No. _____

In The
Supreme Court of the United States

NICK COONS and DR. ERIC NOVACK,

Petitioners,

v.

JACOB J. LEW, SYLVIA BURWELL,
ERIC HOLDER, JR., and BARACK OBAMA,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

CLINT BOLICK
KURT ALTMAN
CHRISTINA SANDEFUR*
**Counsel of Record*
GOLDWATER INSTITUTE
SCHARF-NORTON CENTER FOR
CONSTITUTIONAL LITIGATION
500 E. Coronado Rd.
Phoenix, AZ 85004
(602) 462-5000
litigation@goldwaterinstitute.org

Counsel for Petitioners

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

QUESTIONS PRESENTED

1. A person may seek prospective relief to prevent the consummation of a threatened injury, so long as that injury is certain to occur. *See Regional Rail Reorganization Act Cases,* 419 U.S. 102, 142-43 (1974). The Patient Protection and Affordable Care Act mandates that Petitioner purchase health insurance, which requires that he surrender sensitive personal and medical information to third parties, subjecting himself to irreparable harm, or pay a financial penalty. Did the Ninth Circuit err in denying him the right to challenge that Mandate prospectively as an unconstitutional condition on his exercise of personal privacy rights?

2. A case is ripe for review when it presents purely legal questions, where those questions would not be clarified by further factual development, and withholding judicial review would work a hardship on the parties. Petitioner here challenged the constitutionality of an unrepealable, unconstitutional agency which directly affects his financial and professional interests, and whose actions are rendered immune from judicial review. Was the Ninth Circuit correct when, in conflict with other circuit courts of appeals, it forced him to wait until the agency issues its first regulation before asserting his facial separation-of-powers claim against the agency's existence?

RULE 14.1(B) STATEMENT

A list of all parties to the proceeding in the court whose judgment is the subject of the petition is as follows:

> Plaintiffs-Appellants and Petitioners: Nick Coons and Dr. Eric Novack.
>
> Defendants-Appellees and Respondents: Sylvia Burwell (in her official capacity as Secretary of the United States Department of Health and Human Services); Jacob Lew (in his official capacity as Secretary of the United States Department of the Treasury); Eric Holder, Jr. (in his official capacity as Attorney General of the United States); and Barack Hussein Obama (in his official capacity as President of the United States).

This petition has not been filed by or on behalf of a nongovernmental corporation.

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PETITION FOR WRIT OF CERTIORARI

Nick Coons and Dr. Eric Novack respectfully petition for a writ of certiorari to review the judgment of the U.S. Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The decision of the U.S. Court of Appeals for the Ninth Circuit was filed on August 7, 2014, and was not officially reported, but is available at 2014 WL 3866475. The original decision was amended on September 2, 2014, to change the term "Medicare" to "Medicaid" on slip opinion page 7, second paragraph. The amended decision was reported at 762 F.3d 891, and is reproduced in the Appendix (hereafter "App.") at 1. The decisions of the U.S. District Court for the District of Arizona were filed on December 20, 2012, and August 31, 2012. They are not officially reported, but are available at 2012 WL 6674394 (dismissing Count V (privacy)) and at 2012 WL 3778219 (dismissing Count VII (separation-of-power)), respectively. They are reproduced in the Appendix at 22 and 34.

JURISDICTION

The U.S. District Court for the District of Arizona dismissed Plaintiffs' informational privacy claim for lack of ripeness and dismissed Plaintiffs' separation-of-powers claim on the merits. The Court of Appeals for the Ninth Circuit affirmed the District Court's

dismissal of the informational privacy claim and vacated its dismissal on the merits of the separation-of-powers claim, remanding with instructions to dismiss it for lack of jurisdiction instead. Judgment was entered on August 7, 2014. This petition was timely filed within 90 days of August 7, 2014. Accordingly, the Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case involves the separation-of-powers doctrine encompassed in Articles I-III of the United States Constitution; the right of privacy encompassed by the Fourth, Fifth, and Ninth Amendments to the United States Constitution; as well as the following provisions of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010);[1] 26 U.S.C. § 5000A; 42 U.S.C. § 18081; and 42 U.S.C. § 1395kkk. Full statements of each of these constitutional and statutory provisions are reproduced in the Appendix at 43, 56 and 73.

[1] The ACA, Pub. L. No. 111-148, 124 Stat. 119 (2010), was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA"). All citations herein to the ACA are to the ACA as amended by HCERA.

Article I, Section 1 of the United States Constitution provides:

> All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives. (App. at 41).

Article II, Section 1 of the United States Constitution provides in pertinent part:

> The executive Power shall be vested in a President of the United States of America. (App. at 41).

Article III of the United States Constitution provides in pertinent part:

> The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. (App. at 41).

The Fourth Amendment to the United States Constitution provides in pertinent part:

> The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated. . . . (App. at 42).

The Fifth Amendment to the United States Constitution provides in pertinent part:

> No person shall . . . be deprived of life, liberty, or property, without due process of law. . . . (App. at 42).

The Ninth Amendment to the United States Constitution provides:

> The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people. (App. at 42).

STATEMENT OF THE CASE AND SUMMARY OF REASONS FOR GRANTING THE WRIT

A. The Resolution of this Case Directly Affects the Privacy Rights of Millions of Americans Because the ACA Requires Mr. Coons and Virtually Every American to Turn Over Personal Information to Third Parties or Pay a Penalty for Refusing to Do So

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("ACA"), the greatest expansion of federal involvement in health care since the creation of Medicaid and Medicare in 1965. The ACA introduces sweeping intrusions into the personal lives of Americans. The Act's linchpin is the "individual mandate," which forces virtually every American to purchase government-approved health insurance or pay a penalty for refusing to do so. Second Amended Complaint (available at D. Ariz., 2:10-cv-01714-GMS, Docket

No. 41) (hereafter Doc. #41), ¶¶ 16, 19-26; 26 U.S.C. § 5000A(b).[2]

In order to purchase a health insurance plan, a person must disclose medical and other personal information to various third parties, including the insurance company issuing the policy. *Id.* ¶¶ 88-92. Once the person relinquishes that information to the insurance company, it is subject to seizure by the government without a warrant under the voluntary relinquishment to private third parties doctrine, and a host of federal and state laws. *See, e.g., United States v. Miller*, 425 U.S. 435, 443 (1976); *United States v. Jacobsen*, 466 U.S. 109, 117 (1984); 45 C.F.R. § 164.512; Doc. #41 ¶¶ 88-91. Accordingly, data forfeited to obtain insurance is subject to broad and irremediable government appropriation, and the threat of further dissemination is increased by the many well-publicized incidents of security breaches involving the ACA's insurance hub, healthcare.gov. *See infra* Section II(B).

Arizona small business owner Nick Coons does not have health insurance. Doc. #41 ¶¶ 6, 14. If left free to choose, he would prefer not to buy a compliant

[2] In *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), this Court held that "[t]he Federal Government does not have the power [under the Commerce Clause] to order people to buy health insurance," but upheld the individual mandate under Congress's tax power as a tax penalty for not purchasing government-approved health insurance. 132 S. Ct. 2566, 2600-01 (2012).

insurance plan, and would not disclose his personal information and medical history to a private insurance corporation and other third parties. *Id.* ¶¶ 6, 14, 16. However, the individual mandate and tax penalty restrict Mr. Coons' freedom of choice by forcing him either to give up his personal privacy or pay a tax penalty to the government to preserve this right. *Id.* ¶¶ 19-26, 83-85.[3]

B. The ACA Subjects Dr. Novack and Other Physicians to an Unconstitutional Regime that Directly and Tangibly Implicates Their Interests

The ACA's most egregious feature has not yet been reviewed by any court. The Independent Payment Advisory Board ("IPAB") is a group of unelected and unaccountable administrative officials who exercise an unprecedented amount of unchecked authority over the health care industry.

Under the ACA, IPAB is an executive-branch agency of up to 15 members appointed by the President with the advice and consent of the Senate. 42 U.S.C. § 1395kkk(g)(1)-(4). Charged with "reduc[ing] the per capita rate of growth in Medicare spending," 42 U.S.C. § 1395kkk(b), IPAB is given power to take any act it deems "*related to* the Medicare program."

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[3] The *NFIB* Court was not asked and did not answer how the tax penalty affects an individual's privacy rights.

42 U.S.C. § 1395kkk(c)(1)(A) (emphasis added). This and other vague directives in the ACA, combined with its lack of constraints on IPAB give that Board indefinite, virtually unlimited power over both public and private health care in America.

In fact, one of the few actions that is *not* left entirely to IPAB's discretion is that every year it is required to make law unilaterally, without presidential, congressional, or judicial supervision. Whenever its duty is triggered,[4] IPAB must make "detailed and specific" "recommendations" in the form of "*legislative* proposals" that automatically become law, without Congress's vote or the president's signature. 42 U.S.C. §§ 1395kkk(b)(1)-(3), (c)(1)(A), (c)(2)(A)(vi), (d)(1)(A)-(D), and (e)(1), (3). To emphasize, these "recommendations" are not recommendations – they become enforceable law without any action by the elected branches, and with no possibility of judicial review.

[4] IPAB's duty is activated when in his annual report, the Chief Actuary predicts that Medicare spending will exceed a set target rate. 42 U.S.C. § 1395kkk(c)(5)(C). Through 2017, the target rate is the average of medical care inflation and overall inflation (using the Consumer Price Index), and for 2018 and beyond, it is the growth of the economy per capita (using gross domestic product) plus one percent. *Id.*

Until the President appoints members to the Board, the Secretary currently wields this power unilaterally. § 1395kkk(c)(5).[5]

IPAB is a super-legislature with full lawmaking powers that evade notice-and-comment rulemaking and trump Congress's ability to alter or amend its proposals. 42 U.S.C. §§ 1395kkk(d)(2)(D); (d)(3); (d)(4)(B); (d)(4)(D); (e)(1)(f); (e)(3)(B). It is empowered to sidestep the president's constitutional authority to recommend to Congress only such measures as he considers expedient. 42 U.S.C. § 1395kkk(c)(4) (requiring the president to pass the proposals directly to Congress); U.S. Const. art. II, § 3. IPAB removes Congress from its historical role as architect of Medicare policy, and subjects Medicare doctors and patients to a new regime of unaccountable administrators, who

[5] Whether or not IPAB issues its annual legislative proposal, it may take other actions. IPAB's power extends beyond legislating for Medicare and into other government and private health care markets. *See, e.g.,* 42 U.S.C. § 1395kkk(c)(1)(B) (IPAB must submit advisory reports when it does not submit legislative proposals); § 1395kkk(n)(1) (must submit annual public report, taking into account system-wide health care information used in drafting legislative proposals); § 1395kkk(o) (must submit biennial advisements to slow growth in non-federal health care expenditures); § (n)(1)(E) (may take into account "[a]ny other areas that the Board determines affect overall spending and quality of care in the private sector"); § 1395kkk(c)(2)(B)(vii) (must "develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries," taking into account markets beyond Medicare); § 1395kkk(o)(1)(A)-(E) (may create recommendations that require legislation to be implemented).

may all be from one political party. 42 U.S.C. § 1395kkk(g). And IPAB is the final arbiter of its own actions, whose judgment is immunized from judicial and administrative review. 42 U.S.C. § 1395kkk(e)(5). IPAB blurs the boundaries between the three branches of government, usurping power from each and forsaking the corresponding constraints.

Remarkably, the ACA attempts to prohibit Congress from ever eliminating IPAB. Outside of a miniscule window in 2017, the ACA completely insulates IPAB from repeal. *See* 42 U.S.C. §§ 1395kkk(f); (f)(1); (f)(3). Congress can only repeal IPAB by enacting a "Joint Resolution" to that effect, 42 U.S.C. § 1395kkk(f)(1)(C)-(D), but is prohibited from even introducing such a resolution until 2017 *and* no later than February 1, 2017, and the Resolution must be enacted no later than August 15, 2017, or Congress is forever foreclosed from abolishing IPAB. *See* 42 U.S.C. § 1395kkk(f)(3). The ACA also imposes an unprecedented super-majority vote requirement for passage of the resolution: three-fifths of all *elected* members of Congress. 42 U.S.C. § 1395kkk(f)(2)(F). Even in the event such a resolution could clear these hurdles, the dissolution would not become effective until 2020. 42 U.S.C. § 1395kkk(e)(3)(A). If Congress fails to repeal IPAB during this short period, it forever loses the ability to replace IPAB proposals. 42 U.S.C. § 1395kkk(e)(3)(A)(ii).

Dr. Eric Novack is an orthopaedic surgeon who serves as a managing partner of his Arizona surgery practice. Doc. #41 ¶ 7. Approximately 12.5 percent of his practice is composed of Medicare patients, meaning, as with many physicians, a significant portion of his income depends directly on Medicare policy and reimbursement rates. *Id.* The ACA fundamentally transforms the manner by which Dr. Novack is reimbursed under Medicare, with a mandate of effectuating cost control. There is little that he and others subject to IPAB's regime can do to escape the Board's control, limit its authority, or even contest its actions, especially given that their congressional representatives' hands are tied.

