Are You Obligated to Have Medical Insurance?

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Whenever libertarians speak of "government intervention," what is being referred to is the coercion used by tyrannical government to forcefully dictate market behavior, such as by way of price controls, government subsidies, and even nationalization. These so-called "regulations" essentially outlaw how voluntary trade is conducted by declaring specific actions to be *mala prohibita*. By threatening the citizenry with punishment should they disobey the scribblings of administrative agency bureaucrats and congresscritters, Leviathan wishes to stamp out those remnants of the free market which desire nothing more than to be able to exchange goods and services as they see fit, without self-proclaimed rulers imposing their master plan upon them.

I am neither a bar attorney nor licensed to practice law. I am providing information, legal in nature, using government documents as the primary source material, which has been made publicly available. Any interpretation that I give based upon such legal information is done with the intention of complying with the legal maxim of *ignorantia juris non excusat*. Having said that, I would like to proceed in trying to understand the federal government's Affordable Care Act of 2010 (the ACA, which is also known as ObamaCare by its opponents).

You must understand that it is imperative to distinguish between the legal and economic arguments regarding the ACA. Though it is important to understand both, they are distinctive and must be treated as such. Obviously, there is going to be some degree of unavoidable overlap, but I will do the best I can, in spite of the legalese.

Comprehending the implications of the ACA lies first in understanding the legal definitions of the words and phrases being used. 26 USC § 5000A(f) [**Minimum essential coverage**] says:

> *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 USC 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 government 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 benefit 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) is such month 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 Patent Protection and Affordable Care Act shall have the same meaning as when used in such title.*

Why is understanding what "minimum essential coverage" is, important? According to 26 USC § 5000A(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."*

Who is an "applicable individual," anyway? 26 USC § 5000A(d) [**Applicable individual**] defines them as:

> *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 is 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.*

Unless you demonstrate your religious conscience, membership in a health care sharing ministry, incarceration status, or the fact that you scampered across the border, then you are considered to be an "applicable individual" by default. Now, what happens to those "applicable individuals" who fail to maintain "minimum essential coverage?" 26 USC § 5000A(b)(1) [**Shared responsibility payment**, **In general**] says:

> *"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)."*

This "shared responsibility payment" is the legal term for what is in actuality an individual mandate, which is considered to be a legal requirement that certain people buy a good or service. Also variously called the ACA penalty, the penalty tax, or the Individual Mandate Tax by the U.S. House Committee on Ways & Means' *The Wrong Prescription* report, this mandate appears to be a civil tax penalty levied against those who fail to meet the criteria for what constitutes "minimum essential coverage," as defined by 26 USC § 5000A(f). For the sake of brevity, I will refer to this tax penalty using the Ways & Means committee's term, that of IMT.

The IMT is inherently coercive because it was justified as being legitimate by the United States Supreme Court's ruling in National Federation of Independent Business et al. v. Sebelius, Secretary of Health & Human Services, et al. (*NFIB v. Sebelius*). They determined that the IMT was within the delegated power enumerated in the Taxing & Spending Clause (Article 1, Section 8, Clause 1 of the U.S. Constitution), and thus, the Court ruled that the IMT was constitutional. Despite the fact that the Congressional Budget Office (CBO) estimated the distribution of the collected IMT penalties back in 2009 to be 49% of those between 100 – 300% of the Federal Poverty Level (that is, those individuals who earn $11,670 – $35,010 a year, with the per capita US mean income being $28,051), the Court, in their *NFIB* decision, legalized exaction, which is defined by *Ballantine's*, *Bouvier's*, and *Black's* law dictionaries to be:

> *"The excessive or unauthorized taking or collection of moneys as fees or dues by an officer or by a person pretending to be an officer….a willful wrong done by an officer, or by one who, under color of his office, takes more fee or pay for his services than what the law allows…[the officer] exacts what is not his due, when there is nothing due to him…the wrongful act of an officer or other person in compelling payment of a fee or reward for his services, under color of his official authority, where no payment is due." [emphasis added]*

