cms.gov/resources/files/ approved_applications_for_waiver. html. (last visited February 19, 2013).

purpose; (2) primarily employ persons who share the religious tenets of the organization; (3) serve primarily persons who share the religious tenets of the organization; and (4) be a non-profit as described in 26 U.S.C. §§ 6033(a)(1), (a)(3)(A)(i) or (iii), *i.e.*, churches, their integrated auxiliaries, and conventions or associations of churches, or the exclusively religious activities of any religious order. 45 CFR § 147.130(iv)(B). Under the NPRM, only organizations which qualify as churches, their integrated auxiliaries, and conventions or associations of churches, or the exclusively religious activities of any religious order would be considered "religious" enough for an exemption. 78 Fed. Reg. 8,474. Other "eligible organizations" might qualify for an "accommodation" on the contraceptive mandate if the organization (1) opposes coverage for some or all of any contraceptive services required to be covered under §147.130(a)(1)(iv) on religious grounds; (2) is organized and operates as a non-profit; (3) "holds itself out as a religious organization;" and (4) maintains a self-certification. *Id.* For-profit organizations owned by individuals or companies which have similar religious objections are not regarded as "religious enough" for even an accommodation. *Id.* at 8,462. The Administration has determined what is "religious" in violation of the "fixed star in our constitutional constellation" that no governmental official can

determine what is orthodox in religion and compel citizens to comply with its determination. *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943).

Last term the Supreme Court reiterated the importance of protecting the autonomy of religious organizations from secular interference such as that posed by the Preventive coverage mandate and manipulation such as the hierarchical differentiation between "religious employers" and "eligible organizations." *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC*, 132 S. Ct. 694, 706 (2012). "The First Amendment freedoms of speech and association are right[s] enjoyed by religious and secular groups alike," and "the Free Exercise Clause gives special solicitude to the rights of religious organizations." *Id.* at 706. In *Hosanna-Tabor* it was impermissible to contend that the government could determine whether a religious organization had the right to terminate the employment of a ministerial employee. It is impermissible here for the Administration to determine whether a religious organization is religious enough to be exempt from purchasing abortifacients for its employees.

As was true with the effects of the compulsory post-eighth grade public education on Amish beliefs, the detrimental effects of compulsory provision of abortifacients on employers' religious exercise "is not only severe, but inescapable." *Wisconsin v. Yoder*, 406 U.S. 205, 218-19 (1972). The employer

mandate compels employers under threat of crippling financial penalties to "perform acts undeniably at odds with fundamental tenets of their religious beliefs." *Id.* (citing *Braunfeld v. Brown*, 366 U.S. 599, 605 (1961)). Liberty University will face the threat of crippling financial penalties unless it abandons its sincerely held religious belief that life begins at conception and agrees to provide abortifacients to its employees. 26 U.S.C. §4980H; 45 CFR §147.130. This is "precisely the kind of objective danger to the free exercise of religion that the First Amendment was designed to prevent." *Yoder*, 406 U.S. at 218.

The Administration cannot establish that the Preventive mandate is justified by a compelling interest and narrowly tailored to advance that interest. *Smith*, 494 U.S. at 884. Since the Administration itself has determined that certain "religious employers," as well as those who employ fewer than 50 people, do not need to provide Preventive coverage, the government has undermined its claim that the Preventive mandate is necessary to further a compelling interest in providing free contraception, sterilization, and abortifacients. *See Church of the Lukumi Babalu Aye*, 508 U.S. at 547. Neither can the Administration demonstrate that requiring those who do not meet the definition of "religious employer" to purchase Preventive coverage is the least restrictive means of protecting a compelling interest when it has already demonstrated that there is a way to exempt employers

and people from the mandate without violating their First Amendment rights. *Sherbert*, 374 U.S. at 407.

2. The Individual Mandate Violates the Free Exercise Clause.

The religious "gerrymandering" that undercuts claims of religious neutrality is even more pronounced in the individual mandate, since the individual mandate has from the outset differentiated among particular types of religious adherents. 26 U.S.C. §5000A. Nonetheless, the district court and Judge Davis of this Court initially dismissed Plaintiffs' First Amendment challenge to the individual mandate because of the Administration's representations that rights of conscience would be protected from mandatory participation in payment for abortion services. *See Liberty University v. Geithner*, 753 F.Supp.2d at 642-643; *Liberty University v. Geithner*, 671 F.3d at 450 (Davis, J., dissenting). The Administration's removal of conscience protections in the Preventive mandate means that the differential treatment of religious adherents under Section 5000A should be re-examined and found to violate First Amendment free exercise rights.