C. Mr. Coons and Dr. Novack Challenge the Individual Mandate and IPAB

On May 10, 2011, Mr. Coons and Dr. Novack filed a Second Amended Complaint ("Complaint") seeking injunctive and declaratory relief against enforcement of the ACA. The basis of the district court's subject matter jurisdiction is 28 U.S.C. §§ 1331, 1340, and 1346(a)(2).

In their Complaint, Mr. Coons and Dr. Novack alleged several constitutional causes of action. This

petition involves only the privacy and separation-of-powers claims.[6] Mr. Coons challenges the individual mandate tax penalty for unconstitutionally forcing him to choose between disclosing personal information to third-party insurance companies or paying a penalty for refusing to do so. Count V, Doc. #41 ¶¶ 87-92. Dr. Novack challenges IPAB's unprecedented consolidation of unchecked power as a violation of the separation-of-powers doctrine. Count VII, Doc. #41 ¶¶ 115-128.

Although Mr. Coons' challenge involves the burden imposed on his right to exercise his constitutional rights and is not contingent upon future events, *see* Doc. #41 ¶¶ 89-91; the district court nevertheless dismissed Mr. Coons' privacy claim as unripe because "[t]he tax penalty has not yet gone into effect" and

[6] Claims that the ACA's individual mandate and penalty exceed Congress's constitutional authority under the Commerce Clause (Count I, Doc. #41 ¶¶ 27-53) and Necessary and Proper Clause (Count II, *Id.* ¶¶ 54-66) and are not authorized by Congress's taxing power (Count III, *Id.* ¶¶ 67-78) were resolved by this Court in *NFIB*, 132 S. Ct. at 2608, and accordingly dismissed by the District court. (App. at 34). The district court held that the mandate and penalty do not violate Mr. Coons' substantive due process right to medical autonomy (Count IV, Doc. #41 ¶¶ 79-86) and that the individual mandate and penalty preempt protections afforded to Mr. Coons by the Arizona Health Care Freedom Act ("HCFA") (Count VIII, Doc. #41 ¶¶ 129-136). The Ninth Circuit affirmed. Plaintiffs also alleged that IPAB's anti-repeal provisions burden legislators' voting rights, Doc. #41 ¶¶ 93-114, but they voluntarily dismissed this claim due to the Supreme Court's decision in *Nevada Comm'n on Ethics v. Carrigan*, 131 S. Ct. 2343 (2011). None of these claims are raised in this petition.

Mr. Coons had not been asked to relinquish any information. (App. at 30-31). The court acknowledged that the ACA mandates informational disclosures to "authenticate identity [and] determine eligibility" (App. at 31) (quoting 42 U.S.C. § 18081(g)(1), but held that this does not violate Mr. Coons' privacy rights, since he can avoid disclosing personal information by opting to pay the tax penalty. (App. at 32). In other words, a law mandating disclosure of sensitive personal information does not implicate privacy rights if it merely "make[s] it 'more difficult' to exercise that [privacy] right." *Id.*

The district court also held that IPAB did not violate separation-of-powers, declaring without explanation that the government "has met that test" of "clearly delineat[ing] the general policy, the public agency which is to apply it, and the boundaries of this delegated authority." (App. at 37). But the court failed to identify any "intelligible principle" in the ACA that constrains IPAB, and it did not consider the greater question of whether IPAB violates the principles of separation-of-powers by consolidating the executive, judicial, and legislative powers while being accountable to none.

Plaintiffs timely appealed to the Ninth Circuit, which affirmed dismissal of Mr. Coons' privacy claim on the grounds that "Coons has not alleged that any third party has sought private medical information." (App. at 17). Such a holding fundamentally misconstrues this Court's doctrine of unconstitutional conditions and sets a dangerous precedent that a plaintiff

must give up his privacy – and suffer irreparable injury – before he can assert his rights in court. *See infra* Section I.

The Ninth Circuit also vacated the IPAB decision on the merits, holding instead that the separation-of-powers claim is unripe because the Board has not yet taken any action. (App. at 8-12). The court's rejection of Novack's standing conflicts with this Court's standing jurisprudence as expressed in *Buckley v. Valeo*, 424 U.S. 1 (1976), and elsewhere; contributes to the confusion among lower courts grappling with the application of that standard; and leaves Americans like Dr. Novack with no recourse to challenge any aspect of IPAB. *See infra* Section II.

Mr. Coons and Dr. Novack now respectfully ask this Court to issue a writ of certiorari to resolve these questions of great national importance and provide guidance to the lower courts struggling to apply its standing and ripeness rules.

REASONS FOR GRANTING THE PETITION

This petition presents issues of national importance that, if left unanswered, will perpetuate confusion among the lower courts and prevent plaintiffs from enforcing privacy rights and the Constitution's structural protections.

I. THE DECISION BELOW DISMISSING MR. COONS' PRIVACY CLAIM FOR LACK OF RIPENESS CONFLICTS WITH THIS COURT'S UNCONSTITUTIONAL CONDITIONS JURISPRUDENCE AND THE PRECEDENTS OF OTHER CIRCUITS IN A WAY THAT COULD INFLICT SWEEPING AND IRREPARABLE HARMS ON PRIVACY RIGHTS

A. The Ninth Circuit's Rule Conflicts with This Court's Unconstitutional Conditions Doctrine

In holding that Mr. Coons cannot challenge the unconstitutional condition on his right to personal privacy until he relinquishes the personal information that he objects to disclosing (App. at 15-17), the Ninth Circuit joined the Sixth Circuit in excluding privacy rights from the robust protections of this Court's unconstitutional conditions jurisprudence. *See U.S. Citizens Ass'n v. Sebelius*, 705 F.3d 588, 602-03 (6th Cir. 2013) ("[A]ny injury plaintiffs may suffer by disclosing their private health information to insurance companies is highly speculative at this point."). These decisions inexplicably carve out a special rule of standing for privacy rights that renders those rights more vulnerable than others, such as property rights.

The ACA unconstitutionally forces Americans like Mr. Coons to choose between disclosing personal information to insurance companies or paying a tax penalty to preserve that personal privacy. Doc. #41 ¶¶ 88-92; 42 U.S.C. § 18081(g)(1); 26 U.S.C.

§ 5000A(f). In other words, Mr. Coons challenges the unconstitutional condition – the very fact that he has to choose between disclosing private information and paying a penalty. In rejecting this claim as unripe, the Ninth and Sixth Circuits have set a troubling precedent that a plaintiff must give up his privacy – and suffer irreparable injury – before he can challenge that unconstitutional condition.

This Court has described the unconstitutional conditions doctrine as "an overarching principle . . . that vindicates the Constitution's enumerated rights by preventing the government from coercing people into giving them up." *Koontz v. St. Johns River Water Mgmt. Dist.*, 133 S. Ct. 2586, 2594 (2013). That doctrine forbids the government from "pressuring someone into forfeiting a constitutional right." *Id*. at 2595. A plaintiff need not forfeit a right in order to sue to protect it, because it is the *choice itself* that offends the Constitution. *Id*. In other words, the constitutional violation occurs when the government commands a person to choose between surrendering a right or paying a penalty, not when the person actually surrenders that right.[7]

[7] On this issue, the Ninth and Sixth Circuits are also at odds with other circuits. *See, e.g., Whitney v. Heckler*, 780 F.2d 963, 968, n.6 (11th Cir. 1986) ("It is well established that an issue is ripe for judicial review when the challenging party is placed in the dilemma of incurring the disadvantages of complying or risking penalties for noncompliance.").

In *Koontz*, this Court recently reaffirmed this principle with regard to property rights, holding that a plaintiff could sue when the government ordered a landowner to fund offsite construction projects on public lands in exchange for a development permit, even where the plaintiff refused to accede to the condition. The government's "[e]xtortionate demands for property . . . run afoul of the Takings Clause not because they take property but because they *impermissibly burden the right* not to have property taken without just compensation." *Id.* (emphasis added). Property owners need not first relinquish their property before they can bring an unconstitutional conditions case. *See also Nollan v. California Coastal Comm'n*, 483 U.S. 825, 828-30 (1987) (property owners successfully challenged requirement that they provide a public easement across property as a condition to approval of rebuilding permit without agreeing to provide the easement); *Dolan v. City of Tigard*, 512 U.S. 374, 382-83 (1994) (property owners successfully challenged requirement that they dedicate property to improve city drainage system and provide a pedestrian pathway as a condition to approval of

building permit without agreeing to dedicate the property).[8]

There is no basis for imposing different prerequisites for claims involving unconstitutional conditions on privacy rights. In fact, this Court has recognized in the context of privacy rights that the Constitution prohibits "obstacles [that] . . . impact[ ] upon the . . . freedom to make a constitutionally protected decision." *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977). Yet the court below held that in any challenge to an unconstitutional condition encumbering a privacy right, the government can evade review until the plaintiff does surrender the protected information, forcing a plaintiff to acquiesce in the burden imposed on his choice to exercise his rights.

Just as a "contrary rule [for property rights] would . . . enable the government to evade the limitations of [the takings clause] simply by phrasing its

[8] The unconstitutional conditions doctrine applies in *any* context where the government penalizes a person for exercising a constitutional right, not just to property rights. *See, e.g., Board of County Com'rs, Wabaunsee County, Kan. v. Umbehr*, 518 U.S. 668 (1996) (termination of government contract in retaliation for employee's exercise of First Amendment rights is an unconstitutional condition on free speech); *Memorial Hospital v. Maricopa County*, 415 U.S. 250, 258 (1974) (imposing residency requirement for medical care "[p]enalize[s] those persons . . . who have exercised their constitutional right of interstate migration") (internal citation omitted); *Speiser v. Randall*, 357 U.S. 513 (1958) (state requirement that veterans pledge a loyalty oath as a condition of receiving a property-tax exemption is an unconstitutional condition on free speech).

demands for property as conditions precedent to permit approval," *Koontz*, 133 S. Ct. at 2595, the rule adopted by the Ninth and Sixth Circuits enables the government to evade constitutional privacy protections by imposing a tax penalty on exercising those rights. That rule is squarely at odds with the well-established tenet that it is forced choice *itself* that is the gravamen of any unconstitutional conditions claim, and such claim is ripe the moment the government makes that demand. The standard should not apply differently to burdens on privacy rights. It is important that the Court harmonize this decision with its own precedents and with those of other circuits.

B. By Requiring a Plaintiff to Give Up His Privacy – and Suffer Irreparable Injury – Before He Can Challenge an Unconstitutional Condition, the Decision Below Makes Challenges to Such Conditions Futile.

The decision below requires a plaintiff to relinquish his privacy rights before he can challenge an unconstitutional burden on his decision to exercise those rights, establishing a rule that forces plaintiffs to suffer irreparable injuries before they are entitled to their day in court. But by that point, judicial review would likely be futile.

Mr. Coons objects to the ACA's coercing him into disclosing sensitive personal information to anyone, including private insurance companies,[9] Doc. #41 ¶¶ 14-16, 20-26, 88-92, government health insurance exchange portals, and other third parties. (App. at 31-32), 42 U.S.C. § 18081(g)(1) (requiring disclosure of information to determine eligibility and coverage). But once Mr. Coons discloses this information to an insurance company, that information is subject to government appropriation. Doc. #41 ¶¶ 88-92. Federal law authorizes insurance companies to disclose personal medical information, history, and records to government agencies without the individual's consent for a variety of purposes, including public health activities, specialized government functions, judicial and administrative proceedings, and law enforcement and regulatory purposes. *See generally* 45 C.F.R. § 164.512 ("uses and disclosures for which an authorization or opportunity to agree or object is not required"); *see also* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110

[9] Although the ACA prevents many insurance plans from denying coverage or setting premiums on the basis of medical history, 42 U.S.C. § 300gg *et seq.*, insurance companies nevertheless routinely request information about an insured's pre-existing medical conditions. An insurance company's solvency depends on its ability to assess risk and set premiums at an appropriate level, which would be nearly impossible without having any information about a customer's medical history. The total extent of information Coons would be forced to turn over in exchange for a compliant insurance plan is a matter on which Coons would seek discovery on remand.

Stat. 1936; 42 U.S.C. §§ 1320a-3a, 1395cc (permitting the federal government to collect personal information from insurers). Moreover, under the voluntary relinquishment to private third parties doctrine, any information Coons discloses to an insurer may be seized by the government without a warrant, because this Court has held that individuals lack a reasonable expectation of privacy in information they "voluntarily" share by contracting with private companies. *Miller*, 425 U.S. at 443; *Jacobsen*, 466 U.S. at 117.

Thus by penalizing Coons for withholding information from insurance corporations, the ACA also compels him to make that information widely available for broad government appropriation.

