Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)

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Summary

Among its many provisions, the Patient Protection and Affordable Care Act (ACA) restructures the private health insurance market, sets minimum standards for health coverage, and, beginning in 2014, mandates that most U.S. residents obtain health insurance coverage or pay a penalty. The law provides for the establishment by 2014 of state-based health insurance exchanges for the purchase of private health insurance. Qualifying individuals and families will be able to receive federal subsidies to reduce the cost of purchasing coverage through the exchanges. ACA also expands eligibility for Medicaid; amends the Medicare program in ways that are intended to reduce the growth in spending; and makes other changes to the tax code, Medicare, Medicaid, and many other federal programs.

In addition, ACA appropriates billions of dollars to support new or existing grant programs and other activities. These mandatory appropriations include funds for a temporary insurance program for individuals who have been uninsured for several months and have a preexisting condition, as well as funding for states to plan and establish exchanges. ACA also provides funding for various Medicare and Medicaid demonstration programs, for the creation of a Center for Medicare and Medicaid Innovation to test and implement innovative payment and service delivery models, and for an independent board to provide Congress with proposals for reducing Medicare cost growth and improving quality of care for Medicare beneficiaries.

ACA provides funding for health workforce and maternal and child health programs, and establishes three multi-billion dollar funds. The first fund will provide a total of $11 billion over five years for community health centers and the National Health Service Corps. (A separate appropriation provides $1.5 billion for health center construction and renovation.) The second fund will support comparative effectiveness research through FY2019 with a mix of appropriations and transfers from the Medicare trust funds. The third fund, for which ACA provides a permanent annual appropriation, is intended to support prevention, wellness, and other public health-related programs authorized under the Public Health Service Act (PHSA).

Generally, the FY2013 mandatory appropriations in ACA would be fully sequestrable at the rate applicable to nonexempt nondefense mandatory spending, under a sequestration order triggered by the Budget Control Act.

Lawmakers opposed to ACA introduced numerous bills in the 112th Congress, several of which saw legislative action. They included measures to repeal ACA and replace it with new law; repeal or amend specific ACA provisions; eliminate certain mandatory appropriations and rescind all unobligated funds; and block or otherwise delay ACA implementation. Similar legislation may be introduced and debated during the 113th Congress.

In addition to the mandatory appropriations discussed in this report, ACA authorizes new funding for numerous existing discretionary grant and other programs, primarily ones authorized under the PHSA. The law also creates a number of new discretionary grant programs and activities and provides for each an authorization of appropriations. Funding for all these discretionary programs and activities is subject to action by congressional appropriators. A companion product, CRS Report R41390, *Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)*, summarizes all the provisions in ACA that include an authorization of appropriations.

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Introduction

The Patient Protection and Affordable Care Act (ACA)[1] made significant changes to the way health care is financed, organized, and delivered in the United States. Among its many provisions, ACA restructures the private health insurance market, sets minimum standards for health coverage, and, beginning in 2014, mandates that most U.S. residents obtain health insurance coverage or pay a penalty. The law provides for the establishment by 2014 of state-based health insurance exchanges for the purchase of private health insurance. Qualifying individuals and families will be able to receive federal subsidies to reduce the cost of purchasing coverage through the exchanges.

In addition to expanding private health insurance coverage, ACA, as enacted, requires state Medicaid programs to expand coverage to all eligible nonelderly, non-pregnant individuals under age 65 with incomes up to 133% of the federal poverty level (FPL). States that elect not to expand their Medicaid programs risk losing their existing federal Medicaid matching funds. Under ACA, the federal government will initially cover 100% of the expansion costs, phasing down to 90% of the costs by 2020. On June 28, 2012, the U.S. Supreme Court, in *National Federation of Independent Business v. Sebelius,* found that the Medicaid expansion violated the Constitution by threatening states with the loss of their existing federal Medicaid matching funds.[2] The Court precluded the Secretary of Health and Human Services (HHS) from penalizing states that choose not to participate in the Medicaid expansion (see text box below). ACA also amends the Medicare program in an effort to reduce the rate of its projected growth; imposes an excise tax on insurance plans found to have high premiums; and makes many other changes to the tax code, Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and other federal programs.