What proof do I have to offer that the Court has legalized this form of criminality? Read the following excerpts from the case ruling (and if you happen to find another legal definition for the word "exaction," then I'd like to see it):

> *"Congress's decision to label this **exaction** a "penalty" rather than a "tax" is significant*

> *because the Affordable Care Act describes many other exactions it creates as "taxes. " Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally."*
>
> *"The **exaction** the Affordable Care Act imposes on those without health insurance looks like a tax in many respects. The "[s]hared responsibility payment," as the statute entitles it, is paid into the Treasury by "taxpayer[s]" when they file their tax returns. 26 U. S. C. §5000A(b)."*
>
> *"We have similarly held that **exaction** not labeled taxes nonetheless were authorized by Congress's power to tax."*
>
> *"Our precedent demonstrates that Congress had the power to impose the **exaction** in §5000A under the taxing power, and that §5000A need not be read to do more than impose a tax."*
>
> *"We have never held that any **exaction** imposed for violation of the law is an exercise of Congress' taxing power—even when the statute calls it a tax, much less when (as here) the statute repeatedly calls it a penalty."*
>
> *"So the question is, quite simply, whether the **exaction** here is imposed for violation of the law. It unquestionably is."*
>
> *"We never have classified as a tax an **exaction** imposed for violation of the law, and so too, we never have classified as a tax an **exaction** described in the legislation itself as a penalty."*
>
> *"But we have never—never—treated as a tax an **exaction** which faces up to the critical difference between a tax and a penalty, and explicitly denominates the **exaction** a "penalty." Eighteen times in §5000A itself and elsewhere throughout the Act, Congress called the exaction in §5000A(b) a "penalty." " [emphasis added]*

At least 10 times I was able to find where the Court thinks of the IMT as an exaction, albeit a constitutionally valid one! I think it is more than fair to say that the IMT is blatantly coercive, besides being hypocritical, in that the government is now "authorized" to commit what it considers *in its own law books* to be a crime! I must say, what would society devolve into without an all-powerful monolithic institution that grants unto itself the moral right to steal your property?

Are there exemptions from being obligated to satisfy the "minimum essential coverage" requirement, in order to avoid the imposition of the IMT? Thankfully, there are, pursuant to 26 USC § 5000A(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 (as 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 calender 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 calender 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 calender 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) Membership 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 calender 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 calender 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.*

Did you notice 26 USC § 5000A(e)(2), which deals with taxpayers being below the filing threshold? Considering the fact that section 1412(b)(1)(B) of the ACA cross references as 42 USC § 18082(b)(1)(B), we can see that:

> *"The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual* ***shall be made on the basis of the individual's household income*** *for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available." [emphasis added]*

Did you notice where it said there about the eligibility of a person "shall be made on the basis of the *individual's household income*" with regards to tax credits? Feel free to read 26 USC § 6012(a)(1) for yourself, but I think it is fair to conclude that if you are not liable, as a U.S. citizen, to file a federal income tax return, then the IMT cannot be imposed against you for failure to hold a medical insurance policy, because you are not obligated to hold such a policy in the first place. In other words, **liability for paying the federal income tax is tied at the hip with the imposition of the**

IMT; if you have no federal income tax liability, then you have no obligation to hold a medical insurance policy. As the old adage goes, "you can't squeeze blood from a stone," which is exactly why I think the drafters of the ACA wrote it the way they did.

So, how do you avoid the IMT *without* holding a medical insurance policy? Well, I first recommend that you determine whether or not you are liable to file federal income tax returns. An easy way to do this is to use the IRS' "Interactive Tax Assistant," specifically under the section entitled, "Do I Need to File a Tax Return?" For reasons I have just stated, if it happens to be the case that you are *not* liable, then you are off the hook, *but* if it turns out that you are, then I would recommend you check to see if you happen to qualify for those other exemptions, as listed under 26 USC § 5000A(d) & (e). Failing that, you should then ponder the economic calculation technique for gauging just how badly the IMT is going to make you pay, which I will address following the economic arguments from an Austrian perspective regarding the ACA.