The risk of dissemination, misappropriation, or abuse when the government acquires this information has intensified given the well-publicized incidents of security failures involving implementation of the ACA. For example, Michael Astrue, former HHS general counsel and Commissioner of the Social Security Administration, has revealed that the government's system for collecting personal information in exchanges would "leave members of the public open to identity theft," would result in "exposure of address for victims of domestic abuse and others," and would "inflict on the public the most widespread violation of the Privacy Act in our history." Michael Astrue, *Privacy Be Damned*, The Weekly Standard,

Aug. 5, 2013.[10] Earlier this year, David Kennedy, head of computer security consulting firm TrustedSec LLC, told the House Science, Space and Technology Committee that "HealthCare.gov is not secure today" and that "nothing has really changed" since a hearing several months before when experts recommended shutting down the website immediately due to security concerns. David Morgan and Jim Finkle, *Republicans warn of security flaws in Obamacare website*, Reuters, Jan. 16, 2014.[11] Recently, these concerns were further substantiated when a "low-level" hacker was able to break into the healthcare.gov website. Brett Norman, *GOP Chorus Attacks Obamacare Over Healthcare.gov Hack*, Politico, Sept. 4, 2014.[12]

The government itself has come to similar conclusions about healthcare.gov's security. In 2013, the

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[10] *Available at* http://www.weeklystandard.com/articles/privacy-be-damned_741033.html.

[11] *Available at* http://www.reuters.com/article/2014/01/16/us-usa-healthcare-security-idUSBREA0F07X20140116.

[12] *Available at* http://www.politico.com/story/2014/09/healthcare-gov-hacked-consumer-information-not-breached-110611.html. Further concern over government abuse stems from the revelation that the very same IRS official who supervised the targeting of politically conservative groups seeking tax-exempt status now oversees the IRS' enforcement of PPACA. *See* John Parkinson and Steven Portnoy, *IRS Official in Charge During Tea Party Targeting Now Runs Health Care Office*, ABC News, May 16, 2013, *available at* http://abcnews.go.com/blogs/politics/2013/05/irs-official-in-charge-during-tea-party-targeting-now-runs-health-care-office/.

Department of Health and Human Services ("HHS") concluded that it "could not assess . . . efforts to identify security controls and system risks for the [Health Insurance Exchange's Electronic] Hub and implement safeguards and controls to mitigate identified risks" and that it "could not assess . . . whether vulnerabilities identified by the testing would be mitigated." HHS Office of Inspector General, *Observations Noted During the OIG Review of CMS's Implementation of the Health Insurance Exchange – Data Services Hub*, Aug. 2013, at 4-5.[13] Recent investigations have revealed that over a year later, CMS had not implemented a variety of security processes and "had not fully remediated two critical vulnerabilities." HHS Office of Inspector General, *Health Insurance Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls*, Sept. 2014, at 7-8.[14]

Around this same time, the Government Accountability Office identified "a number of weaknesses in specific technical security controls [that] jeopardized Healthcare.gov-related-systems" because "CMS did not establish a shared understanding of security roles and responsibilities with all parties involved in securing Healthcare.gov systems." Statement of Gregory C. Wilshusen, Director, Information Security

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[13] *Available at* http://oig.hhs.gov/oas/reports/region1/181330070.pdf.

[14] *Available at* http://oig.hhs.gov/oas/reports/region1/181430011.pdf.

Issues, *Information Security and Privacy Controls Should Be Enhanced to Address Weaknesses* (GAO-14-871T), Sept. 18, 2014, at 1.[15] According to the GAO, "the [healthcare.gov] systems and the information they contain remain at increased risk of unauthorized use, disclosure, modification, or loss." *Id.*

Requiring Mr. Coons to relinquish his personal information before he can challenge the unconstitutional burden on his privacy rights forces him to suffer dual injuries: the unconstitutional burden on exercising his privacy rights, *and* the risk that his information will be further disseminated or misappropriated. A plaintiff should not have to suffer an injury, and risk even further injuries, before challenging an unconstitutional condition on his rights. This Court should grant Mr. Coons' petition to address this important question.

[15] *Available at* http://www.gao.gov/assets/670/665879.pdf.

II. THE DECISION BELOW DISMISSING NOVACK'S SEPARATION-OF-POWERS CLAIM CONFLICTS WITH DECISIONS OF THIS COURT, DENYING AGGRIEVED PARTIES THEIR SOLE MEANS OF RECOURSE AGAINST AN UNACCOUNTABLE AGENCY

A. In Light of Conflicting Precedents, Lower Courts Need Guidance Regarding Whether a Plaintiff Can Challenge His Subjection to an Unconstitutional Regime that Affects His Interests

This Court has "reaffirmed[ ] the central judgment of the Framers of the Constitution that, within our political scheme, the separation of governmental powers into three coordinate Branches is essential to the preservation of liberty." *Mistretta v. United States*, 488 U.S. 361, 380 (1989). "[T]his system . . . was deliberately so structured to assure full, vigorous, and open debate on the great issues affecting the people and to provide avenues for the operation of checks on the exercise of governmental power." *Bowsher v. Synar*, 478 U.S. 714, 722 (1986). With the growth of the administrative state, it is critical that some avenue exist for courts to ensure respect for these

structural principles.[16] Unfortunately, due to conflicts among the lower courts regarding whether and when a plaintiff may bring facial separation-of-powers challenges to administrative agencies, violations are likely to evade review. This is especially true where, as here, a constitutional challenge is a plaintiff's *only recourse* against extreme consolidations of power wielded by a single unaccountable agency.

In *Buckley*, 424 U.S. at 117, this Court established that "[p]arty litigants with sufficient concrete interests at stake may have standing to raise constitutional questions of separation of powers with respect to an agency designated to adjudicate their rights." (Citation omitted). Thus, various candidates for federal office and political organizations could challenge the Federal Elections Commission on separation-of-powers grounds even though "*many of its . . . functions remain*[*ed*] *as yet unexercised*." *Id.* at 116 (emphasis added).

Implicitly applying the *Buckley* standard in *Metropolitan Wash. Airports Auth. v. Citizens for Abatement*

[16] Indeed, Justices of this Court have voiced concerns over modern application of the separation-of-powers doctrine. *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 487 (2001) (Thomas, J., concurring) (expressing a "willing[ness] to address the question whether our delegation jurisprudence has strayed too far from our Founders' understanding of separation of powers"); *Mistretta*, 488 U.S. at 422 (Scalia, J., dissenting) (due to misapplication of separation-of-powers doctrine, "Congress will find delegation of its lawmaking powers much more attractive in the future").

of Aircraft Noise, Inc., 501 U.S. 252 (1991) ("*MWAA*"), this Court held that a citizens' group whose aim was to reduce aircraft noise could bring a separation-of-powers claim against a Board of Review empowered to veto reductions in air traffic at Washington National Airport. Plaintiffs had standing despite their attenuated relationship with the agency because the agency "creat[ed] an impediment to a reduction in [aircraft noise]" and thus "injure[d] [plaintiffs] by making it more difficult for [them] to reduce noise and activity." *Id.* at 265 (citations omitted).

A plaintiff subject to and affected by an unconstitutional agency thus has standing to challenge that agency for violating separation-of-powers. Just as the Board of Review was created to maintain or increase air traffic in *MWAA*, the ACA empowers IPAB to reduce – but not to increase – Medicare reimbursements in order to achieve a net reduction in total Medicare spending. 42 U.S.C. § 1395kkk(b). Just as the creation of the Board of Review decreased plaintiffs' ability to reduce airport noise, *MWAA*, 501 U.S. at 265, IPAB's directive to "reduce the per capita rate of growth in Medicare spending," 42 U.S.C. § 1395kkk(b) combined with its broad and virtually unreviewable powers to enact law decreases Dr. Novack's ability to maintain Medicare reimbursement rates and alters the procedure by which Dr. Novack is reimbursed for treating Medicare patients. Doc. #41 ¶¶ 7, 128. Thus, the decision below is in clear and stark conflict with this Court's decision in *MWAA*.

Making matters worse, lower courts apply the standards of *Buckley* and *MWAA* haphazardly. First, there is no clear consensus as to what constitutes "a proper nexus with the agency-defendant . . . [to] have standing to assert a separation of powers claim," William Marks, *Bond, Buckley, and the Boundaries of Separation of Powers Standing*, 67 Vand. L. Rev. 505, 519 (2014), because "[t]he contours of *Buckley's* standing analysis are not well-defined." *KG Urban Enters., LLC v. Patrick*, 693 F.3d 1, 15 (1st Cir. 2012). Thus, the First Circuit held that a casino development company and potential applicant for a gaming license did *not* have standing to challenge the composition of an advisory regulatory agency charged with implementing that licensing scheme. *Id.* The Court held that *Buckley*'s requirement that a plaintiff have "sufficient concrete interests at stake" was "not so broad" as to apply to *all* "individual[s] subject to the jurisdiction of a regulatory agency." *Id.*

Likewise, the Sixth Circuit ruled that attorneys lacked standing to challenge the National Security Agency's use of warrantless wiretaps on separation-of-powers grounds because they could not show that the general use of wiretaps inflicted a "burden on the performance of their professional obligations." *American Civil Liberties Union v. National Sec. Agency*, 493 F.3d 644, 674 (6th Cir. 2007). Yet the Third Circuit held that a witness subpoenaed to testify before a Presidential Commission on organized crime did have standing to raise a separation-of-powers challenge to the composition of the Commission even though he

could not "prove that the same harm would not have occurred at the hands of a properly constituted entity." *In re President's Comm'n on Organized Crime Subpoena of Scarfo*, 783 F.2d 370, 374 (3d Cir. 1986).

The D.C. Circuit imposes the most stringent standing requirement for separation-of-powers cases. It held that a group of businesses, associations, labor unions, and individuals that had allegedly suffered serious financial damage as a result of monetary instability lacked standing to challenge the Federal Open Market Committee ("FOMC") on separation-of-powers grounds because *Buckley* does not confer standing on plaintiffs who are not "*directly subject* to the governmental authority they seek to challenge but merely assert that they are *substantially affected* by the exercise of that authority." *Committee for Monetary Reform v. Board of Governors of the Fed. Reserve Sys.*, 766 F.2d 538, 543 (D.C. Cir. 1985) (emphasis added). It also denied standing to a long-term bondholder challenging the appointment of members to the FOMC. *Reuss v. Balles*, 584 F.2d 461 (D.C. Cir. 1978). Dissenting from that decision, Chief Judge J. Skelly Wright rejected the court's narrow application of the *Buckley* standard, arguing that the bondholder had standing because his "interests will be affected by the actions taken by the FOMC which directly influence prevailing interest rates and, thus, the value of appellant's property." *Id.* at 471-72 (Wright, C.J., dissenting). Under *Buckley*, he contended, a plaintiff has standing when he "has a concrete interest in the decisions of the agency." *Id.*

This confusion has resulted in inconsistent applications within the D.C. Circuit. A federal district court in that circuit held that a government contractor who acquired 80 percent of his business from contracts with an Air Force base scheduled for closure under the Base Closure and Realignment Act lacked a sufficient agency nexus to bring a separation-of-powers challenge against the Base Closure Commission, while civilians employed at military bases subject to closure *could* bring a challenge because the agency exercised a "significant degree of authority and control . . . over these civilian employees." *National Fed'n of Fed. Emps. v. United States*, 727 F. Supp. 17, 21 (D.D.C. 1989). Despite its strict interpretation of *Buckley*, the D.C. Circuit affirmed the district court's ruling with respect to employee standing. 905 F.2d 400, 402 (D.C. Cir. 1990).

Because he receives Medicare reimbursements for over 12.5 percent of his practice, Doc. #41 ¶ 7, Dr. Novack falls under IPAB's authority to act in any way that it considers "related to the Medicare program." Subjecting Dr. Novack's practice to IPAB's unconstrained bureaucracy directly implicates his financial and medical interests and subjects him to a procedure for determining reimbursements that IPAB's existence has already set in motion. Doc. #41 ¶¶ 99-102; *see Barnum Timber Co. v. E.P.A.,* 633 F.3d 894, 901 (9th Cir. 2011) (citations omitted) (this "Court routinely recognizes probable economic injury resulting from governmental actions that alter competitive conditions as sufficient to satisfy" standing). Thus,

Dr. Novack's "concrete interests [are] at stake." *Buckley*, 424 U.S. at 117. Furthermore, because IPAB's determinations are final and are not subject to judicial or administrative review, 42 U.S.C. § 1395kkk(e)(5), the IPAB is "designated to adjudicate [Dr. Novack's] rights." *Buckley*, 424 U.S. at 117. Yet the Ninth Circuit did not consider Dr. Novack to be properly "subject to the jurisdiction of a governmental entity established in violation of the Constitution" for purposes of *Buckley* standing. (App. at 12, n.4). Accordingly, this Court should grant the petition to clarify *Buckley*'s standing rule.

B. Lower Courts Need Guidance Regarding Whether a Plaintiff May Bring a Facial Constitutional Challenge Before an Agency Has Acted

Just as there is confusion among the lower courts regarding whether a plaintiff has standing to bring facial separation-of-powers claims, there is also confusion as to when such a claim is ripe for review. Facial constitutional challenges to a governmental entity or statutory regime are typically ripe even before the agency acts because they do not rely on further factual development. Facial separation-of-powers challenges attack the constitutionality of the agency *itself*, not any particular agency action. The constitutional violation occurs *when the agency is created*, not when it issues its regulations. When Congress violates the Constitution by enacting a

statute that contravenes the Constitution's structural protections, "the violation must inhere in the text of the statute itself" and "the merits of the constitutional claim cannot turn at all on the facts of enforcement." Nicholas Quinn Rosenkranz, *The Subjects of the Constitution*, 62 Stan. L. Rev. 1209, 1235-36 (2010). "Post-enactment facts should never matter to the merits of such a claim, because the constitutional violation is already complete." *Id.* at 1245.