ACA included numerous appropriations that provide billions of dollars to support new and existing grant programs and other activities. Several other provisions require the HHS Secretary to transfer amounts from the Medicare Part A and Part B trust funds for specified purposes. This report summarizes all these mandatory spending provisions[3] and, using publicly available information, provides details on the status of obligation of the funds. It also includes a brief discussion of ACA-related discretionary spending, which is provided in and controlled by annual appropriations acts. Finally, the report provides some analysis of the impact that a sequestration triggered by the Budget Control Act might have on ACA mandatory spending in FY2013. This report is periodically revised and updated to reflect important legislative and other developments.

[1] ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended multiple health care and revenue provisions in ACA. Several other bills that were subsequently enacted during the 111th and 112th Congresses made more targeted changes to specific ACA provisions (see Appendixes B and C). All references to ACA in this report refer to the law as amended. Note that previous CRS reports on the Patient Protection and Affordable Care Act used the acronym PPACA to refer to the law. CRS is now using the more common acronym ACA.

[2] *NFIB v. Sebelius*, No. 11-393, slip op. (June 28, 2012), available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[3] Mandatory spending, also known as direct spending, refers to outlays from budget authority (i.e., the authority to incur financial obligations that result in government expenditures) that is provided in laws other than annual appropriations acts. Mandatory spending includes spending on entitlement programs.

U.S. Supreme Court Decision on ACA (June 28, 2012)

In *National Federation of Independent Business v. Sebelius (NFIB)* the Court ruled on the constitutionality of both the individual mandate, which requires most U.S. residents (beginning in 2014) to carry health insurance or pay a penalty, and the Medicaid expansion. The Court upheld the individual mandate as a constitutional exercise of Congress's authority to levy taxes. The penalty is to be paid by taxpayers when they file their tax returns and enforced by the Internal Revenue Service.

In a separate opinion, the Court found that compelling states to participate in the ACA Medicaid expansion—which the Court determined to be essentially a new program—or risk losing their existing federal Medicaid matching funds was coercive and unconstitutional under the Spending Clause of the Constitution and the Tenth Amendment. The Court's remedy for this constitutional violation was to prohibit HHS from penalizing states that choose not to participate in the expansion by withholding any federal matching funds for their existing Medicaid program. However, if a state accepts the new ACA expansion funds (initially a 100% federal match), it must abide by all the expansion coverage rules.

Under *NFIB v. Sebelius*, all other provisions of ACA remain fully intact and operative. For more information, see CRS Report R42698, *NFIB v. Sebelius: Constitutionality of the Individual Mandate*, by Erika K. Lunder and Jennifer Staman; and CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

Mandatory Appropriations and Fund Transfers in ACA

ACA appropriated billions of dollars for a number of short-term health care programs for targeted groups, including (1) $5 billion for the Pre-Existing Condition Insurance Plan (PCIP), a temporary insurance program to provide health insurance coverage for uninsured individuals with a preexisting condition; (2) $5 billion for a temporary reinsurance program to reimburse employers for a portion of the costs of providing health benefits to early retirees aged 55-64; and (3) $6 billion for the Consumer Operated and Oriented Plan (CO-OP) program, to establish temporary health insurance cooperatives. ACA also included money for states to plan and establish health insurance exchanges.

The law created a Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS), and appropriated $10 billion for the FY2011-FY2019 period—and $10 billion for each subsequent 10-year period—for CMMI to test and implement innovative payment and service delivery models. It also established and funded an Independent Payment Advisory Board (IPAB) to make recommendations to Congress for achieving specific Medicare spending reductions if costs exceed a target growth rate. IPAB's recommendations are to take effect unless Congress overrides them, in which case Congress would be responsible for achieving the same level of savings.

ACA also established four special funds and appropriated substantial amounts to each. First, the Community Health Center Fund (CHCF) will provide a total of $11 billion in annual appropriations over five years (FY2011-FY2015) for community health center operations and the National Health Service Corps. A separate ACA appropriation provided $1.5 billion for health center construction and renovation. While CHCF funding may have been intended to supplement annual discretionary appropriations for health centers and the NHSC program, the funds have

partially supplanted discretionary health center funding and have become the sole source of funding for the NHSC program, which received no discretionary funds in FY2012.[4] Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) will support comparative effectiveness research through FY2019 with a mix of annual appropriations—some of which are offset by revenues from a fee imposed on private health plans—and transfers from the Medicare Part A and Part B trust funds.