Granting preferential status to some religious adherents violates the fundamental tenet that government is not to exhibit covert hostility against religion through unequal treatment of certain religious groups. *Church of the Lukumi Babalu Aye*, 508 U.S. at 531. Categories of selection are of "paramount concern

when a law has the incidental effect of burdening religious practice." *Id.* Here, certain religious adherents will not face the Hobson's choice of either violating their religious beliefs by purchasing coverage for abortion and abortifacients or incurring financial penalties for adhering to their religious beliefs.

Under Section 5000A, individuals must demonstrate that they have obtained "minimum essential coverage," which the Administration has determined must include coverage for abortion or abortifacients, or pay a graduated penalty. 26 U.S.C. §5000A; 42 U.S.C. §§ 300gg-13, 18022; 45 CFR §147.130. Only two groups of religious adherents are exempt from the mandate, and hence, from the Preventive mandate: those who qualify under a narrowly defined religious conscience exemption and equally narrow "health care sharing ministry" exemption. 26 U.S.C. §5000A(d)(2). The "religious conscience" exemption provides that individuals who are members of religious sects which have been in existence since December 31, 1950, which have tenets against participation in government support programs, and which have demonstrated that they provide care for dependent members are exempt. 26 U.S.C. §5000A(d)(2) (citing 26 U.S.C. §1402).

The "health care sharing ministry exemption" provides that people who are members of non-profit organizations in existence continuously since December 31,

1999, which share a common set of ethical or religious beliefs and have continuously shared medical expenses among members in accordance with those beliefs are exempt. *Id.* Plaintiffs Waddell and Merrill, whose sincerely held religious beliefs prevent them from paying for or participating in abortions, including abortifacients, but who are not members of the preferred organizations, are denied protection of their First Amendment rights. Their beliefs are deemed less worthy of protection.

Consequently, as is true with its creation of the "religious employer" exemption under Section 4980H, the Administration is determining who is sufficiently "religious" for an exemption from mandated purchase of an insurance policy that must include coverage for abortifacients. As is true under the employer mandate, the Administration is exceeding the boundaries of the Free Exercise clause by declaring what is "orthodox" in religion. *Barnette*, 319 U.S. at 642.

Since the individual mandate leaves an appreciable number of individuals without mandated coverage that includes Preventive coverage, it cannot be said to be necessary to further any kind of compelling interest in providing free contraception/abortifacients. *Church of the Lukumi Babalu Aye*, 508 U.S. at 547. Neither can the Administration demonstrate that requiring parties outside of the preferred organizations to violate their sincerely held religious beliefs is the least

restrictive means when it has already demonstrated that it can protect its interest by exempting those who are part of a preferred religion or organization. *Sherbert*, 374 U.S. at 407. The individual mandate cannot survive strict scrutiny and violates the First Amendment.

C. The Act And Its Implementation Violates Equal Protection.

The Act makes distinctions among religious adherents, permitting those who meet narrowly drawn criteria to avoid the mandates. 26 U.S.C. §5000A(d)(2). The district court and Judge Davis found that those distinctions were rational means of meeting Congress' legitimate end of decreasing the number of people who do not have the means to pay for medical care. *Liberty University v. Geithner*, 753 F.Supp.2d at 644; *Liberty University v. Geithner*, 671 F.3d at 452 (Davis, J., dissenting). The same cannot be said of the Administration's new religiously-based distinctions within its Preventive coverage mandate, which undermine the purported goal of providing free Preventive coverage to all policyholders. The significant differences between the exemptions in 26 U.S.C. §5000A(d)(2), the "religious employer" exemption, and proposed "eligible organization" accommodation in 45 C.F.R. §147.130, require reconsideration of the Equal Protection challenge. That reconsideration should also include strict scrutiny analysis instead of rational basis review.