Ripeness is a "question of timing. . . . Its basic rationale is to prevent the courts, through premature adjudication, from entangling themselves in abstract disagreements." *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580 (1985) (citations omitted). A primary inquiry of ripeness is "whether the courts would benefit from further factual development of the issues presented." *Ohio Forestry Ass'n, Inc. v. Sierra Club*, 523 U.S. 726, 733 (1998).

Thus, this Court held that citizens living near the site of proposed nuclear power plants could challenge the constitutionality of a nuclear accident liability statute before it was enforced because the statute made it easier for power plants to be constructed. *Duke Power Co. v. Carolina Envtl. Study Group, Inc.*, 438 U.S. 59, 81-82 (1978). Ripeness is also a lesser barrier where, as here, the statutory framework prohibits affected persons from obtaining judicial review of an agency's actions. *Regional Rail Reorganization Act Cases*, 419 U.S. 102, 144 (1974). In such cases, a constitutional challenge is *the only*

means of recourse, and "there is no better time to decide the constitutionality of the Act[ ]." *Id.* at 144.

Yet the lower courts are in disarray as to when a facial constitutional challenge to an agency or regime is ripe. Some have followed this Court, recognizing that facial challenges to governmental agencies or statutory regimes are ripe when the agency is formed. For example, civilians employed at military bases could bring a separation-of-powers challenge against the Base Closure Commission even though their military base had not yet been – and might never be – selected for closure. *National Fed'n of Fed. Emps.*, 727 F. Supp. at 21, *aff'd*, 905 F.2d 400, 402 (D.C. Cir. 1990). Similarly, in *Synar v. United States*, an employee association's separation-of-powers challenge to Congress's power to remove an executive officer was ripe even though removal had not been attempted because the executive's mere subservience to the legislative branch already created the separation-of-powers problem. 626 F. Supp. 1374, 1392 (D.D.C. 1986), *aff'd sub nom. Bowsher v. Synar*, 478 U.S. 714 (1986).

Likewise, the First Circuit held that a retired municipal employee could challenge a statutory disability retirement scheme even though his benefits had not yet been reduced because the uncertainty of a reduction in benefits hinders his ability to adequately arrange his financial affairs. *Riva v. Com. of Mass.*, 61 F.3d 1003, 1011-12 (1st Cir. 1995). Moreover, "he mounts a facial challenge to the state law, and . . . [the] court is capable of resolving it with no further

factual exposition." *Id.*; *see also Whitney*, 780 F.2d at 968 n.6 (doctors who had not raised their rates could nevertheless challenge a temporary statutory freeze on Medicare fees because their case "raises a facial attack on the constitutionality of § 2306 and presents a purely legal question, [and the court] will never be in a better position to decide the issue").

Yet the Ninth Circuit's decision requires that an agency must take an action before a plaintiff may sue. (App. at 9-11). In the decision below, it held that because IPAB has not yet "exercise[d] its discretion to recommend reduction in reimbursement rates," *id.* at 11, Dr. Novack does not "face a realistic danger of sustaining direct injury as a result of the statute's operation or enforcement." *Id.* at 9 (quoting *Thomas v. Anchorage Equal Rights Comm'n*, 220 F.3d 1134, 1139 (9th Cir. 2000)). Yet Dr. Novack does not challenge the statute's operation or enforcement; rather, he challenges the statute that creates IPAB.[17] That decision is in clear and irreconcilable conflict with decisions of the First, Eleventh, and D.C. Circuits.

The question of whether a plaintiff who is subjected to an unconstitutional regime must wait until the agency acts before bringing a facial separation-of-powers challenge is of great nationwide importance

[17] Additionally, Dr. Novack is injured by market displacements IPAB's existence has already set in motion as doctors and patients prepare for the coming regulations. Doc. #41 ¶¶ 99-102. *See Barnum,* 633 F.3d at 901.

and essential to establishing uniformity among the lower courts. Declining to consider the case now leaves intact multiple conflicts among circuit courts and places Americans at the mercy of an unaccountable Board that unilaterally makes law affecting public and private health care. Since the law insulates IPAB's actions from judicial review, this constitutional challenge is the only recourse against the Board.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be *granted*.

DATED: November 5, 2014.

Respectfully submitted,

CLINT BOLICK
KURT ALTMAN
CHRISTINA SANDEFUR*
**Counsel of Record*
GOLDWATER INSTITUTE
SCHARF-NORTON CENTER FOR
CONSTITUTIONAL LITIGATION
500 E. Coronado Rd.
Phoenix, AZ 85004
(602) 462-5000
litigation@goldwaterinstitute.org

Counsel for Petitioners

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NICK COONS; and
ERIC N. NOVACK, M.D.,

Plaintiffs-Appellants,

v.

JACOB L. LEW, in his official capacity as Secretary of the United States Department of the Treasury; KATHLEEN SEBELIUS, in her official capacity as Secretary of the United States Department of Health and Human Services; ERIC H. HOLDER, JR., Attorney General, in his official capacity as Attorney General of the United States; and BARACK HUSSEIN OBAMA, in his official capacity as President of the United States,

Defendants-Appellees.

No. 13-15324

D.C. No. 2:10-cv-01714-GMS

ORDERED AND AMENDED

Appeal from the United States District Court
for the District of Arizona,
G. Murray Snow, District Judge, Presiding

Argued and Submitted
June 10, 2014 – San Francisco, California

Filed August 7, 2014
Amended September 2, 2014

Before: Mary M. Schroeder, Susan P. Graber, and Jay S. Bybee, Circuit Judges.

Opinion by Judge Graber

COUNSEL

Christina Sandefur (argued), Clint Bolick, Kurt Altman, and Nicholas C. Dranias, Goldwater Institute, Phoenix, Arizona, for Plaintiffs-Appellants.

Jeffrey E. Sandberg (argued), Dana Kaersvang, and Alisa B. Klein, Attorneys, John S. Leonardo, United States Attorney, and Stuart F. Delery, Acting Assistant Attorney General, Civil Division, United States Department of Justice, Washington, D.C., for Defendants-Appellees.

Timothy Sandefur, Pacific Legal Foundation, Sacramento, California, for Amici Curiae.

ORDER

The opinion filed on August 7, 2014, and published at 2014 WL 3866475, is amended by the opinion filed concurrently with this order, as follows:

On slip opinion page 7, second paragraph, lines 5 and 6, change "Medicare" to "Medicaid".

The time for filing petitions for panel rehearing and for rehearing en banc shall remain the same from the August 7, 2014, original filed date of the opinion.

OPINION

GRABER, Circuit Judge:

Plaintiffs Nick Coons and Eric N. Novack brought a facial constitutional challenge to two provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *as amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("Affordable Care Act"): the individual mandate, which requires that individuals maintain a minimum level of health insurance coverage or pay a penalty; and the establishment of the Independent Payment Advisory Board ("IPAB"), a new advisory board charged with issuing budget recommendations for the Medicare program in the event that the program exceeds growth projections. Plaintiffs also sought a declaration that the Arizona Health Care Freedom Act ("Arizona Act"), which amends the Arizona constitution to make it lawful to abstain from purchasing health insurance without paying any penalty, is not preempted by the Affordable Care Act. After the Supreme Court issued *National Federation of Independent Business v. Sebelius,* 132 S. Ct. 2566 (2012), the district court dismissed Plaintiffs' claims and entered judgment for Defendants Timothy Geithner, Kathleen Sebelius, Eric Holder, Jr., and Barack Hussein Obama, in their official capacities. Reviewing de novo, *Stout v. FreeScore, LLC,* 743 F.3d 680, 684 (9th Cir. 2014); *Demers v. Austin,* 746 F.3d 402, 409 (9th Cir. 2014), we affirm in part, and in part

vacate and remand with instructions to dismiss for lack of jurisdiction.

BACKGROUND

In March 2010, Congress passed and the President signed into law the Affordable Care Act. The Act establishes a comprehensive regulatory system intended to increase the number of Americans covered by medical insurance and to decrease the cost of medical care. Two of its provisions are at issue in this appeal: the provision commonly known as the individual mandate, 26 U.S.C. § 5000A; and the provision establishing IPAB, 42 U.S.C. § 1395kkk.

The individual mandate is codified in Title 26 of the Internal Revenue Code. 26 U.S.C. § 5000A. The mandate requires all "applicable individuals," *id.* § 5000A(d), and their dependents to maintain "minimum essential coverage," *id.* § 5000A(f), for every month beginning in January 2014, *id.* § 5000A(a). If an individual fails to meet that requirement and does not qualify for an exemption, *id.* § 5000A(e), the individual must pay a penalty, termed the "shared responsibility payment," with his or her annual income tax return, *id.* § 5000A(b).

IPAB is a new 15-member administrative board that will monitor the growth of Medicare spending and, if actual growth exceeds projected growth, will develop and submit recommendations to reduce the growth rate to the "savings target" set by the Chief Actuary of the Centers for Medicare & Medicaid

Services. 42 U.S.C. § 1395kkk. The requirement that IPAB issue recommendations for a given year is triggered only if the Chief Actuary determines that actual growth will exceed projected growth in a particular year. *Id.* § 1395kkk(b). If the Chief Actuary makes that determination, then IPAB is required to recommend measures to reduce growth that the Secretary of Health and Human Services ("Secretary") must implement in the absence of an affirmative veto by Congress.[1] *Id.* If IPAB fails to make the required recommendations for a given year, for lack of membership or otherwise, its duties fall to the Secretary. *Id.* § 1395kkk(c)(5). Once IPAB completes its recommendations, it must submit them to Congress and the President. *Id.* § 1395kkk(c)(3). If instead the Secretary completes the recommendations, the Secretary must submit them to the President, who must in turn submit the proposal to Congress within two days. *Id.* § 1395kkk(c)(4)-(5). The scheme then provides, through congressional rulemaking power, *id.* § 1395kkk(d)(5), detailed procedures by which Congress must either consider and vote on the recommendations or pass superseding legislation, *id.* § 1395kkk(d). In the absence of superseding legislation, *id.* § 1395kkk(e)(3)(A)(i), the Secretary must implement the recommendations as submitted to Congress and the President, *id.* § 1395kkk(e)(1).

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[1] IPAB also has the authority, at its discretion, to make non-binding, advisory proposals to Congress. 42 U.S.C. § 1395kkk(c).

In August of 2010, Coons and Novack, along with two members of Congress,[2] filed an omnibus facial challenge to the Affordable Care Act in the United States District Court for the District of Arizona. Coons is a citizen of Arizona, is not exempt from the Affordable Care Act, does not have private medical insurance, and does not want to purchase private medical insurance or share his private medical history with third parties. Novack is a citizen of Arizona and a physician who manages a surgery practice that cares for patients, 12.5% of whom receive care funded by Medicare reimbursements. Plaintiffs challenge the individual mandate and the establishment of IPAB on several theories, including claims that those provisions: violate their constitutional rights; exceed Article I legislative power under the Commerce Clause, Necessary and Proper Clause, Spending Clause, and taxation power; and violate Article I's non-delegation principle. Plaintiffs also seek a declaration that the Arizona Act is not preempted by the Affordable Care Act.

Plaintiffs' challenge was one of many similar cases filed nationwide. One such case reached the United States Supreme Court. The Court reviewed the individual mandate and two other provisions expanding Medicaid coverage, 42 U.S.C.

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[2] The second amended complaint included Coons, Novack, and United States House of Representatives members Jeff Flake and Trent Franks as plaintiffs. But Representatives Flake and Franks did not appeal. Unless otherwise specified, therefore, "Plaintiffs" refers to Coons and Novack only.

§§ 1396a(a)(10)(A)(i)(VIII), 1396c, to decide whether the provisions exceeded Article I legislative power under the Commerce Clause, the Spending Clause, or Congress' taxation power. While the Supreme Court's decision was pending, Defendants moved to dismiss all of Plaintiffs' claims, and the parties filed cross-motions for summary judgment. The district court stayed this action pending the Supreme Court's disposition.

In *National Federation of Independent Business,* the Supreme Court upheld the individual mandate as a proper exercise of Congress' taxation power, 132 S. Ct. at 2600, but struck, as exceeding Spending Clause power, the portion of the Medicaid expansion provision that withdrew all federal Medicaid funding, including funding provided for programs predating the expansion, from states that refused to adopt the expansion, *id.* at 2606-07. Following that decision, the district court lifted the stay in Plaintiffs' case and granted Defendants' motion to dismiss all claims that challenged the individual mandate for exceeding Article I lawmaking power. The district court also held that the establishment of IPAB did not violate Article I's non-delegation principle. After receiving further briefing, the district court dismissed the remaining claims[3] and entered final judgment for

[3] After the Supreme Court issued its decision in *Nevada Commission on Ethics v. Carrigan,* 131 S. Ct. 2343 (2011), Plaintiffs voluntarily dismissed count six of their complaint, which challenged features of the Affordable Care Act as violative of Plaintiffs Flake and Franks' First Amendment rights.

Defendants. Plaintiffs Coons and Novack timely appealed, and we have jurisdiction under 28 U.S.C. § 1291.