The ACA is nothing more complicated than a price control. In several respects, it's just like Medicaid, but noticeably worse. As Hunter Lewis pointed out last year, if you need a new doctor because your current doctor is not within the "approved network," you're just simply out of luck because no doctor will take you on as a patient. This is because the ACA compliant insurance policies do not pay them enough. It has already happened to Medicaid patients, and it is likely to happen to ACA exchange policy holders as well for exactly the same reason.

To paraphrase Lewis, ACA exchange policies are terrible due to the capstones placed on how much older and sicker insured patients can be charged. The only way for the insurance companies to "balance the equation," as it were, is to provide incentives for younger and healthier people to become medical insurance customers. In the attempt to hoodwink this potential customer base, however, the drafters of the ACA miscalculated when they neglected to account for the fact that this younger demographic values price over quality. Given the fact that the IMT *already* drives up the cost of medical insurance premiums anyway, it becomes financially advantageous for these younger folks to forgo medical insurance entirely and just pay the IMT, even if, in some cases, they decide later to pay for private medical insurance that does *not* satisfy the "minimum essential coverage" requirement – if they can find them at all.

In the light of the fact that the average young adult can perform economic calculation for his own selfish benefit more accurately than the master planners of the ACA can do for an entire country, then one should consider the ramifications of the IMT not being a severe enough civil penalty to deter these hapless taxpayers. Insurance companies appear to be gambling on the assumption that doctors will take gargantuan cuts in pay while still providing the same quality of medical services to their patients, but this will only come to pass ***if*** the doctors go along with it, because if they don't, then the ACA exchange policyholders will be left holding the bag, since they will be the ones literally paying for useless medical insurance. This situation will continue to deteriorate as the insurance companies are the ones making the decisions as to how much they are paying the doctors for their medical services, even to the point of paying them different rates for the exact same services. Eventually, given enough time, more doctors will take early retirement and fewer students will want to enter the medical field. As the supply of medicine shrinks, the demand for medical services, fueled by the *moral hazard* of government subsidies enjoyed by qualified ACA exchange policyholders, will increase, thereby dramatically reducing the quality of medical products and services.

Rising medical prices are the inevitable result of the ACA, despite whatever price controls the government coercively imposes upon the population at large. Half-hearted arguments in favor of the ACA and its IMT are seldom little more than puny justifications for the welfare state, especially due to the prolific government subsidies for individual exchange policyholders. As Yuri Maltsev, a Russian expat, described the Soviet medical system:

> *"The system had many decades to work, but widespread apathy and low quality of work paralyzed the healthcare system. In the depths of the socialist experiment, the healthcare institutions in Russia were at least a hundred years behind the average US level. Moreover, the filth, odors, cats roaming the halls, drunken medical personnel, and absence of soap and cleaning supplies added to an overall impression of hopelessness and frustration that paralyzed the system. According to official Russian estimates, 78 percent of all AIDS victims in Russia contracted the virus through dirty needles or HIV-tainted blood in the state-run hospitals..[i]n order to receive minimal attention by doctors and nursing personnel, patients had to pay bribes. I even witnessed a case of a 'nonpaying' patient who died trying to reach a lavatory at the end of the long corridor after brain surgery. Anesthesia was usually 'not available' for abortions or minor ear, nose, throat, and skin surgeries. This was used as a means of extortion by unscrupulous medical bureaucrats."*

Some might argue, "Hey, that was Russia, but we're American, so it can't happen here, right?" Perhaps we should again listen to Maltsev who survived that period of Russia's history since he might give us some indication as to the likelihood of something similar happening here in the States:

> *"In supporting the call for socialized medicine, American healthcare professionals are like sheep demanding the wolf: they do not understand that the high cost of medical care in the United States is partially based in the fact that American healthcare professionals have the highest level of remuneration in the world. Another source of the high cost of our healthcare is existing government regulations on the industry**, regulations that prevent competition from lowering the cost**. Existing rules such as 'certificates of need,' licensing, and other restrictions on the availability of healthcare services prevent competition and, therefore, result in higher prices and fewer services." [emphasis added]*

Those "higher prices and fewer services" sound an awful lot like those government medical insurance programs (like Medicare and Medicaid) where referrals are at times as many as three deep before you get the right specialist who might be able to heal you. Maltsev is also right that market competition is at odds with government regulations, because such regulations are inherently designed to stifle innovation and customer service, much to the benefit of government cronies, but often at the loss of human life.