The district court applied rational basis to the Section 5000A exemptions because it found that exempting members of religious sects who oppose health insurance and provide for their adherent's medical care and those who participate in health care sharing organizations that pay medical costs served a secular purpose of accommodating those who met Congress' goals of covering health care costs in an alternative manner. *Liberty University v. Geithner,* 753 F.Supp.2d at 611, 644. This Court has found that is the proper approach for an equal protection challenge to a regulation that applies selectively to religious activity if the distinction is strictly secular. *Olsen v. Comm'r*, 709 F.2d 278, 283 (4th Cir.1983). However, if a plaintiff can show that the basis for the distinction is religious, then the court must apply heightened scrutiny. *Id.* (citing *Gillette v. United States*, 401 U.S. 437, 452 (1971)). The Administration's crafting of its "religious employers" exemption to the Preventive coverage mandate and subsequent proposal for an "accommodation" for "eligible organizations" but not for for-profit companies founded on religious principles, is a religious distinction that must be analyzed under strict scrutiny.

In its latest rulemaking, the Administration has gone beyond merely accommodating those with alternative means of paying for health care to dictating which employers are sufficiently "religious" to warrant conscience protection

against having to pay for abortifacients. 45 C.F.R. §147.130, 78 Fed. Reg. 8,474. According to the Administration, only organizations that qualify as "churches, their integrated auxiliaries, and conventions or associations of churches, or the exclusively religious activities of any religious order" can be considered "religious," and therefore, entitled to a religious conscience exemption from the Preventive coverage mandate. 45 C.F.R. §147.130,78 Fed. Reg. 8,474. Other non-profit organizations that oppose providing contraceptives/abortifacients on religious grounds are not "religious enough" to be exempt from the requirement, but might be entitled to an "accommodation." 78 Fed. Reg. 8,474. However, they will only be entitled to an "accommodation" if they "hold themselves out" as "religious" (whatever that means). *Id.* Even then, their conscience rights are not really protected because employers with insurance carriers must arrange for third parties to provide abortifacient coverage, and self-insureds, like Liberty University, do not even have that alternative since the employer is the only real source of payment. *Id.* at 8,475. Business owners whose religious views preclude contraceptives/abortifacients and companies founded on those principles are not afforded any conscience protection if the business is a for-profit enterprise. *Id.* at 8,462. Unlike the Section 5000A exemptions, or the administrative notice provision upheld in *Olsen*, these provisions categorize participants on the basis of

how religious the Administration determines them to be, thus making a distinction based upon the perceived strength or value of religious beliefs. The Preventive mandates must be analyzed under strict scrutiny, not rational basis. *Olsen*, 709 F.2d at 283.

Even if rational basis were applied to the religiously-based distinctions, they still could not be upheld under equal protection. The mandates do not advance legitimate legislative goals in a rational fashion. *Schweiker v. Wilson*, 450 U.S. 221, 234 (1981), And they certainly are not narrowly tailored to achieve a compelling interest, *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 237-38 (1995). If the Administration's interest is to ensure that free contraceptives/abortifacients are available to all women, then exempting those who participate in health-sharing ministries, belong to certain religious sects, are members of Indian tribes, employ fewer than 50 employees, or qualify as "religious employers" from requirements for "minimum essential coverage," including the Preventive coverage requirement, does not further, but undermines, that interest. If the Administration's goal is to protect religious conscience rights by crafting an exemption, the differential hierarchy established in the "religious employer" exemption and "eligible organizations" "accommodation" does not further that goal, because a significant percentage of those who have sincerely held

religious beliefs against facilitating abortion are excluded from the definitions. *See Church of Lukumi Babalu Aye*, 508 U.S. at 547.

The mandates do not treat all similarly situated people or employers alike, and, therefore violate Equal Protection. *Plyler v. Doe*, 457 U.S. 202, 216 (1982); *City of Cleburne v. Cleburne Living Ctr*., 473 U.S. 432, 442 (1985). Employers such as Liberty University, which is not a church or part of a religious order, but which has sincerely held religious beliefs against facilitating or paying for abortifacients, must abandon its beliefs or pay crippling financial penalties, while organizations with the same sincerely held religious beliefs are not required to relinquish their First Amendment rights. Individuals such as Plaintiffs Waddell and Merrill who are not members of health sharing ministries or recognized religious sects are required to abandon their sincerely held religious beliefs or pay a penalty, while individuals with identical religious beliefs do not face such a Hobson's choice. The Administration has created religiously based distinctions within the individual and employer mandates that violate Equal Protection.