DISCUSSION

Plaintiffs argue on appeal that the district court erred by dismissing their challenge to the establishment of IPAB and their challenge to the individual mandate as violative of Coons' substantive due process rights to medical autonomy and informational privacy and by holding that the Affordable Care Act preempts the Arizona Act. We disagree with their arguments for the reasons that follow.

A. Article I Non-Delegation Challenge

Novack challenges the establishment of IPAB on the ground that it violates Article I's non-delegation principle. But we first must address the threshold question whether Novack satisfies the demands of Article III for ripeness. The framers of Article III designed the federal courts to act retrospectively and to avoid encroaching, through the issuance of advisory opinions, on the prospective lawmaking role of the legislature. *United Pub. Workers of Am. (C.I.O.) v. Mitchell,* 330 U.S. 75, 89 (1947). "For adjudication of constitutional issues, concrete legal issues, presented in actual cases, not abstractions, are requisite." *Id.* (internal quotation marks omitted). This requirement has led to the doctrine of ripeness, which contains

"both a constitutional and a prudential component." *Portman v. County of Santa Clara,* 995 F.2d 898, 902 (9th Cir. 1993). The constitutional component derives from Article III and, if it is not satisfied, we lack jurisdiction to reach the merits of a dispute. *Thomas v. Anchorage Equal Rights Comm'n,* 220 F.3d 1134, 1139 (9th Cir. 2000) (en banc).

"The constitutional component of the ripeness inquiry is often treated under the rubric of standing and, in many cases, ripeness coincides squarely with standing's injury in fact prong." *Id.* at 1138. When addressing the sufficiency of a showing of injury-in-fact grounded in potential future harms, Article III standing and ripeness issues often "boil down to the same question." *Susan B. Anthony List v. Driehaus,* 134 S. Ct. 2334, 2341 n.5 (2014) (internal quotation marks omitted). In that context, "ripeness can be characterized as standing on a timeline," and the analysis for both standing and ripeness is essentially the same. *Thomas,* 220 F.3d at 1138.

"In assuring that this jurisdictional prerequisite is satisfied, we consider whether the plaintiffs face a realistic danger of sustaining direct injury as a result of the statute's operation or enforcement." *Id.* at 1139 (internal quotation marks omitted). A plaintiff's "injury must be concrete, particularized, and actual or imminent; fairly traceable to the challenged action; and redressable by a favorable ruling. Although imminence is concededly a somewhat elastic concept, it cannot be stretched beyond its purpose, which is to

ensure that the alleged injury is not too speculative for Article III purposes – that the injury is *certainly* impending. Thus, we have repeatedly reiterated that threatened injury must be *certainly impending* to constitute injury in fact, and that allegations of *possible* future injury are not sufficient." *Clapper v. Amnesty Int'l USA,* 133 S. Ct. 1138, 1147 (2013) (citations, internal quotation marks, and brackets omitted).

Novack alleges that the establishment of IPAB will certainly harm him in the future because he is an orthopedic surgeon and manages a surgery practice in Arizona that receives 12.5% of its patient care payments from Medicare reimbursements. He argues that, because IPAB is empowered to make recommendations on reimbursement rates, 42 U.S.C. § 1395kkk(c)(2)(A)(iv), his challenge is ripe because he will suffer financial harm as a result of IPAB's recommendations. Novack argues, in the alternative, that the establishment of IPAB will set in motion market displacements that will harm him financially, which he contends is sufficient to satisfy Article III.

Although it is possible that some future IPAB action might harm Novack, his allegations of future financial harm are highly speculative and are not certainly impending. *Clapper,* 133 S. Ct. at 1147. The Affordable Care Act does provide that – if the Chief Actuary makes the requisite finding – IPAB will have the discretion to recommend reduced reimbursement rates to providers, 42 U.S.C. § 1395kkk(c)(2)(A)(iv),

but IPAB is prohibited from recommending a reduction until January 1, 2019, *id.* § 1395kkk(c)(2)(A)(iii). Novack's allegations that, because IPAB is authorized to reduce and not increase reimbursement rates, "the statute is imminently likely to decrease his reimbursements for services that he renders to Medicare patients, and otherwise affects his practice," are exactly the kinds of "allegations of possible future injury" that the Supreme Court has held are insufficient to establish injury-in-fact. *Clapper,* 133 S. Ct. at 1147. Speculative allegations with respect to a potential future reduction in Medicare reimbursement rates that are "wholly contingent upon the occurrence of unforeseeable events" are insufficient to satisfy the constitutional prong of our ripeness doctrine. *Thomas,* 220 F.3d at 1141. Accordingly, Novack's challenge to IPAB grounded on the contention that IPAB could exercise its discretion to recommend reduction in reimbursement rates some time after 2019, thereby causing him injury, is unripe.

Novack's challenge to IPAB predicated on a market displacement theory of injury-in-fact is equally unripe. In particular, Novack cites allegations in the complaint that, "*if* [IPAB's speculated reductions in reimbursement rates] are anticipated to become law," health care providers and the market *might* react negatively. (Emphasis added.) Those allegations are insufficient to establish standing under the market displacement theory of injury-in-fact. *See Barnum Timber Co. v. EPA,* 633 F.3d 894, 900-01 (9th

Cir. 2011). Unlike the plaintiff in *Barnum,* who alleged that EPA regulations on one property had already affected the market and had already reduced the market value of plaintiff's property, *id.* at 901, Novack alleges only speculative future market displacement that is contingent on a series of events, including IPAB action, that has not yet occurred and may never occur. Such speculative alleged injuries present a dispute that is "not justiciable, because it is not ripe for court review." *Ohio Forestry Ass'n v. Sierra Club,* 523 U.S. 726, 732 (1998). Moreover, Novack does not allege that he actually has suffered financial harm from the alleged market forces.

In sum, Novack's allegations of future injury are too speculative to satisfy the constitutional requirement of ripeness.[4] The district court, therefore, lacked jurisdiction to adjudicate the merits of Novack's challenge to the establishment of IPAB. Accordingly, we vacate the district court's judgment on this claim and remand with instructions to dismiss the claim for lack of jurisdiction.

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[4] Novack argues, in the alternative, that he has suffered an injury-in-fact simply by virtue of being subject to the jurisdiction of the IPAB. The Supreme Court has held that, in certain circumstances, merely being subject to the jurisdiction of a governmental entity established in violation of the Constitution confers Article III standing. *See Buckley v. Valeo,* 424 U.S. 1, 117-18 (1976) (per curiam). But IPAB has no jurisdiction over Novack or his practice of medicine. Novack's allegations that his financial interests will be affected indirectly by IPAB's future regulatory actions do not suffice to render Novack subject to IPAB's jurisdiction.

B. Substantive Due Process and the Individual Mandate

Coons challenges the individual mandate on the ground that it violates his right to substantive due process provided by the Fifth and Ninth Amendments. He argues that the mandate burdens directly his rights to medical autonomy and informational privacy and, in the alternative, burdens his informational privacy right indirectly by conditioning the exercise of his right not to share his private medical information on a requirement that he pay a penalty.

1. Medical Autonomy

The Supreme Court has recognized fundamental rights to determine one's own medical treatment, *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health,* 497 U.S. 261, 278 (1990), and to refuse unwanted medical treatment, *Washington v. Glucksberg,* 521 U.S. 702, 724 (1997), and has recognized a fundamental liberty interest in medical autonomy, *Planned Parenthood of Se. Pa. v. Casey,* 505 U.S. 833, 851 (1992). Coons contends that the individual mandate unduly burdens his right to medical autonomy by "forcing him to apply limited financial resources to obtaining a health care plan he does not desire or forcing him to save his income and pay a penalty" and by "forcing him to create or risk creating an intimate relationship concerning his health and medical care with millions of non-physician intermediaries employed by

health insurers, rather than directly with the physician of his choice."

In order to determine whether the individual mandate implicates Coons' rights to medical autonomy, we must examine what the individual mandate actually requires. The Affordable Care Act provides that an individual must obtain from any source, public or private, medical insurance that meets statutory minimums of coverage, 26 U.S.C. § 5000A(a); or must pay a penalty, in the form of a tax, *id.* § 5000A(b). The individual mandate does *not* require that an individual select a particular insurance plan, does *not* require that the individual use an insurance plan once purchased, and does *not* restrict an individual's right to contract for care directly with the physician of his or her choosing.

The fact that the individual mandate forces Coons to expend funds on either medical insurance or a penalty implicates Plaintiff's economic interests only – a substantive due process right abandoned long ago by the Supreme Court. *See Ferguson v. Skrupa,* 372 U.S. 726, 730 (1963) ("The doctrine that prevailed in *Lochner, Coppage, Adkins, Burns,* and like cases – that due process authorizes courts to hold laws unconstitutional when they believe the legislature has acted unwisely – has long since been discarded."). As noted, contrary to Coons' contentions, the individual mandate does not force him into an intimate relationship with an intermediary insurer or preclude the doctor-patient relationship of his choice. He remains free to obtain medical insurance of his

own choosing – or to obtain no insurance, but at a financial cost – and to use or not use any such insurance in selecting future doctor-patient relationships. To the extent that Coons simply wishes to remain uninsured *and* free from the mandatory payment, the Supreme Court no longer recognizes such a right as fundamental.

We thus join the Sixth Circuit in upholding the individual mandate against a substantive due process challenge grounded in medical autonomy. *U.S. Citizens Ass'n v. Sebelius,* 705 F.3d 588 (6th Cir. 2013).

2. Informational Privacy

The Supreme Court has recognized a fundamental privacy right in non-disclosure of personal medical information. *Whalen v. Roe,* 429 U.S. 589, 599 (1977). But, "the right to informational privacy is not absolute; rather, it is a conditional right which may be infringed upon a showing of proper governmental interest." *Tucson Woman's Clinic v. Eden,* 379 F.3d 531, 551 (9th Cir. 2004) (internal quotation marks omitted). In order "to determine whether the governmental interest in obtaining information outweighs the individual's privacy interest," we weigh the following factors: "(1) the type of information requested, (2) the potential for harm in any subsequent nonconsensual disclosure, (3) the adequacy of safeguards to prevent unauthorized disclosure, (4) the degree of the need for access, and (5) whether there is an express statutory mandate, articulated public policy,

or other recognizable public interest militating toward access." *Id.* at 551.

Coons contends that the individual mandate burdens impermissibly his fundamental right to privacy in his medical information by requiring him to provide medical information to third-party insurance providers. He speculates that insurers will "solicit sensitive information from customers" in order to set risk premiums. He also asserts that such a disclosure would make his medical information available for warrantless government seizure. But Coons has not alleged that he has applied for medical insurance or that any third party has requested that he disclose his medical information as a condition precedent to obtaining the minimum required coverage.[5] Those omissions frustrate our ability to weigh the relevant factors delineated in *Tucson Woman's Clinic.*

Because Coons' challenge would require evaluating a speculative intrusion, his challenge is prudentially unripe.[6] *See San Luis & Delta-Mendota Water Auth. v. Salazar,* 638 F.3d 1163, 1173 (9th Cir. 2011). The Supreme Court has held that prudential ripeness depends on two factors: "the fitness of the issues for

[5] Indeed, at oral argument, counsel represented that Coons has no intention of obtaining insurance.

[6] Because Coons' unconstitutional conditions claim also rests on the contention that the penalty constitutes an undue burden on his ability to exercise his informational privacy rights, that challenge, too, is prudentially unripe.

judicial decision and the hardship to the parties of withholding court consideration." *Abbott Labs. v. Gardner,* 387 U.S. 136, 149 (1967). Here, as noted, Coons has not alleged that any third party has sought private medical information. Because we have no way to know who might seek what kind of information, further factual development would "'significantly advance [our] ability to deal with the legal issues presented.'" *San Luis & Delta-Mendota Water Auth.,* 638 F.3d at 1173 (quoting *Nat'l Park Hospitality Ass'n v. Dep't of Interior,* 538 U.S. 803, 812 (2003)). Moreover, Coons does not contend that he is currently at risk of being forced to disclose information protected by his substantive due process right, so a holding of unripeness would work no hardship against him. Judicial resolution of this issue should await a concrete dispute. We hold, therefore, that the district court did not err in declining to reach the merits of Coons' informational privacy claim for lack of ripeness.[7]

C. Preemption

Finally, Plaintiffs appeal the district court's holding that the Affordable Care Act preempts the

[7] Plaintiffs did not ask the district court for leave to amend, nor have they argued on appeal that the district court erred in dismissing their claim without affording them leave to amend their second amended complaint. Therefore, the district court did not err in dismissing Plaintiffs' claims without leave to amend.

Arizona Act. We evaluate under the Supremacy Clause, U.S. Const. art. VI, cl. 2, whether the Arizona Act, as a state law, is displaced by the Federal Affordable Care Act.

In November of 2010, eight months after the Affordable Care Act became law, Arizona voters amended their state constitution through the Arizona Act to provide, in pertinent part:

> A. To preserve the freedom of Arizonans to provide for their health care:
>
> 1. A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system.
>
> 2. A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.
>
> B. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

C. This section does not:

. . . .

4. Affect laws or rules in effect as of January 1, 2009.

5. Affect the terms or conditions of any health care system to the extent that those terms and conditions do not have the effect of punishing a person or employer for paying directly for lawful health care services or a health care provider or hospital for accepting direct payment from a person or employer for lawful health care services.