The only realistically pragmatic way for doctors to continue providing good quality medical services at reasonable costs is for the government to STOP forcibly intervening all the damn time and let market forces, through the price system, work on its own. Unfortunately, Leviathan has no incentive to stop such interference, because not only did its Supreme Court justify it by way of the Constitution's Taxing Clause, but also because they won't stop themselves from accepting all the lobbying and

campaign contribution monies from the corporatists who reap the profits from the medical insurance companies.

I think that about sums it up, economically speaking. You can't "master plan" other people's lives by way of government legislation and court rulings, because there is absolutely no way for the drafters of the ACA (or those ABA lawyers who sanction their words) to know or anticipate the needs of literally *millions* of people who live on this portion of the North American continent. No one man knows better how to run someone else's life better than he does, and for him to pretend that he *does* know better is the height of arrogance.

What does this mean, though, for you, personally? Well, should it be the case that you are obligated to satisfy the "minimum essential coverage" requirement, as demanded by the government under 26 USC § 5000A(a), then your decision whether to satisfy the requirement or pay the IMT ultimately comes down to whichever option lowers your transaction costs. In order to determine this, you'll need to look at the government's formula for calculating the penalty tax, and then compare the cost of the penalty tax *as applied to you* against the cost of whatever insurance policy premiums you are looking at that satisfy the "minimum essential coverage" requirement. Consider also the cost of the IMT *vis-a-vis* a medical insurance premium that does *not* satisfy the "minimum essential coverage" requirement.

Calculating the cost of the IMT necessarily requires the government's formula, which is detailed at 26 USC § 5000A(c). I will lay it out for you here in the form of bullet points for your convenience, yet the *NFIB v. Sebelius* case nicely explains it as well. The individual mandate's penalty tax is graduated (much like the federal income tax), and is computed, explains Chief Justice Roberts, "as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance." In other words, the IMT looks like this:

- 2014
    - 1% of an individual's household income, but no less than $95
        - 26 USC § 5000A(c)(2)(B)(i), 26 USC § 5000A(c)(3)(B)
- 2015
    - 2% of an individual's household income, but no less than $325
        - 26 USC § 5000A(c)(2)(B)(ii), 26 USC § 5000A(c)(3)(B)
- 2016 – forever
    - 2.5% of an individual's household income, but no less than $695
        - 26 USC § 5000A(c)(2)(B)(iii), 26 USC § 5000A(c)(3)(A)

As you can see, in two years time the IMT will be > $695. The question, that that point, would be if it is cheaper for you to simply pony up and pay the IMT *in addition to* whatever medical expenses you incur, or whether the premiums for the new exchange policies are truly "competitive" (and remember, the IMT is a ***monthly*** penalty, as per 26 USC § 5000A(c), so multiply accordingly). Unless I am

misunderstanding something, the costs imposed by the IMT are a pretty bitter pill to swallow for those who are obligated under the ACA to hold a qualified medical insurance policy.