Third, the Prevention and Public Health Fund (PPHF), for which ACA provided a permanent annual appropriation, is intended to support prevention, wellness, and other public health-related programs and activities authorized under the Public Health Service Act (PHSA).[5] PPHF funds have been used to support several new discretionary grant programs authorized by ACA. The funds are also supplementing, and in some cases supplanting, annual discretionary appropriations for a number of established programs, including ones that were reauthorized by ACA (see discussion below under "Discretionary Spending in ACA"). Fourth, ACA provided $1 billion to the Health Insurance Reform Implementation Fund (HIRIF) to help cover the administrative costs of implementing the law.

In addition, ACA appropriated $2.4 billion for maternal and child health programs. Overall, the law included more than $100 billion in direct appropriations over the 10-year period FY2010-FY2019, including $40 billion to provide two more years of funding for CHIP.

Table 1 summarizes all the ACA provisions that include an appropriation of funds, or a transfer of amounts from the Medicare trust funds. The provisions are grouped under the following headings: (1) Private Health Insurance; (2) Medicaid and the State Children's Health Insurance Program (CHIP); (3) Medicare; (4) Fraud and Abuse; (5) Health Centers and the National Health Service Corps (NHSC); (6) Health Workforce; (7) Community-Based Prevention and Wellness; (8) Maternal and Child Health; (9) Long-Term Care; (10) Comparative Effectiveness Research; (11) Biomedical Research; and (12) ACA Implementation: Administrative Expenses.

Each table row provides information on a specific ACA provision, organized across four columns. The first column shows the ACA section or subsection number. The second column indicates whether the provision is freestanding (i.e., new statutory authority that is not amending an existing statute) or amendatory (i.e., amends an existing statute such as the PHSA, either by adding a new program or amending an existing one). The third column gives a brief description of the program or activity, including details of the appropriation or fund transfer. The entry also includes the name of the administering HHS agency and, if applicable, the Catalog of Federal Domestic Assistance (CFDA) number for the grant program.[6] The fourth column shows the amount of obligations to date, based on information in the HHS Tracking Accountability in Government Grants System (TAGGS), unless specified otherwise. The TAGGS database is a central repository for grants awarded by all the HHS operating divisions (agencies) and several

[4] For more information, see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

[5] Section 3205 of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96, 126 Stat. 156) reduced ACA's appropriations to the PPHF over the period FY2013-FY2021 by a total of $6.25 billion. Under ACA, the PPHF would have received a total of $16.75 billion over that nine-year period; P.L. 112-96 reduced that amount to $10.50 billion. See **Table 1** and **Appendix B**.

[6] CFDA is a government-wide compendium of federal grant and other assistance programs. Each program is assigned a unique five-digit number, XX.XXX, where the first two digits represent the funding agency and the second three digits represent the program. Programs funded by the Department of Health and Human Services begin with the number 93. For more information, see https://www.cfda.gov.

offices within the Office of the Secretary. It is updated daily with new data provided by these entities.[7]

Readers are also encouraged to visit the website of the Center for Consumer Information and Insurance Oversight (CCIIO, within CMS),[8] which is responsible for implementing ACA's private health insurance provisions, as well as HealthCare.gov, which is tracking ACA implementation state-by-state. Both sites include factsheets, press releases, and other information on the ACA grant programs and activities summarized in this report.

In many instances, ACA provides *annual appropriations* of specified amounts for one or more fiscal years. These funds must be obligated during the fiscal year in which the funds become available for obligation. A few provisions are *multiple-year appropriations*, in which the amount appropriated is available for obligation for a definite period of time in excess of one fiscal year (e.g., for the period FY2011 through FY2014). Often the provision includes additional language stating that the funds are to remain available "until expended" or "without fiscal year limitation." One ACA provision (i.e., Section 1311) appropriates an unspecified amount—such sums as may be necessary, or SSAN—and authorizes the HHS Secretary to determine the amount necessary for the grant program.[9] Generally, the ACA appropriations or fund transfers are for one or more fiscal years through FY2019. However, ACA includes four provisions (i.e., Sections 3021(a), 3403, 10323(b), and 4002) that continue to provide annual or multiple-year appropriations beyond FY2019.