D. For the purposes of this section:

. . . .

5. "Penalties or fines" means any civil or criminal penalty or fine, tax, salary or wage withholding or surcharge or any named fee with similar effect established by law or rule by a government established, created or controlled agency that is used to punish or discourage the exercise of rights protected under this section.

Ariz. Const. art. XXVII, § 2.

"The question whether a certain state action is pre-empted by federal law is one of congressional intent. The purpose of Congress is the ultimate touchstone." *Gade v. Nat'l Solid Wastes Mgmt. Ass'n,* 505 U.S. 88, 96 (1992) (internal quotation marks and brackets omitted).

The Affordable Care Act presents a classic case of preemption by implication because the Arizona Act "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 98 (internal quotation marks omitted). The Supreme Court has recognized that the individual mandate is a proper exercise of Congress' Article I taxing power, *Nat'l Fed'n of Indep. Bus.,* 132 S. Ct. at 2600, and we affirm the constitutionality of the Affordable Care Act again today. The Arizona Act provides that its citizens may forego minimum health insurance coverage and abstain from paying any penalties, Ariz. Const. art. XXVII, § 2, which is exactly what the individual mandate requires. The Arizona Act thereby stands as an obstacle to Congress' objective to expand minimum essential health coverage nationwide through the individual mandate, 26 U.S.C. § 5000A, and is, therefore, preempted under the Supremacy Clause. *See Gade,* 505 U.S. at 103 ("A state law . . . is preempted if it interferes with the methods by which the federal statute was designed to reach [its] goal." (internal quotation marks omitted)).

CONCLUSION

We affirm the district court's holding that the individual mandate does not violate Plaintiff Coons' substantive due process right to medical autonomy, and we affirm the dismissal, for lack of ripeness, of Coons' challenge to the individual mandate for violation of his substantive due process right to informational privacy. We also affirm the district court's

holding that the Affordable Care Act preempts the Arizona Act. Finally, with respect to Plaintiff Novack's challenge to IPAB, we vacate the district court's decision on the merits of the claim and remand with instructions to dismiss it for lack of jurisdiction.

AFFIRMED in part, VACATED in part and REMANDED with instructions. Costs on appeal shall be awarded to Defendants-Appellees.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Nick Coons, et al., Plaintiffs, v. Timothy Geithner, et al., Defendants.	No. CV-10-1714-PHX-GMS **ORDER**

Pending before the Court are portions of Defendants' Motion to Dismiss (Doc. 42), Motion for Summary Judgment (Doc. 65)[1], and Plaintiffs' Motion to Treat Defendants' Motion to Dismiss as a Motion for Summary Judgment in Part (Doc. 48). For the reasons stated below, Plaintiffs' remaining Counts IV, V, and VIII are dismissed.

BACKGROUND

Plaintiffs challenge the constitutionality of the Patient Protection and Affordable Care Act of 2010 ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA"). Plaintiffs are Nick Coons and two members of the United States House of

[1] The Court directed the parties to file supplemental briefing on Counts IV, V, and VIII in its previous Order. (Doc. 84.) The Supplemental Briefs were filed consecutively. (Docs. 85-86.)

Representatives, Jeff Flake and Trent Franks. (Doc. 35).

On August 31, 2012, this Court dismissed Counts I, II, III, VI, and VII in light of the Supreme Court's opinion in *Nat'l Fed'n of Indep. Bus. v. Sebelius,* 132 S. Ct. 2566 (2012), and ordered supplemental briefing on whether the PPACA (IV) violates the Fifth and Ninth Amendments by restricting Plaintiff Coons' medical autonomy, (Doc. 35 ¶¶78-85), (V) violates the Fourth, Fifth and Ninth Amendments by violating Plaintiffs' privacy, (*id.* ¶¶ 86-91), and (VIII) pre-empts Arizona state health care legislation, (*id.* ¶¶ 127-134).

DISCUSSION

I. LEGAL STANDARD

"A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *U.S. v. Salerno*, 482 U.S. 739, 745 (1987). "[W]here an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems." *Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg. and Constr. Trades Council*, 485 U.S. 568, 575 (1988). A facial challenge must fail "where the statute has a plainly legitimate sweep." *Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 449 (2008) (internal quotations omitted).

II. ANALYSIS

A. Pre-emption

Plaintiff's Count VIII alleges that Arizona's Health Care Freedom Act ("HCFA") prohibits the operation of the PPACA in Arizona, and that the HCFA is not pre-empted by the PPACA. State laws are pre-empted when they directly conflict with federal law. *Id.* (citing *Crosby v. National Foreign Trade Council,* 530 U.S. 363, 372 (2000)). This includes cases where "compliance with both federal and state regulations is a physical impossibility," *Florida Lime & Avocado Growers, Inc. v. Paul,* 373 U.S. 132, 142-143 (1963), and those instances where the challenged state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," *Hines v. Davidowitz,* 312 U.S. 52, 67 (1941); *see also Crosby,* 530 U.S. at 373 ("What is a sufficient obstacle is a matter of judgment, to be informed by examining the federal statute as a whole and identifying its purpose and intended effects.").

"The purpose of Congress is the ultimate touchstone in every pre-emption case." *Wyeth v. Levine*, 555 U.S. 555, 565 (2009) (internal citations omitted). However, courts should assume that "the historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Arizona*, 132 S. Ct. at 2501 (citing *Wyeth*, 555 U.S. at 565).

The PPACA conflicts with Arizona's HCFA as embodied in the Arizona Constitution. *See* Ariz. Rev.

Stat. ("A.R.S.") 36-1301; Ariz. Const. XXVII, § 2. The federally-enacted PPACA includes a requirement to maintain minimum essential health insurance coverage. 26 U.S.C. § 5000A(a). Beginning in 2014, if a taxpayer fails to meet that requirement and is not exempt, a tax is imposed under the statute. *See id.* § 5000A(f)(1), (c). The Supreme Court has held that this "penalty" is in fact imposed "under the taxing power, and that § 5000A need not be read to do more than impose a tax." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2598. The purpose of the taxing provision, as described by Congress, is to "add millions of new consumers to the health insurance market . . . and . . . increase the number and share of Americans who are insured." 42 U.S.C. § 18091(C). Congress wanted to achieve "near-universal coverage" and "to induce the purchase of health insurance" so that individuals do not wait to do so until they need care. *Id.* at § 18091(D), (I); *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2574.

By contrast, the HCFA prohibits laws that levy taxes when an individual pays for health care without using a public or private third party. Ariz. Const. XXVII, § 2(A)(1), (D)(5). The purpose of the HCFA is to "preserve the freedom of Arizonans to provide for their health care." Ariz. Const. XXVII, § 2(A). The HCFA provides that "[a] law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system." *Id.* § 2(A)(1). The term "compel" is defined as including the usage of "penalties or fines." *Id.*

§ 2(D)(1). Furthermore, "[a] person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services." *Id.* § 2(A)(2).

"Penalties or fines" are defined in the HCFA as including any government taxes. *Id.* at § 2(D)(5). To permit the HCFA to operate would frustrate the purpose of the PPACA by allowing Arizona, and virtually all states, to exempt their citizens from its tax penalties, thus frustrating Congress's intent to encourage the purchase of minimal health insurance. Therefore the two laws are in direct conflict and Arizona's constitutional provision is preempted. Plaintiffs argue that the PPACA provision guaranteeing the freedom not to participate in a Federal health insurance program, 42 U.S.C. § 18115, evinces a Congressional intent not to preempt the HCFA. (Doc. 85 at 3.) However the plain text of the PPACA provision cited by Plaintiffs merely purports to preserve the right of an individual to decline to participate in any Federal health insurance program; it does not prohibit the government from imposing a cost on individuals for doing so. It is true that the PPACA does not "compel" taxpayers to buy insurance: the "shared responsibility payment" is not so high that there is really no choice but to buy health insurance. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2574. However the price of making that choice is to pay a tax.

Plaintiffs further argue that enforcing the tax penalty would "supersede Arizona's authority to shield individual liberty from federal power thwarting the

very aim of American federalism." (*Id.* at 6.) Federalism, central to the constitutional design, adopts the principle that both the National and State Governments have elements of sovereignty the other is bound to respect. *Arizona v. United States*, 132 S. Ct. 2492, 2500-01 (2012) (citing *Gregory v. Ashcroft,* 501 U.S. 452, 457 (1991)). However, it is a "familiar and well-established principle" that the Supremacy Clause, U.S. Const., Art. VI, cl. 2, invalidates state laws that "interfere with, or are contrary to," legitimate federal law. *Hillsborough County, Fla. v. Automated Med. Laboratories, Inc.*, 471 U.S. 707, 712 (1985) (internal citations omitted). In light of the Supreme Court's decision in *Nat'l Fed'n of Indep. Bus.* explicitly endorsing Congress's use of the taxing power in passing the PPACA however, this Court cannot conclude that the Congress's use of that power in passing the PPACA is illegitimate under our constitutional system.

B. Substantive Due Process

1. Right to Medical Autonomy

Plaintiffs argue that the PPACA's tax penalty provision "reduces the health care treatments and doctor-patient relationships [Plaintiff Coons] can afford to choose, thereby unduly burdening his right to medical autonomy." (Doc. 85 at 6.) In defining the right to "medical autonomy," Plaintiffs refer to cases that "bar[ ] the government from compelling individuals to undergo medical procedures," *see Cruzan v.*

Dir., Missouri Dept. of Health, 497 U.S. 261 (1990), and that prevent the government "from interfering with an individual's choice to obtain care," *see Roe v. Wade*, 410 U.S. 113; *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438. (Doc. 51 at 37.)

The Supreme Court has observed that the Due Process Clause specially protects those fundamental rights which are, objectively, "deeply rooted in this Nation's history and tradition", and are such that "neither liberty nor justice would exist if they were sacrificed." *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (internal citations omitted). Moreover, the Court has required in substantive due process cases a "careful description" of the asserted fundamental liberty interest. *Id.* (citing *Reno v. Flores*, 507 U.S. 292, 302 (1993) and *Cruzan,* 497 U.S. at 277-278). Plaintiffs have asserted a right to "medical autonomy" derived from a line of cases protecting the right to an abortion, to contraception and to refuse lifesaving treatment. (Doc. 51 at 37.) However, there is no recognized substantive due process right to "choose[ ] which doctors an individual sees." (*Id.* at 36-37.) Although there is constitutional protection for "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" that does not mean that "any and all important, intimate, and personal decisions are so protected." *Glucksberg*, 521 U.S. at 726-28 (citing *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 834 (1992)). Plaintiffs have not adequately

asserted a substantive due process right to choose medical providers and treatment.

2. Right to Informational Privacy

Plaintiff Coons alleges that he has "a constitutionally-protected privacy right not to be compelled to disclose his personal medical records and other sensitive information." (Doc 85 at 7.) He contends that the PPACA's tax provision unduly burdens that right by forcing him to either share such information with the Government and insurance companies or pay the tax penalty. *Id.* However, this claim fails both for a lack of ripeness and because, at least at the rate the penalty is now set, Coons retains the option to not submit information to third parties by paying the tax penalty.

There is a constitutionally-protected privacy interest "in avoiding disclosure of personal matters." *In re Crawford*, 194 F.3d 954, 958 (9th Cir. 1999) (citing *Whalen*, 429 U.S. at 599-600). That interest "encompasses medical information and its confidentiality." *Norman-Bloodsaw v. Lawrence Berkeley Lab.*, 135 F.3d 1260, 1269 (9th Cir. 1998) (internal citations omitted). However, "the right to informational privacy is not absolute; rather, it is a conditional right which may be infringed upon a showing of proper governmental interest." *Planned Parenthood of S. Ariz. v. Lawall*, 307 F.3d 783, 790 (9th Cir. 2002) (citing *In re Crawford,* 194 F.3d at 959). The Supreme Court has distinguished cases limiting government power to

regulate "marriage, procreation, contraception, family relationships, and child rearing and education," from cases involving the right to informational privacy. *Whalen,* 429 U.S. at 600. Accordingly, the compelled disclosure of medical information does not always "pose a sufficiently grievous threat" to patients' interest in keeping it private "to establish a constitutional violation." *Id.* at 600-602 (stating that disclosure to state employees is one of the "unpleasant invasions of privacy that are associated with many facets of health care," such as those "disclosures . . . to insurance companies and to public health agencies.").

Plaintiffs' claim that the PPACA violates their right to informational privacy is unripe. (Doc. 86 at 3-4.) Ripeness depends on two factors: "the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." *San Luis & Delta-Mendota Water Auth. v. Salazar*, 638 F.3d 1163, 1173 (9th Cir. 2011) (citing *Abbott Laboratories v. Gardner*, 387 U.S. 136, 149 (1967), *abrogated on other grounds*, *Califano v. Sanders*, 430 U.S. 99 (1977)). Plaintiffs' claim is unripe insofar as they argue that they will be forced to disclose confidential medical information to third parties. The tax penalty has not yet gone into effect and Plaintiffs have not alleged a specific disclosure requested by an insurance company. *See* 26 U.S.C. § 5000A(a). For example, Plaintiffs allege that companies may request "preexisting medical conditions information" but they do not allege that it has in fact been requested from

them. (Doc 51 at 40.) This court is not able to examine such things as "the type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, . . . [and] the adequacy of safeguards to prevent unauthorized disclosure." *Crawford*, 194 F.3d at 959.