D. The Act And Its Implementation Violates The Establishment Clause.

The differential treatment of religious adherents under the individual and employer mandates also violates the Establishment Clause. *Larson v. Valente*, 456 U.S. 228, 244 (1982). The Establishment Clause forbids the government from

punishing anyone for "entertaining or professing religious beliefs or disbeliefs, for church attendance or non-attendance." *Everson v. Bd. of Educ*., 330 U.S. 1, 15-16 (1947). The Supreme Court has repeatedly held that as well as prohibiting favoritism, the Establishment Clause forbids hostility toward any religion. *Lynch v. Donnelly*, 465 U.S. 668, 673 (1984).

"The central purpose of the Establishment Clause [is] the purpose of ensuring governmental neutrality in matters of religion." *Gillette v. United States*, 401 U.S. 437, 449 (1971). The mandates are anything but religiously neutral and should be declared unconstitutional.[30]

IV. THE EMPLOYER MANDATE IS NOT SEVERABLE.

If this Court should determine that the employer mandate is unconstitutional in its entirety, then it should consider whether the remainder of the Act can survive without it. In making such an inquiry the Court should "seek to determine what Congress would have intended in light of the Court's constitutional holding." *United States v. Booker*, 543 U.S. 220, 246 (2005). A court must ask "whether [after removing the invalid provision] the [remaining] statute will function in a manner consistent with the intent of Congress." *Alaska Airlines v. Brock*, 480 U.S.

[30] Plaintiffs incorporate by reference their argument on the Establishment Clause in their Opening Brief, Dkt # 10, pp. 52-54.

678, 685 (1987). It is this Court's duty to determine whether an act of Congress can survive when a critical component of the law is stricken. *Id.* at 684.

A review of Congress' findings regarding the "minimum essential coverage" requirement that underlies the employer mandate reveals that Congress' intent is that the Act cannot survive without it. 42 U.S.C. §18091. Congress explained that "[t]he 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." 42 U.S.C. §18091(2)(C). "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." 42 U.S.C. §18091(2)(D). If the employer mandate is invalidated, then the mechanism for providing the increased number of insured citizens that Congress relies upon in the Act will be gone along with the revenues and alleged cost savings that Congress cited as critical to reducing the economic burdens posed by those without health insurance. *Id.* That pronouncement establishes that the employer mandate is not severable.

Furthermore, if the Act is found to violate the Origination Clause, then the entire Act must fail without consideration of severability.

CONCLUSION

The AIA does not bar Plaintiffs' challenges to the employer mandate. The employer mandate is not a valid exercise of Congress' enumerated powers. Because the substance of the Act originated in the Senate, it violates the Origination Clause. The Act and its implementation of the individual and employer mandates violate RFRA, the Free Exercise, Equal Protection, and Establishment clauses. Based upon the foregoing, this Court should declare that the employer mandate is unconstitutional, and since it is not severable, that the entire Act is unconstitutional.

Dated: February 27, 2013.

Mathew D. Staver
Anita L. Staver
Liberty Counsel
1053 Maitland Ctr Commons
Second Floor
Maitland, FL 32751
(800) 671-1776 Telephone
(407) 875-0770 Facsimile
court@lc.org Email
Attorneys for Appellants

/s/Mary E. McAlister
Stephen M. Crampton
Mary E. McAlister
Liberty Counsel
P.O. Box 11108
Lynchburg, VA 24506
(434) 592-7000 Telephone
(434) 592-7700 Facsimile
court@lc.org Email
Attorneys for Appellants

CERTIFICATE OF COMPLIANCE

1. This brief has been prepared using 14 point, proportionately spaced Times New Roman typeface in Microsoft Office Word 2010.

2. Exclusive of the corporate disclosure statement; table of contents; table of citations; statement with respect to oral argument; addendum of statutes and the certificate of service, the brief contains 13,602 words.

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

February 27, 2013.

/s/Mary E. McAlister
Mary E. McAlister
Liberty Counsel
P.O. Box 11108
Lynchburg, VA 24506
(434) 592-7000
court@lc.org
Attorney for Appellants

CERTIFICATE OF SERVICE

I hereby certify that on February 27, 2013, I served the Supplemental Opening Brief on Remand and Statutory Addendum served on all parties or their counsel of record through the CM/ECF system.