Table 2 provides additional details on each of the appropriations (and fund transfers) summarized in **Table 1**. It shows the amount available for obligation in each fiscal year (or multi-year period) over the 10-year period FY2010 through FY2019. Note that the provisions are organized and grouped under the same headings used in **Table 1**. The final column in **Table 2** ("Total") shows for each provision the cumulative amount of appropriations or fund transfers through FY2019. In several cases, that amount has yet to be determined (see table entries for ACA Sections 1311, 3403, 6301(d) & (e), 9023(e), and 10323(a)). For three of the provisions that provide appropriations beyond FY2019, the table shows the cumulative amount appropriated through FY2019 (see table entries for ACA Sections 3021(a), 4002, and 10323(b)). Unless otherwise stated, references to the Secretary in both tables refer to the HHS Secretary. A list of the acronyms used in this report is provided in **Appendix A**.

Lawmakers opposed to specific provisions in ACA, or to the entire law, introduced numerous bills in the 112th Congress to modify or repeal the law, including legislation to eliminate some of the mandatory appropriations discussed in this report. **Appendix B** summarizes the ACA-related authorizing legislation enacted during the 112th Congress, as well as the House-passed bills that would have modified or repealed ACA. **Appendix C** summarizes the ACA-related provisions in annual appropriations acts for FY2011-FY2013.

[7] To access and search the TAGGS database, go to http://www.taggs.hhs.gov/.

[8] http://cciio.cms.gov

[9] Two other ACA provisions (i.e., Sections 5508(c), and 9023(e)) also appropriate SSAN to carry out a program, but in each case there is an upper limit on the amount that may be appropriated. Another provision (i.e., Section 10323(a)) requires the HHS Secretary to transfer SSAN from the Medicare trust funds to carry out a pilot program.

Discretionary Spending in ACA

In addition to its impact on mandatory spending, implementation of ACA is having an effect on discretionary spending, which is provided in and controlled by annual appropriations acts. The law reauthorized appropriations for numerous *existing* discretionary grant programs and activities authorized under the PHSA. While the authorizations of appropriations for many of those programs expired prior to their reauthorization in ACA, most of them continued to receive an annual appropriation. ACA also created a number of *new* discretionary grant programs and provided for each an authorization of appropriations.

Funding for all these discretionary programs will depend on future action taken by congressional appropriators. However, with the renewed emphasis on reducing federal spending, it may prove difficult to secure funding for new programs and activities. Even existing programs with an established appropriations history may find it a challenge to maintain funding at current levels. A companion product, CRS Report R41390, *Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)*, provides more detailed analysis of all the provisions in ACA that provide an authorization of appropriations for an existing or new program.

In addition to discretionary spending on grant programs authorized (or reauthorized) by ACA, the Congressional Budget Office (CBO) estimates that both HHS and the Internal Revenue Service (IRS) will incur substantial administrative costs to implement the policies established by ACA. The IRS is responsible for implementing the eligibility determination, documentation, and verification processes for ACA's health exchange subsidies, while HHS must implement numerous changes to Medicare, Medicaid, and CHIP, as well as some of the reforms to the private health insurance market.

As already noted, ACA established a $1 billion implementation fund (i.e., HIRIF) to help cover the administrative expenses associated with implementing the law. While HHS has used the HIRIF to cover its own ACA administrative costs, the department has transferred a significant portion of HIRIF funding to the IRS. HHS projected that all the HIRIF funds would be obligated by the end of FY2012. Thereafter, ACA administrative costs will have to be funded through annual discretionary appropriations (see **Appendix C**).

Potential Impact of Spending Cuts Under the Budget Control Act

The Budget Control Act of 2011 (BCA) included procedures and a timetable for enactment of a bill to reduce the federal deficit.[10] In the event that Congress and the President failed to enact such legislation, as was the case, the BCA required the President to order across-the-board spending cuts—a process known as sequestration—for all nonexempt direct (i.e., mandatory) and discretionary spending programs on January 2, 2013. That deadline was delayed for two months, until March 1, 2013, by the American Taxpayer Relief Act of 2012 (ATRA).[11] ATRA also reduced the total amount of spending cuts for FY2013 by $24 billion, from $109.33 billion to $85.33

[10] P.L. 112-25, 125 Stat. 240.