Of course, you also need to consider the risks of being punished by the Internal Revenue Service (IRS) should you ever decide to up the ante and engage in civil disobedience by refusing to pay the IMT. Although Chief Justice Roberts said that the IRS is not allowed to criminally prosecute or file either liens or levies against taxpayers who are obligated to pay the IMT but who refuse to do so, I think there is a statutory contradiction here. According to 26 USC § 5000A(g)(1):

> *"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."*

But then if you continue reading into 26 USC § 5000A(g)(2), you see that:

> *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.*

So, it begs the question – does the IRS have the legal authority under the ACA to place liens and levies upon taxpayers who fail to hold a qualified medical insurance policy *and* refuse to pay the IMT? Are the ***monthly*** penalty taxes going to be "assessed and collected in the same manner as an assessable penalty," *or* are liens and levies prohibited to the IRS because even the Secretary cannot use them? I think the clue that points to a definitive answer is the phrase "Notwithstanding any other provision of law," but good luck trying to interpret what *that* is supposed to mean, absent litigation.

What concerns me more, though, is the fact that the IRS, in light of its history and its treatment of taxpayers of all kinds, is the Administrative Agency tasked with collecting the IMT in the first place. It seems to me to be the case that there is a serious financial and personnel beef-up of the IRS so

they can "administer" the IMT that much easier. According to the 2010 U.S. House of Representatives' Ways & Means committee report, *The Wrong Prescription: Democrats' Health Overhaul Dangerously Expands IRS Authority*, some congresscritters admitted that the IRS *is* the chief enforcer of the ACA. They directly quote from Vol. II of the National Taxpayer Advocate's 2009 Annual Report to Congress, (and I will add the rest of that entire paragraph), which says:

> *"When social program delivery is grafted to traditional IRS activities, there arises a potential conflict with the IRS' traditional mission [of revenue collection]. For example, when New Zealand's tax agency, Inland Revenue, was charged by the government with running social and family programs through the tax system through implementation of the Working for Families Tax Credits, the agency underwent a comprehensive analytical redesign process. With the growth of these programs administered by the IRS, the agency should consider revising its mission statement to explicitly acknowledge its dual roles: tax compliance and social program delivery."*

In other words, G. Edward Griffin was right when he said in *The Creature from Jekyll Island* that the whole point of contemporary taxation is to force social engineering upon the populace. Not only does the *The Wrong Prescription* report go onto mention the 2009 CBO chart that showed that 49% of the IMT is projected to burden those between 100 – 300% of the Federal Poverty Level, but also their projected figure of "16,500 additional IRS employees" to allegedly enforce collection of the IMT is based upon the 2009 IRS Data Book. According to Table 30 of the Data Book, in 2008 there were 90,210 total IRS employees (with only 87,728 of them working full-time), and in 2009 there were 93,337 total IRS employees (with only 91,082 of them working full-time). Although there appears to be a mild growth at play here, if you also examine the 2011 and 2013 IRS data books, you would see that in 2010 there were 94,346 total IRS employees (with only 92,148 of them working full-time), in 2011 there were 91,380 total IRS employees (with only 88,308 of them working full-time), in 2012 there were 89,551 total IRS employees (with only 86,743 of them working full-time), and in 2013 there were only 83,616 total IRS employees (with only 81,296 of them working full-time). I must say, if I'm right, should there were a beef-up of the IRS, it's certainly *not* in terms of the quantity of its personnel, for between 2009 – 2013, there are ~ 10,000 ***less*** total IRS employees.

Surely, there is more evidence about how the IRS plans to enforce the IMT, right? According to a 2010 Congressional Research Service (CRS) letter to congresscritter Tom Coburn, the assessment of the penalty tax, as well as a understandable description of *how* the IRS proceeds with collections, is provided, and some of the questions I posed earlier are answered. For instance,

> *"Section 5000A(g)(2) of the IRC [Internal Revenue Code] limits the means the IRS may employ to collect the penalty established in the section. First, the taxpayer is protected from either criminal prosecution or penalty for failure to pay the penalty. Second, the IRS is prohibited from either filing a NFTL [notice of federal tax lien] or levying any property in an effort to collect the penalty. There is no prohibition, however, on establishing a statutory lien against the taxpayer's property under § 6321."*