Defendants argue that "[b]ecause [P]laintiffs' medical information is 'shielded by statute from unwarranted disclosure' . . . [P]laintiffs have no due process claim." (Doc. 86 at 5 (citing *NASA v. Nelson*, 131 S. Ct. 746, 762 (2011).) Defendants point to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. § 164.502, and the PPACA, 42 U.S.C. § 18081(g)(1), as strictly limiting the manner in which insurance companies and the Government may use or disclose individuals' medical information. This Court can only assess the adequacy of privacy protections under the PPACA and the HIPAA if applied to a disclosure request made by a third party to Coons. His claim is unripe.

Coons may be arguing that the PPACA violates his constitutional rights because it requires him to disclose personal information to third parties *at all* or to pay the tax penalty. (Doc 51 at 38-39.) The PPACA would require an applicant for insurance coverage to provide information necessary to "authenticate identity [and] determine eligibility." 42 U.S.C. § 18081(g)(1). Coons would need to provide some basic information to an insurance company or to the Government in order to obtain "minimum essential coverage." *See* 26 U.S.C. § 5000A(f). However, the

Government is not "forcing him to disclose medical information to third parties when he would otherwise keep such information private." (Doc. 51 at 39.) Coons has the lawful option of paying the tax penalty rather than obtaining health insurance and submitting personal information to third parties. 26 U.S.C. § 5000A(b)(1); *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2597. Even assuming that Coons has a constitutional right to informational privacy not to disclose personal information to insurance companies, the fact that the PPACA may make it "more difficult" to exercise that right does not invalidate the Act. *Casey,* 505 U.S. at 874. Although the PPACA may induce Coons to submit an insurance application or claims to third parties, he still has the option not to do so. Therefore, the PPACA does not violate Plaintiffs' right to informational privacy no matter the extent of the disclosures requested by those third parties.

CONCLUSION

The PPACA does not violate Plaintiff Coons' substantive due process rights because the Act provides him with the option to directly pay for health care services by paying the tax penalty. Moreover, the PPACA's individual mandate and tax provision preempt the HCFA and the Arizona Constitution. Accordingly, Counts IV, V, and VIII are **dismissed**.

IT IS THEREFORE ORDERED that Defendants' Motion to Dismiss (Doc. 42) and Motion for

Summary Judgment (Doc. 65) as to Counts IV, V, and VIII are **granted.**

IT IS FURTHER ORDERED that Plaintiffs' Motion to Treat Defendants' Motion to Dismiss as a Motion for Summary Judgment in Part (Doc. 48) is **denied as moot**. The Clerk of Court is directed to terminate this action.

Dated this 19th day of December, 2012.

/s/ G. Murray Snow
G. Murray Snow
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Nick Coons, et al., Plaintiffs, vs. Timothy Geithner, et al., Defendants.	No. CV-10-1714-PHX-GMS **ORDER**

Pending before the Court are Defendants' Motion to Dismiss (Doc. 42), Plaintiffs' Motion to Treat Defendants' Motion to Dismiss as a Motion for Summary Judgment in Part (Doc. 48), Plaintiffs' Motion for Partial Summary Judgment (Doc. 49), Defendants' Motion for Summary Judgment (Doc. 65), Plaintiffs' Motion to Strike Defendants' Statement of Facts (Doc. 73), and Plaintiffs' Motion for Leave to file a Sur Reply. (Doc. 75). For the reasons stated below, Counts I, II, III, VI, and VII are dismissed, and Plaintiffs are invited to submit a 7-page supplemental brief regarding Counts IV, V, and VIII.

BACKGROUND

Plaintiffs challenge the constitutionality of the Patient Protection and Affordable Care Act of 2010 ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA"). Plaintiffs are Nick

Coons and two members of the United States House of Representatives, Jeff Flake and Trent Franks. (Doc. 35).

The complaint includes six active primary counts, namely (I) the PPACA exceeds Congress's power under the Commerce Clause, (Doc. 35 ¶¶ 26-52), (II) it exceeds the implied power granted by the necessary and proper clause (*id*. ¶¶ 53-65), (III) it exceeds the federal government's taxing power, (*id.* ¶¶ 66-77), (IV) it violates the Fifth and Ninth Amendments by restricting Plaintiffs' medical autonomy (*id.* ¶¶ 78-85), (V) it violates the Fourth, Fifth and Ninth Amendments by violating their privacy (*id.* ¶¶ 86-91),[1] and (VII) it violates the doctrine of the separation of powers by establishing the Independent Payment Advisory Board "IPAB" (*id.* ¶¶ 114-126), and one alternate count, namely that (VIII) the Act does not pre-empt Arizona state health care legislation. (*Id.* ¶¶ 127-134). On January 17, 2012, this Court stayed the proceedings pending the outcome of a facial challenge to the PPACA at the United States Supreme Court. (Doc. 81). On June 28, 2012, the Supreme Court issued its opinion in *Nat'l Fed'n of Indep. Bus. v. Sebelius,* 132 S. Ct. 2566 (2012). In that opinion, the Court upheld all portions of the PPACA that are challenged in this lawsuit, and limited the application of certain provisions that are not challenged here. *See id.*

[1] Plaintiffs voluntarily dismissed Count VI of their Amended Complaint (Doc. 51 at 58).

DISCUSSION

I. Legal Standard

"A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *U.S. v. Salerno*, 482 U.S. 739, 745 (1987). "[W]here an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems." *Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg. and Constr. Trades Council*, 485 U.S. 568, 575 (1988). In passing the PPACA, "it is reasonable to construe what Congress has done as increasing taxes on those who have a certain amount of income, but choose to go without health insurance," and "[s]uch legislation is within Congress's power to tax." *Nat'l Fed'n of Indep. Bus.* 132 S.Ct. at 2608.

II. Discussion

A. Commerce Clause, Necessary and Proper Clause, and Taxing Power

The Supreme Court's ruling completely resolves three of Plaintiffs' remaining seven counts. According to that ruling, "the individual mandate cannot be upheld as an exercise of Congress's power under the Commerce Clause," and also cannot "be sustained under the Necessary and Proper Clause as an essential component of the insurance reforms." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2592, 2608, at [sic]

Nevertheless, PPACA may be construed as a tax on those who fail to obtain health insurance and are not otherwise exempted, and is thereby a constitutional exercise of Congress's taxing power. *Id.* at 1608. Therefore, Count III is dismissed on the merits and Counts I and II are dismissed as moot.

B. Anti-Delegation

Plaintiffs next argue that the Congress improperly delegated its legislative authority in violation of Article I of the United States Constitution by passing the Act. *See* U. S. CONST. art. I, § 1. ("All legislative Powers herein granted shall be vested in a Congress of the United States."). The anti-delegation doctrine requires only that Congress provide an "intelligible principle" when enacting legislation, and "[i]n the history of the Court we have found the requisite 'intelligible principle' lacking in only two statutes, one of which provided literally no guidance for the exercise of discretion, and the other of which conferred authority to regulate the entire economy on the basis of no more precise a standard than stimulating the economy by assuring 'fair competition.'" *Whitman v. American Trucking Ass'n*, 531 U.S. 457, 474 (2001). To survive an anti-delegation challenge, Congress need only "clearly delineate[ ] the general policy, the public agency which is to apply it, and the boundaries of this delegated authority." *Mistretta v. U.S.*, 488 U.S. 361, 372-73 (1989) (quoting *American Power & Light Co. v. SEC,* 329 U.S. 90, 105 (1946)); *see generally* 42 U.S.C. § 1395kkk. It has met that test here.

Plaintiffs offer a number of criticisms of the PPACA, but it is not the job of this court to weigh in on the wisdom of legislation so long as it is constitutional. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2608. ("Under the Constitution, that judgement is reserved to the people.").

C. Substantive Due Process and Pre-emption

In Count Four, Plaintiff Coons claims that the Act violates his "right to medical autonomy by forcing him to apply limited financial resources to obtaining a health care plan he does not desire." (Doc. 35 at 20). In Count Five, Plaintiffs allege that the Act violates the Fourth, Fifth, and Ninth Amendments because it compels individuals to "authorize access to personal medical records and information to health insurance issuers." (Doc. 35 at 22). In Count VIII, Plaintiffs argue that the individual mandate and penalty provisions of the PPACA, "even if constitutional, are preempted by the Arizona Constitution and the state's Health Care Freedom Act." (Doc. 49 at 2). *See* Ariz. Rev. Stat. ("A.R.S.") § 36-1301; ARIZ. CONST. XXVII, § 2(A).[2]

The Court notes that all of these counts depend upon reading the statute as mandating the purchase

[2] As a matter of law, state laws or constitutions cannot preempt federal laws. *See Arizona v. United States*, 132 S. Ct. 2492, 2501 (2012) ("[S]tate laws are preempted when they conflict with federal law.").

of health insurance. Construed under the taxing power, the Act does not directly compel people to purchase health insurance, and does not penalize them for paying for health care directly. Those who forgo purchasing insurance must pay a tax, but, "if someone chooses to pay rather than obtain health insurance, [he has] fully complied with the law." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2597. Since, construed as a tax, the provisions that Plaintiffs have cited do not mandate the purchase of health insurance, it is not clear that they mandate the violation of Plaintiffs' "medical autonomy," compel disclosure of medical information, or conflict with Arizona laws that permit people to choose not to purchase health insurance. Nevertheless, since Plaintiffs have not had an opportunity to brief the question of whether the Act denies them a substantive due process right or conflicts with Arizona state law when construed as a tax, they will be granted the opportunity to do so now.

CONCLUSION

In light of the Supreme Court's decision upholding the constitutionality of the Patient Protection and Affordable Care Act, Counts I, II, III, VI and VII are **dismissed**.

IT IS HEREBY ORDERED:

1. Defendants' Motion to Dismiss (Doc. 42) is granted in part and denied in part.

2. Plaintiffs will have **fourteen (14) days** from the date of this Order to submit a brief of no longer than seven (7) pages addressing whether Counts IV, V, and VIII survive given the Supreme Court's interpretation of the Act in *Nat'l Fed'n of Indep. Bus.* 132 S.Ct. 2566.

3. Defendants will have **fourteen (14) days** from the date Plaintiffs submit their brief to submit a seven (7) page response.

4. Plaintiffs' Motion to Treat Defendants' Motion to Dismiss as a Motion for Summary Judgment in Part (Doc. 48) is granted in part and denied in part.

5. Plaintiffs' Motion for Partial Summary Judgment (Doc. 49) is denied.

6. Defendants' Motion for Summary Judgment (Doc. 65) is granted in part and denied in part.

7. Plaintiffs' Motion to Strike (Doc. 73) is denied as moot.

8. Plaintiffs' Motion for Leave to file a Sur Reply (Doc. 75) is granted. DATED this 31st day of August, 2012.

/s/ G. Murray Snow
G. Murray Snow
United States District Judge

RELEVANT CONSTITUTIONAL PROVISIONS

ARTICLE I.

SECTION 1. All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives.

ARTICLE II.

SECTION 1. The executive Power shall be vested in a President of the United States of America.

* * *

SECTION 3. He shall from time to time give to the Congress Information of the State of the Union, and recommend to their Consideration such Measures as he shall judge necessary and expedient; he may, on extraordinary Occasions, convene both Houses, or either of them, and in Case of Disagreement between them, with Respect to the Time of Adjournment, he may adjourn them to such Time as he shall think proper; he shall receive Ambassadors and other public Ministers; he shall take Care that the Laws be faithfully executed, and shall Commission all the Officers of the United States.

ARTICLE III.

SECTION 1. The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish.

* * *

ARTICLE [IV.]

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated[.]

* * *

ARTICLE [V.]

No person shall . . . be deprived of life, liberty, or property, without due process of law[.]

* * *

ARTICLE [IX.]

The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

RELEVANT STATUTORY PROVISIONS

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.

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

(a) Establishment of program

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

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

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

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

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

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

(4) whether to grant a certification under section 18031(d)(4)(H) of this title attesting that, for purposes of the individual responsibility requirement under section 5000A of Title 26, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) Information required to be provided by applicants

(1) In general

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

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

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

(2) Citizenship or immigration status

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

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

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

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

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

(A) Information regarding income and family size

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

(B) Changes in circumstances

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

(4) Employer-sponsored coverage

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

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

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

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

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

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

(5) Exemptions from individual responsibility requirements

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

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

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

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

(1) Information transferred to Secretary

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

(2) Citizenship or immigration status

(A) Commissioner of Social Security

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

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

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

(B) Secretary of Homeland Security

(i) In general

In the case of an individual –

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

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

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

(ii) Information

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

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

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

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

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

(4) Methods

(A) In general

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

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

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

(B) Flexibility

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

and section 6103 of Title 26 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) Verification by Secretary

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

(e) Actions relating to verification

(1) In general

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

(2) Verification

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

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

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

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

(B) Exemption from individual responsibility

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

(3) Inconsistencies involving attestation of citizenship or lawful presence

If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1396a(ee) of this title (as in effect on January 1, 2010).