[11] P.L. 112-240, 126 Stat. 2313.

billion. This final section of the report provides an overview of the BCA's mechanisms for reducing spending. As discussed below, a FY2013 sequestration would impact many of the ACA mandatory appropriations summarized in this report.

BCA Background

The BCA authorized the President to increase the nation's debt limit by at least $2.1 trillion (and up to $2.4 trillion under certain conditions) in three installments and established procedures designed to reduce future federal spending by a comparable amount.[12] To achieve the spending reductions, the law placed enforceable limits, or caps, on discretionary spending for each of FY2012 through FY2021. CBO estimated that adhering to these limits, which grow by approximately 2% each year, would reduce federal spending by $917 billion through FY2021, compared to the projected level of spending if annual appropriations were to grow at the rate of inflation.[13]

In addition, the BCA created a Joint Select Committee on Deficit Reduction (Joint Committee) and instructed it to develop deficit-reduction legislation for Congress to consider under expedited floor procedures. If, by January 15, 2012, Congress and the President failed to enact a Joint Committee bill reducing the deficit by an amount greater than $1.2 trillion over the period FY2012-FY2021, then automatic annual spending reductions would be triggered beginning in FY2013. On November 21, 2011, the Joint Committee announced that it was unable to agree on a deficit-reduction bill. This meant that automatic spending reductions totaling $1.2 trillion were set to take effect, pursuant to the procedures and timetable established in the BCA, unless new legislation to modify or repeal the law was enacted.

Based on the formula in the BCA, the automatic spending reductions would cut $109.33 billion for each fiscal year over the period FY2013-FY2021. [Note: ATRA's $24 billion adjustment for FY2013 is discussed below.] Each year's cut would be equally divided between defense and nondefense spending. The annual spending reduction in each of these two categories (i.e., $54.67 billion) would be further divided proportionately between discretionary spending and nonexempt direct (i.e., mandatory) spending. In FY2013, both the discretionary and the direct spending reductions in the two categories would be achieved through sequestration—a largely across-the-board cancellation of budgetary resources in nonexempt accounts. In each of the remaining fiscal years through FY2021, discretionary spending reductions would be achieved through a downward adjustment of the BCA spending limits, while direct spending reductions would continue to be executed through sequestration.

Under the sequestration rules, reductions in Medicare payments to health care providers and health plans (which account for most of Medicare spending) are capped at 2%. Many other federal direct spending programs, accounting for most of the government's entitlement and other direct spending (excluding Medicare), are exempt from sequestration altogether.[14]

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[12] For a more detailed examination of all the provisions in the BCA, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

[13] U.S. Congressional Budget Office, *Analysis of Budget Control Act*, August 1, 2011. Available at http://www.cbo.gov/publication/41626.

[14] The sequestration exemptions and rules are specified in sections 255 and 256, respectively, of the Balanced Budget and Emergency Deficit Control Act (BBEDCA). For more information, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

Discretionary spending reductions in FY2013 also would be achieved through a sequestration of nonexempt discretionary appropriations. The sequestration rules exempt some discretionary spending, notably for veterans' health care and Pell grants.[15] For each of the remaining fiscal years (i.e., FY2014-FY2021), discretionary spending reductions would be achieved by lowering the BCA discretionary spending caps. There would be no across-the-board cuts through sequestration. Instead, the Appropriations Committees would decide how to apportion the cuts within the reduced cap.

The BCA requires the OMB to calculate, and the President to order, a sequestration of nonexempt discretionary appropriations for FY2013 and nonexempt direct spending for each of FY2013 through FY2021. As already noted, the sequestration for FY2013 was to be ordered on January 2, 2013. However, ATRA amended the BCA by delaying the sequestration order by two months. The President is now instructed to order a FY2013 sequestration on March 1, 2013. The BCA requires the sequestrations for subsequent fiscal years (i.e., FY2014-FY2021) to occur at the time of the President's annual budget submission in early February.