Alisa B. Klein, Esq.
United States Department of Justice, Civil Appellate Division
950 Pennsylvania Ave., NW, Room 7235
Washington DC 20530
(202) 514-1597
alisa.klein@usdoj.gov

/s/Mary E. McAlister
Liberty Counsel
P.O. Box 11108
Lynchburg, VA 24506
(434) 592-7000
court@lc.org
Attorney for Plaintiffs

STATUTORY ADDENDUM

15 U.S.C. §1011

§ 1011. Declaration of policy

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. §1012

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not

regulated by State law.

26 U.S.C. § 36B

§ 36B. Refundable credit for coverage under a qualified health plan

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

(b) Premium assistance credit amount.--For purposes of this section--

(1) In general.--The term "premium assistance credit amount" means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) Premium assistance amount.--The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of--

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 13111 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:

In the case of household income (expressed as a percent of poverty	The initial premium	The final premium

line) within the following income tier:	percentage is--	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%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

(ii) Indexing.--

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

the preceding calendar year.

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

(III) Failsafe.--Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and 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)2 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).

26 U.S.C. § 4980H. Shared responsibility for employers regarding health coverage

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

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

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and

> Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

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

> (b) Large employers offering coverage with employees who qualify for premium tax credits or cost-sharing reductions.--
>
> (1) In general.--If--
>
> (A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and
>
> (B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

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

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

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

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

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

(2) Applicable large employer.--

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

(B) Exemption for certain employers.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Full-time employee.--

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

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

(5) Inflation adjustment.--

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

(i) such dollar amount, and

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

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

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

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

(d) Administration and procedure.--

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

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

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

[(e) Redesignated (d)]

26 U.S.C. § 5000A. Requirement to maintain minimum essential coverage

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

(b) Shared responsibility payment.--

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

imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

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

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

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

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

(c) Amount of penalty.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by

substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Religious exemptions.--

(A) Religious conscience exemption.--Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient

Protection and Affordable Care Act which certifies that such individual is--

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

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

(B) Health care sharing ministry.--

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

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

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

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

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

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

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

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

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

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

(1) Individuals who cannot afford coverage.--

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

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

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

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

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

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

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

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

(4) Months during short coverage gaps.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section

349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

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

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

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

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

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

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

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

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

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

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

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

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

(g) Administration and procedure.--

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

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

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

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

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

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

42 U.S.C. § 300gg-13

§ 300gg-13. Coverage of preventive health services

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for--

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

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and1

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

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

(5) for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

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

(b) Interval

(1) In general

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

(2) Minimum

The interval described in paragraph (1) shall not be less than 1 year.

(c) Value-based insurance design

The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

42 U.S.C. § 18022. Essential health benefits requirements

(a) Essential health benefits package

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

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

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

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

(b) Essential health benefits

(1) In general

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

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

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

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

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

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

(2) Limitation

(A) In general

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

(B) Certification

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

(3) Notice and hearing

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

(4) Required elements for consideration

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the

addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

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

(5) Rule of construction

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

42 U.S.C.A. § 18023

§ 18023. Special rules

(a) State opt-out of abortion coverage

(1) In general

A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

(2) Termination of opt out

A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

(b) Special rules relating to coverage of abortion services

(1) Voluntary choice of coverage of abortion services

(A) In general

Notwithstanding any other provision of this title (or any amendment made by this title)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) Abortion services

(i) Abortions for which public funding is prohibited

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) Abortions for which public funding is allowed

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(2) Prohibition on the use of Federal funds

(A) In general

If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of Title 26 (and the amount (if any) of the advance payment of the credit under section 18082 of this title).

(ii) Any cost-sharing reduction under section 18071 of this title (and the amount (if any) of the advance payment of the reduction under section 18082 of this title).

(B) Establishment of allocation accounts

In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall-

(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan

of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

(C) Segregation of funds

(i) In general

The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

(ii) Allocation accounts

The issuer of a plan to which subparagraph (A) applies shall deposit--

(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

(D) Actuarial value

(i) In general

The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

(ii) Considerations

In making such estimate, the issuer--

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than $1 per enrollee, per month.