(4) Inconsistencies involving other information

(A) In general

If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by

persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) Reasonable effort

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

(ii) Notice and opportunity to correct

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

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

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

(B) Specific actions not involving citizenship or lawful presence

(i) In general

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

(ii) Eligibility or amount of credit or reduction

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

(iii) Employer affordability

If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of Title 26 or cost-sharing reduction under section 18071 of this title because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of Title 26 .

(iv) Exemption

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

(C) Appeals process

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

(f) Appeals and redeterminations

(1) In general

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

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

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

(2) Employer liability

(A) In general

The Secretary shall establish a separate appeals process for employers who are notified under subsection

(e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of Title 26 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to –

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

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

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

(B) Confidentiality

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

(i) the employer may be notified as to the name of an employee and whether or not the employee's

income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) Confidentiality of applicant information

(1) In general

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

(2) Receipt of information

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

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

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

(h) Penalties

(1) False or fraudulent information

(A) Civil penalty

(i) In general

If –

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

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

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

(ii) Reasonable cause exception

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

(B) Knowing and willful violations

Any person who knowingly and willfully provides false or fraudulent information under subsection (b)

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $250,000.

(2) Improper use or disclosure of information

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

(3) Limitations on liens and levies

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

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

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

(i) Study of administration of employer responsibility

(1) In general

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

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

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

(2) Report

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

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42 U.S.C. § 1395kkk.
Independent Payment Advisory Board

(a) Establishment

There is established an independent board to be known as the "Independent Payment Advisory Board".

(b) Purpose

It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending –

(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as "a determination year") the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as "an implementation year");

(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as "a proposal year") a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

(c) Board proposals

(1) Development

(A) In general

The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

(B) Advisory reports

Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of

whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d). In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.

(2) Proposals

(A) Requirements

Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program

spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1395i-2, 1395i-2a, or 1395r of this title, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1395x(u) of this title) and suppliers (as defined in section 1395x(d) of this title) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D of this subchapter, such as reductions

in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1395w-115(a) of this title that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1395w-113(a)(4) of this title, and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1395w-23(a)(1)(B) of this title that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1395w-23(n) of this title. Any such recommendation shall not affect the base beneficiary premium percentage specified under 1395w-113(a) of this title or the full premium subsidy under section 1395w-114(a) of this title.

(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

(vi) The proposal shall only include recommendations related to the Medicare program.

(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8)

while maintaining or enhancing beneficiary access to quality care under this subchapter.

(B) Additional considerations

In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible –

(i) give priority to recommendations that extend Medicare solvency;

(ii) include recommendations that –

(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1395x(u) of this title) and suppliers (as defined in section 1395x(d) of this title);

(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates;

(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under subchapter XIX of this chapter; and

(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.

(C) No increase in total Medicare program spending

Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

(D) Consultation with MedPAC

The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1395b-6 of this title for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

(E) Review and comment by the Secretary

The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the

Secretary for the Secretary's review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

(F) Consultations

In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1396 of this title.

(3) Submission of Board proposal to Congress and the President

(A) In general

(i) In general

Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall submit a proposal under this section to Congress and the President on January 15 of each year (beginning with 2014).

(ii) Exception

The Board shall not submit a proposal under clause **(i)** in a proposal year if the year is –

(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of

such paragraph does not exceed the growth rate described in clause (ii) of such paragraph; or

(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year.

(iii) Start-up period

The Board may not submit a proposal under clause (i) prior to January 15, 2014.

(B) Required information

Each proposal submitted by the Board under subparagraph (A)(i) shall include –

(i) the recommendations described in paragraph (2)(A)(i);

(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

(iv) a legislative proposal that implements the recommendations; and

(v) other information determined appropriate by the Board.

(4) Presidential submission to Congress

Upon receiving a proposal from the Secretary under paragraph (5), the President shall within 2 days submit such proposal to Congress.

(5) Contingent secretarial development of proposal

If, with respect to a proposal year, the Board is required, but fails, to submit a proposal to Congress and the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit –

(A) such proposal to the President; and

(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

(6) Per capita growth rate projections by Chief Actuary

(A) In general

Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of

the Centers for Medicare & Medicaid Services shall determine in each such year whether –

(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

(B) Medicare per capita growth rate

(i) In general

For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending (calculated as the sum of per capita spending under each of parts A, B, and D of this subchapter).

(ii) Requirement

The projection under clause (i) shall –

(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1395w-4(d) of this title furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

(II) take into account any delivery system reforms or other payment changes that have been enacted or

published in final rules but not yet implemented as of the making of such calculation.

(C) Medicare per capita target growth rate

For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in –

(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in –

(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

(7) Savings requirement

(A) In general

If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall

establish an applicable savings target for the implementation year.

(B) Applicable savings target

For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of –

(i) the total amount of projected Medicare program spending for the proposal year; and

(ii) the applicable percent for the implementation year.

(C) Applicable percent

For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of –

(i) in the case of –

(I) implementation year 2015, 0.5 percent;

(II) implementation year 2016, 1.0 percent;

(III) implementation year 2017, 1.25 percent; and

(IV) implementation year 2018 or any subsequent implementation year, 1. 5 percent; and

(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

(8) Per capita rate of growth in national health expenditures

In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.

(d) Congressional consideration

(1) Introduction

(A) In general

On the day on which a proposal is submitted by the Board or the President to the House of Representatives and the Senate under subsection (c)(3)(A)(i) or subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

(B) Not in session

If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

(C) Any member

If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

(D) Referral

The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

(2) Committee consideration of proposal

(A) Reporting bill

Not later than April 1 of any proposal year in which a proposal is submitted by the Board or the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

(B) Calculations

In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the

3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

(C) Committee jurisdiction

Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

(D) Discharge

If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

(3) Limitation on changes to the Board recommendations

(A) In general

It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(B) Limitation on changes to the Board recommendations in other legislation

It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(C) Limitation on changes to this subsection

It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

(D) Waiver

This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(E) Appeals

An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(4) Expedited procedure

(A) Consideration

A motion to proceed to the consideration of the bill in the Senate is not debatable.

(B) Amendment

(i) Time limitation

Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

(ii) Germane

No amendment that is not germane to the provisions of such bill shall be received.

(iii) Additional time

The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

(iv) Amendment not in order

It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings

target established under subsection (c)(7)(B) for such implementation year.

(v) Waiver and appeals

This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

(C) Consideration by the other house

(i) In general

The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

(ii) Before passage

If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

(iii) After passage

If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

(iv) Disposition

Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

(v) Limitation

Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill –

(I) is related only to the program under this subchapter; and

(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(D) Senate limits on debate

(i) In general

In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith

shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

(ii) Motion to further limit debate

A motion to further limit debate on the bill is in order and is not debatable.

(iii) Motion or appeal

Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

(iv) Final disposition

After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

(E) Consideration in conference

(i) In general

Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the

Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

(ii) Time limitation

Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

(iii) Final disposition

After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

(iv) Limitation

Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto

if the conference report, message, or an amendment thereto –

(I) is related only to the program under this subchapter; and

(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(F) Veto

If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

(5) Rules of the Senate and House of Representatives

This subsection and subsection (f)(2) are enacted by Congress –

(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(e) Implementation of proposal

(1) In general

Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

(2) Application

(A) In general

A recommendation described in paragraph (1) shall apply as follows:

(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

(ii) In the case of a recommendation relating to payments to plans under parts C and D of this subchapter, such recommendation shall apply to plan

years beginning on the first day of the first calendar year that begins after such August 15.

(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

(B) Interim final rulemaking

The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

(3) Exceptions

(A) In general

The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or the President to Congress pursuant to this section if –

(i) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.'; and

(ii) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

(B) Limited additional exception

(i) In general

Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if –

(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).

(ii) Limited additional exception may not be applied in two consecutive years

This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

(iii) No affect on requirement to submit proposals or for Congressional consideration of proposals

Clause (i) and (ii) shall not affect –

(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).

(4) No affect on authority to implement certain provisions

Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

(5) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

(f) Joint resolution required to discontinue the Board

(1) In general

For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution –

(A) that is introduced in 2017 by not later than February 1 of such year;

(B) which does not have a preamble;

(C) the title of which is as follows: 'Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Payment Advisory Board under section 1899A of the Social Security Act'; and

(D) the matter after the resolving clause of which is as follows: "That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.".

(2) Procedure

(A) Referral

A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(B) Discharge

In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such

committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

(C) Consideration

(i) In general

In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

(ii) Debate limitation

In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10

hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

(iii) Passage

In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

(iv) Appeals

Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

(D) Other House acts first

If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

(i) The joint resolution of the other House shall not be referred to a committee.

(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution –

(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

(II) the vote on final passage shall be on the joint resolution of the other House.

(E) Excluded days

For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

(F) Majority required for adoption

A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

(3) Termination

If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017 –

(A) the Chief Actuary of the Medicare & Medicaid Services shall not –

(i) make any determinations under subsection (c)(6) after May 1, 2017; or

(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

(B) the Board shall not submit any proposals, advisory reports, or advisory recommendations under this section or produce the public report under subsection (n) after January 16, 2018; and

(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

(g) Board membership; terms of office; Chairperson; removal

(1) Membership

(A) In general

The Board shall be composed of –

(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

(B) Qualifications

(i) In general

The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health

facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(ii) Inclusion

The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmacoeconomics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(iii) Majority nonproviders

Individuals who are directly involved in the provision or management of the delivery of items and services covered under this subchapter shall not constitute a majority of the appointed membership of the Board.

(C) Ethical disclosure

The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

(D) Conflicts of interest

No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

(E) Consultation with Congress

In selecting individuals for nominations for appointments to the Board, the President shall consult with –

(i) the majority leader of the Senate concerning the appointment of 3 members;

(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

(iii) the minority leader of the Senate concerning the appointment of 3 members; and

(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

(2) Term of office

Each appointed member shall hold office for a term of 6 years except that –

(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that

member's predecessor was appointed shall be appointed for the remainder of such term;

(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

(3) Chairperson

(A) In general

The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

(B) Duties

The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to –

(i) the appointment and supervision of personnel employed by the Board;

(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

(iii) the use and expenditure of funds.

(C) Governance

In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

(D) Requests for appropriations

Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

(4) Removal

Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

(h) Vacancies; quorum; seal; Vice Chairperson; voting on reports

(1) Vacancies

No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

(2) Quorum

A majority of the appointed members of the Board shall constitute a quorum for the transaction of

business, but a lesser number of members may hold hearings.

(3) Seal

The Board shall have an official seal, of which judicial notice shall be taken.

(4) Vice chairperson

The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

(5) Voting on proposals

Any proposal of the Board must be approved by the majority of appointed members present.

(i) Powers of the Board

(1) Hearings

The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

(2) Authority to inform research priorities for data collection

The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

(3) Obtaining official data

The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

(4) Postal services

The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(5) Gifts

The Board may accept, use, and dispose of gifts or donations of services or property.

(6) Offices

The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

(j) Personnel matters

(1) Compensation of members and Chairperson

Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of Title 5. The Chairperson shall be compensated at a rate equal to

the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of Title 5.

(2) Travel expenses

The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of Title 5, while away from their homes or regular places of business in the performance of services for the Board.

(3) Staff

(A) In general

The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

(B) Compensation

The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of Title 5, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) Detail of Government employees

Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) Procurement of temporary and intermittent services

The Chairperson may procure temporary and intermittent services under section 3109(b) of Title 5, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(k) Consumer advisory council

(1) In general

There is established a consumer advisory council to advise the Board on the impact of payment policies under this subchapter on consumers.

(2) Membership

(A) Number and appointment

The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the [sic] March 23, 2010.

(B) Qualifications

The membership of the council shall represent the interests of consumers and particular communities.

(3) Duties

The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

(4) Open meetings

Meetings of the consumer advisory council shall be open to the public.

(5) Election of officers

Members of the consumer advisory council shall elect their own officers.

(6) Application of FACA

The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

(l) Definitions

In this section:

(1) Board; Chairperson; Member

The terms "Board', "Chairperson', and "Member" mean the Independent Payment Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

(2) Medicare

The term "Medicare" means the program established under this subchapter, including parts A, B, C, and D of this subchapter.

(3) Medicare beneficiary

The term "Medicare beneficiary" means an individual who is entitled to, or enrolled for, benefits under part A of this subchapter or enrolled for benefits under part B of this subchapter.

(4) Medicare program spending

The term "Medicare program spending" means program spending under parts A, B, and D net of premiums.

(m) Funding

(1) In general

There are appropriated to the Board to carry out its duties and functions –

(A) for fiscal year 2012, $15,000,000; and

(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

(2) From trust funds

Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1395i of this title and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(n) Annual public report

(1) In general

Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this subchapter.

(2) Requirements

Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1395aaa(b)(7)(B) of this title).

(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

(C) Epidemiological shifts and demographic changes.

(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

(o) Advisory recommendations for non-Federal health care programs

(1) In general

Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this subchapter and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations –

(A) that the Secretary or other Federal agencies can implement administratively;

(B) that may require legislation to be enacted by Congress in order to be implemented;

(C) that may require legislation to be enacted by State or local governments in order to be implemented;

(D) that private sector entities can voluntarily implement; and

(E) with respect to other areas determined appropriate by the Board.

(2) Coordination

In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

(3) Available to public

The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.