Now keep in mind that it is stated earlier in the CRS letter that a "silent lien" is a statutory federal tax lien under 26 USC § 6321 that is made *before* a NFTL has been made. In any case, this ***interpretation*** seems to resolve what appeared to me to be a statutory contradiction between 26 USC § 5000A(g)(1) & 26 USC § 5000A(g)(2). Interestingly enough, the CRS letter also mentions how to calculate the IMT itself:

> *"The annual flat dollar amount is assessed per individual or dependent without coverage and will be phased in over three years. The amount is set at $95 for 2014; $325 for 2015; and $695 in 2016 and thereafter. Although this is a fixed per person amount**, it is capped at three times this amount per year, regardless of the number of individuals in the taxpayer's household who actually lack adequate coverage during the year…[**t]he 'percentage of income' is determined by first subtracting the taxpayer's filing threshold from the taxpayer's household income. The result is then multiplied by the applicable percentage. As with the flat dollar amount, the applicable percentage to be used is phased in over three years, set at 1% for 2014, 2% for 2015, and 2.5% thereafter…[t]he greater of the amount calculated as either the 'flat dollar amount' or the 'percentage of income' is divided by twelve to determine the penalty due for each month for which the penalty is applicable. The total amount assessed for the taxable year shall not exceed the national average of the annual premiums of a bronze level health insurance plan, for the applicable family size, offered through the Exchanges created under PPACA." [emphasis added]*

I'm not sure where they got the idea that the flat dollar amount was capped at only three times a year, because this would seem to contradict the fact that the IMT is a ***monthly*** tax. In any case, it would be prudent for you to discover the nationally average price of the annual premiums for a "bronze level health insurance plan," so you can take that figure into account for your economic calculations.

What about the claims made by the House Republicans regarding the increases in the IRS' budget? According to a 2011 letter to IRS Commissioner Douglas Schulman, congresscritter Dave Camp asked Schulman to account for how many "tens of millions" the IRS received from the $1,000,000,000 Health Insurance Reform Implementation Fund (HIRIF) at the Department of Health and Human Services (HHS). In Schulman's reply a month later, addressed to congresscritter Charles Boustany, Schulman claims that HHS "allocated administrative funding from the fund created in the authorizing statute" (which would be HIRIF). He then says that the Office of Management and Budget "apportioned $23.2 million of funds in FY 2010 to support the IRS' initial planning and implementation efforts." Schulman also says that "the current full-year plan, which is subject to change, totals $215 million, of which approximately 67% is for information technology," presumably from the HIRIF. Granted, while I acknowledge that the IRS has 10,000 less employees, this increase in its spending, particularly only for the enforcement of the IMT, is troubling to say the least.

As if that wasn't bad enough, the Treasury Inspector General for Tax Administration (TIGTA) issued a 2013 report about the ACA's information reporting requirements. TIGTA found that:

> *"Revenue provisions contained in the legislation are designed to generate $438 billion to help pay for the overall cost of health care reform…[t]he IRS must ensure that all the information needed to accurately and effectively administer these provisions is provided by employers, insurers, and taxpayers. By doing so, the IRS can significantly improve its ability to manage the burden placed on employers, insurers, and taxpayers who must comply with the various Affordable Care Act requirements as well as improve its ability to accurately administer Affordable Care Act fees, penalties, and tax credits. Therefore, the IRS should consider collecting additional third-party information that could expand its ability to ensure taxpayer compliance with the Affordable Care Act provisions and requirements…..[t]he IRS should also ensure that all information necessary to maximize the IRS's ability to verify compliance with other tax-related provisions within the Affordable Care Act is requested from third parties and processes are developed to use the information effectively. The IRS agreed with our recommendations."*

It would seem that even more of your privacy is going to be violated, as if the NSA wasn't doing enough of that all by itself. According to a IRS video press release, employers will be *gradually* required to accurately report the value of health insurance coverage on W-2 forms. The idea of America could never be killed by a massive catastrophe, but only by a death of a billion cuts, and that is exactly what these administrative agency bureaucrats have done and are continuing to do; no wonder so much freedom has been lost.