(E) Ensuring compliance with segregation requirements

(i) In general

Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

(ii) Clarification

Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

(3) Rules relating to notice

(A) Notice

A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

(B) Rules relating to payments

The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

(4) No discrimination on basis of provision of abortion

No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions

(c) Application of State and Federal laws regarding abortion

(1) No preemption of state laws regarding abortion

Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) No effect on Federal laws regarding abortion

(A) In general

Nothing in this Act shall be construed to have any effect on Federal laws regarding--

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) No effect on Federal civil rights law

Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(d) Application of emergency services laws

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as “EMTALA”).

EXECUTIVE ORDER NO. 13535

<March 24, 2010, 75 F.R. 15599>

ENSURING ENFORCEMENT AND IMPLEMENTATION OF ABORTION RESTRICTIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the "Patient Protection and Affordable Care Act" (Public Law 111-148), I hereby order as follows:

Section. 1. Policy. Following the recent enactment of the Patient Protection and Affordable Care Act (the "Act"), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment. The purpose of this order is to establish a comprehensive, Government-wide set of policies and procedures to achieve this goal and to make certain that all relevant actors--Federal officials, State officials (including insurance regulators) and health care providers--are aware of their responsibilities, new and old.

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Numerous executive agencies have a role in ensuring that these restrictions are enforced, including the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and the Office of Personnel Management.

Sec. 2. Strict Compliance with Prohibitions on Abortion Funding in Health Insurance Exchanges. The Act specifically prohibits the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered) in the health insurance exchanges that will be operational in 2014. The Act also imposes strict payment and accounting requirements to ensure that Federal funds are not used for abortion services in exchange plans (except in cases of rape or incest, or when the life of the woman would be endangered) and requires State health insurance commissioners to ensure that exchange plan funds are segregated by insurance companies in accordance with generally accepted accounting principles, OMB funds management circulars, and accounting guidance provided by the Government Accountability Office.

I hereby direct the Director of the OMB and the Secretary of HHS to develop, within 180 days of the date of this order, a model set of segregation guidelines for State health insurance commissioners to use when determining whether exchange plans are complying with the Act's segregation requirements, established in section 1303 of the Act, for enrollees receiving Federal financial assistance. The guidelines shall also offer technical information that States should follow to conduct independent regular audits of insurance companies that participate in the health insurance exchanges. In developing these model guidelines, the Director of the OMB and the Secretary of HHS shall consult with executive agencies and offices that have relevant expertise in accounting principles, including, but not limited to, the Department of the Treasury, and with the Government Accountability Office. Upon completion of those model guidelines, the Secretary of HHS should promptly initiate a rulemaking to issue regulations, which will have the force of law, to interpret the Act's segregation requirements, and shall provide guidance to State health insurance commissioners on how to comply with the model guidelines.

Sec. 3. Community Health Center Program. The Act establishes a new Community Health Center (CHC) Fund within HHS, which provides additional Federal funds for the community health center program. Existing law prohibits these centers from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), as a result of both the Hyde Amendment and longstanding regulations containing the Hyde language. Under the Act, the Hyde language shall apply to the authorization and appropriations of

funds for Community Health Centers under section 10503 and all other relevant provisions. I hereby direct the Secretary of HHS to ensure that program administrators and recipients of Federal funds are aware of and comply with the limitations on abortion services imposed on CHCs by existing law. Such actions should include, but are not limited to, updating Grant Policy Statements that accompany CHC grants and issuing new interpretive rules.

Sec. 4. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect: (i) authority granted by law or Presidential directive to an agency, or the head thereof; or (ii) functions of the Director of the OMB relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees or agents, or any other person.

Barack Obama

45 Code of Federal Regulations § 147.130 Coverage of preventive health services.

(a) Services—

(1) In general. Beginning at the time described in paragraph (b)

of this section, a group health plan, or a health insurance issuer offering

group or individual health insurance coverage, must provide coverage for all

of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to

those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respectto the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits—

(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an

office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose costsharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(v) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider,

the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) Conclusion. In this Example 1, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is

prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) Conclusion. In this Example 2, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 3, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 4, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement for the office visit charge.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Reasonable medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing—(1) In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years (in the individual market, policy years) that begin on or after September 23, 2010, or, if later, for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) Changes in recommendations or guidelines. A plan or issuer is not required

under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a

plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See § 147.140 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

[75 FR 41759, July 19, 2010]