FY2013 Nondefense Direct Spending Reductions

On September 14, 2012, OMB released a report on the potential impact of a sequestration triggered by the failure of the Joint Committee to propose, and Congress and the President to enact, legislation to reduce the deficit by an amount greater than $1.2 trillion.[16] The OMB report provided a breakdown of exempt and nonexempt budget accounts, and included estimates of the FY2013 funding reductions in nonexempt accounts. OMB calculated that sequestration would result in a 7.6% reduction in nonexempt *nondefense* direct (i.e., mandatory) spending.

OMB emphasized that the estimates and budget account classifications in the report are preliminary. The agency noted that "[i]f the sequestration were to occur, the actual results would differ based on changes in law and ongoing legal, budgetary, and technical analysis."[17]

In addition to delaying the FY2013 sequestration order, ATRA reduced the FY2013 sequestration by $24 billion, from $109.33 billion to $85.33 billion. Because the sequestration is divided equally between defense and nondefense spending, each of these two spending categories would be subject to $12 billion less in spending cuts (i.e., $42.67 billion, instead of $54.67 billion). Importantly, OMB's preliminary estimates of the potential impact of a FY2013 sequestration predate ATRA's enactment and, therefore, do not take into account the $24 billion reduction. Applying that adjustment to OMB's calculations significantly reduces the estimated percentage reduction in nonexempt nondefense direct (i.e., mandatory) spending under a FY2013 sequestration order.

The mandatory appropriations in ACA would, in general, be fully sequestrable at the rate applicable to nonexempt nondefense mandatory spending. However, for any given fiscal year in which sequestration was ordered, only new budget authority for that year (including advance appropriations that first become available for obligation in that year) would be reduced.

[15] Ibid. Note that all veterans programs, mandatory and discretionary, are exempt from sequestration.

[16] U.S. Office of Management and Budget, *OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P.L. 112-155)*, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf.

[17] Ibid., p. 1.

Unobligated balances (nondefense only) carried over from previous fiscal years are exempt from a sequestration order.[18] Thus, an FY2013 sequestration order to reduce direct spending would not apply to unobligated ACA funds that had been appropriated in a prior fiscal year (i.e., FY2010-FY2012) and were still available for obligation.

The exemption for unobligated balances carried over from prior fiscal years would apply to a number of ACA appropriations. As already mentioned, the appropriation provision often specifies that the funds are to remain available "until expended" or "without fiscal year limitation." One example is the PCIP program to provide health insurance coverage for eligible individuals who have been uninsured for six months and have a preexisting condition. The program terminates on January 1, 2014. ACA appropriated $5 billion in FY2010, to remain available without fiscal year limitation, to pay claims against the PCIP that are in excess of the premiums collected from enrollees. Any unobligated PCIP funds in FY2013 would be exempt from sequestration.

According to OMB's preliminary analysis, the FY2013 appropriations for both PPHF and PCORTF would also be fully sequestrable at the rate applicable to nonexempt nondefense mandatory spending. However, the reduction in CHCF funding would be capped at 2%. For more discussion and analysis of the effect of BCA-triggered spending reductions on ACA mandatory (and discretionary) spending in FY2013, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

[18] An exemption for nondefense unobligated balances is provided in BBEDCA Section 255(e). It reads as follows: "Unobligated balances of budget authority carried over from prior fiscal years, except balances in the defense category, shall be exempt from reduction under any order issued under this part." 2 U.S.C. §905(e).

Table 1. Summary of Mandatory Appropriations and Medicare Trust Fund Transfers in the Affordable Care Act