Should you decide to apply for an ACA medical insurance policy, anyway (in order to satisfy the "minimum essential coverage" requirement), at least make sure to apply by mail, because hackers have been able to disrupt the HealthCare.gov website by stealing personally identifying information. Another approach would be to apply directly to "your" state government's equivalent of the "exchange marketplace" and bypass HHS at least to a certain extent. For instance, here in Texas, it used to be possible to acquire medical insurance that was created by the Texas legislature called the Texas Health Insurance Pool, but the ACA effectively terminated it. Now, you either have to get it as a group health plan through your employer, or buy directly from an insurance company, such as those on this list provided by the Texas Department of Insurance. Needless to say, if you decide to go this route, you will need to be persistent in asking those insurance representatives whether or not the medical insurance you are considering buying from them satisfies the "minimum essential coverage" requirement. Don't forget to comparison shop, and also compare the best plan you can find with whether it'd be cheaper to just pay the penalty tax instead of the insurance premiums.

There has been some concern regarding the rate of enrollment in ACA exchange policies. Within HHS, the Office of Assistant Secretary for Planning and Evaluation (ASPE) has released five reports dedicated to measuring compliance with the ACA. They do this by measuring only the enrollment of those individuals who buy policies through either the State-Based Marketplaces (SBE) or the Federally-facilitated Marketplace (FFM). According to ASPE's statistics, those who have selected a "marketplace plan" are as follows:

> *October 1, 2013 – November 2, 2013 = 106,185*
>
> *November 3, 2013 – November 30, 2013 = 258,497*
>
> *December 1, 2013 – December 28, 2013 = 1,788,318*
>
> *December 29, 2013 – February 1, 2014 = 1,146,492*
>
> *February 2, 2014 – March 1, 2014 = 942,833*

Therefore, the total enrollments between October 1, 2013 – March 1, 2014 was 4,242,325 people. Keeping in mind that APSE does not mention any details about whether "inapplicable" or "exempted" individuals are still applying for ACA exchange policies, this is still a rather paltry number for something that is supposed to be an individual mandate. According to the Tax Foundation, there were 136,585,712 federal income tax returns for FY 2011. Assuming that figure hasn't changed much since then (or the figure for the total number of those who have purchased medical insurance through either an SBE or FFM), that would mean there is a difference of 132,343,387 taxpayers left. Granted, many of them will satisfy the "minimum essential coverage" requirement under 26 USC § 5000A(a) & (f) through their employer, and there will be those taxpayers who will be exempt pursuant to 26 USC § 5000A(e), or who are otherwise *in*applicable individuals according to 26 USC § 5000A(d). As you can see, that is going to bring the number down quite a bit, but I would bet there would be at least 100,000,000 taxpayers who *are* considered "applicable individuals," and who are *not* exempt from the "minimum essential coverage" requirement, and who *would be* incurring the penalty tax thanks to 26 USC § 5000A(b)(1). If my estimate is correct, then I think the IRS is probably going to have its hands full collecting all of the IMT payments, as well as punishing resisters with liens and levies.

I could describe *ad naseum* about various ACA horror stories, such as the ~ 2,000,000 people who had their medical insurance policies cancelled because of the ACA (some of whom have gotten their cancellation letters uploaded to the MyCancellation.com website), or Stephen Blackwood's mother getting royally screwed by the ACA interfering with her cancer treatments, but those are beyond the scope of this already quite lengthy article. Suffice it to say, the ACA is nothing more than a written collective hallucination that is forcibly imposed on people, especially those who disagree with the body of words in question. Although there still exist individuals who naively believe that laws can solve problems (even in spite of the ACA), I would hope that maybe, **finally**, enough people who are having their wallets squeezed even tighter will appreciate why the overextension of *mala prohibita* is so dangerous to the evolution of human liberty. I predict that because of the legalese within the ACA, coupled with the heavy handedness of the IRS, more and more people will resist paying the federal income tax in the attempt to avoid being obligated to hold the kind of medical insurance that the federal government **thinks** they should have, instead of what they rationally calculate to be in their own selfish best interest.