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
Title I – Private Health Insurance			
1002	New PHSA Sec. 2793	**Consumer Assistance Program (CAP).** Appropriates $30 million, to remain available without fiscal year limitation, for CAP grants to states to enable them (or the exchanges operating in such states) to establish, expand, or provide support for offices of health insurance consumer assistance, and health insurance ombudsman programs. [CMS/CCIIO; CFDA 93.519]	$46 million [Total includes original funding plus recent (summer 2012) awards of additional funds. See http://cciio.cms.gov/programs/consumer/capgrants/index.html.]
1003	New PHSA Sec. 2794	**Review of health insurance premium rates.** Appropriates $250 million for grants to states over the five-year period FY2010-FY2014 to support programs that review annual increases in health insurance premiums. No state may receive less than $1 million or more than $5 million in a grant year. Funds remaining unobligated at the end of FY2014 are to remain available for grants to states for planning and implementing ACA's individual and group market reforms. [CMS/CCIIO; CFDA 93.511]	$159 million [To date, two rounds of rate review grants have been awarded. See http://cciio.cms.gov/programs/marketreforms/rates/index.html.]
1101	New authority	**Pre-Existing Condition Insurance Plan (PCIP).** Requires the Secretary to establish a temporary program—PCIP—to provide health insurance coverage for eligible individuals who have been uninsured for six months and have a pre-existing condition. The PCIP is federally administered in 23 states and DC; the remaining states administer their own PCIP programs. Appropriates $5 billion, to remain available without fiscal year limitation, to pay claims against (and administrative costs of) the PCIP that are in excess of premiums collected from enrollees. [CMS/CCIIO; CFDA 93.529]	According to the most recent quarterly update, net PCIP outlays through September 2012 totaled $1.861 billion. [PCIP has more than 90,000 enrollees to date. See http://cciio.cms.gov/programs/pcip/index.html.]
1102	New authority	**Early Retiree Reinsurance Program (ERRP).** Requires the Secretary to establish a temporary ERRP, ending on January 1, 2014, to provide reimbursement to participating employer-based plans for a portion of the cost of providing health benefits to early retirees age 55-64 and their families. Appropriates $5 billion, to remain available without fiscal year limitation, to carry out the ERRP. [CMS/CCIIO]	According to the most recent program update, ERRP outlays through February 2012 totaled $4.73 billion. [ERRP has provided payments to more than 2,800 employers and other sponsors of retiree plans. See http://cciio.cms.gov/programs/errp/index.html.]
1311	New authority	**Health insurance exchange grants.** Appropriates annually an amount (as determined by the Secretary) necessary to award exchange planning and establishment grants to states. No grants may be awarded after January 1, 2015, by which time exchanges must be self-sustaining. [CMS/CCIIO; CFDA 93.525]	$2.049 billion [See http://cciio.cms.gov/programs/exchanges/index.html.]
1322	New authority	**Consumer Operated and Oriented Plan (CO-OP).** Requires the Secretary to establish the CO-OP program to provide low-interest loans until July 1, 2013, for the creation of nonprofit member-run health insurance issuers that offer qualified health plans in the individual and small group markets. Appropriates $6 billion to carry out the CO-OP program. Note: P.L. 112-10 and P.L. 112-74 together rescinded a total of $2.6 billion of the original appropriation, and P.L. 112-240 rescinded all but 10% of the remaining unobligated funds; see **Appendix C**. [CMS/CCIIO; CFDA 93.545]	According to a December 21, 2012 press release, the CO-OP program has awarded a total of $1.981 billion to 24 nonprofits offering coverage in 24 states. [See http://cciio.cms.gov/programs/coop/index.html.]

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
1323	New authority	**Funding for territories.** Appropriates $1 billion, available for the period FY2014-FY2019, for U.S. territories that elect to establish a health insurance exchange. Funds must be used to provide premium and cost-sharing assistance to territory residents who obtain health insurance coverage through the exchange.	No obligations.
Title II – Medicaid and State Children's Health Insurance Program (CHIP)			
2701	New SSA Sec. 1139B	**Medicaid adult health quality measures.** Requires the Secretary to develop and, not later than January 1, 2012, publish an initial core set of quality measures for Medicaid-eligible adults. Appropriates $60 million for each of FY2010-FY2014, to remain available until expended. Total amount = $300 million. [CMS; CFDA 93.609]	Initial core set of measures published in January 2012. No public information located on funding obligations.
2707	New authority	**Medicaid emergency psychiatric demonstration program.** Appropriates $75 million for FY2011, to remain available for obligation through December 2015, for a three-year demonstration in which eligible states are required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries aged 21 through 64 who are in need of medical assistance to stabilize an emergency psychiatric condition. [CMS/CMMI; CFDA 93.537]	CMS announced the 11 participating states (plus DC) in March 2012. No public information located on funding obligations. [See http://innovations.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/.]
2801	Amends SSA Sec. 1900	**Medicaid and CHIP Payment and Access Commission (MACPAC).** Clarifies and expands MACPAC's duties; for example, to include a review and assessment of payment policies under Medicaid and CHIP and how factors affecting expenditures and payment methodologies enable beneficiaries to obtain services, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations. Appropriates $9 million and transfers from CHIP funding an additional $2 million for FY2010. Total amount = $11 million, to remain available until expended.	ACA funding was obligated in FY2011 and FY2012. [See http://www.macpac.gov/.]
4108	New authority	**Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD).** Requires the Secretary to award five-year grants to states, subject to annual renewal of funding, to provide incentives for Medicaid beneficiaries to participate in evidence-based healthy lifestyle programs to prevent or help manage chronic disease. Appropriates $100 million for the five-year period beginning January 1, 2011, to remain available until expended. [CMS/CMMI; CFDA 93.536]	$30 million [MIPCD grants have been awarded to 10 states. See http://www.innovations.cms.gov/initiatives/MIPCD/index.html.]
4306	Amends SSA Sec. 1139A(e)	**CHIP childhood obesity demonstration program.** Appropriates $25 million for the period FY2010 through FY2014 for a program authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3), which requires the Secretary to conduct a demonstration project to develop a model for reducing childhood obesity. [CDC; CFDA 93.535]	$12 million [Funding has been awarded to four grantees. See http://www.cdc.gov/obesity/childhood/researchproject.html.]

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
10203(d)	Amends SSA Secs. 2104 & 2113	**CHIP annual appropriations, and outreach and enrollment grants.** Appropriates funding for the CHIP program for FY2014 ($19.147 billion) and FY2015 ($21.061 billion); the program previously had been funded through FY2013. Also, extends the time period for CHIP outreach and enrollment grants through FY2015 and increases the existing appropriation for such grants from $100 million to $140 million. [CMS; CFDA 93.767]	In 2009, and again in 2011, CMS awarded $40 million in two-year grants to states and community organizations. In 2010, CMS awarded $10 million in grants to tribal organizations. [See https://www.cms.gov/apps/media/press/release.asp?Counter=4063.]
Medicare			
3014	Amends SSA Sec. 1890(b). New SSA Sec. 1890A	**Medicare quality and efficiency measures.** Expands the duties of the consensus-based entity under contract with CMS pursuant to SSA Sec. 1890 (currently the National Quality Forum). Requires the entity to convene multi-stakeholder groups to provide input on the national priorities for health care quality improvement (developed under ACA). In addition, the multi-stakeholder groups are required to provide input on the selection of quality measures for use in various specified Medicare payment systems for hospitals and other providers, as well as in other health care programs, and for use in reporting performance information to the public. Establishes a multi-step pre-rulemaking process and timeline for the adoption, dissemination, and review of measures by the Secretary. Requires the Secretary to transfer from the Medicare Part A and Part B trust funds $20 million for each of FY2010 through FY2014, to remain available until expended.[a] Total amount = $100 million. [CMS]	No public information located on funding obligations.
3021(a)	New SSA Sec. 1115A	**Center for Medicare and Medicaid Innovation (CMMI).** Requires the Secretary, no later than January 1, 2011, to establish the CMMI within CMS. The purpose of CMMI is to test and evaluate innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished under these programs. In selecting the models, the Secretary is also required to give preference to those that improve the coordination, quality, and efficiency of health care services. Appropriates (1) $5 million for FY2010 for the selection, testing, and evaluation of new payment and service delivery models; and (2) $10 billion for the period FY2011 through FY2019, plus $10 billion for each subsequent 10-year period, to continue such activities and for the expansion and nationwide implementation of successful models. Amounts are to remain available until expended.[b] [CMS]	According to CMS's FY2013 budget justification, FY2011 obligations = $95 million; FY2012 obligations (est.) = $1.693 billion; FY2013 obligations (est.) = $1.362 billion. [For information on CMMI's programs, which include several of the initiatives summarized in this table, see http://www.innovations.cms.gov/.]
3024	New SSA Sec. 1866E	**Medicare independence at home demonstration program.** Requires the Secretary to conduct a three-year Medicare demonstration program, beginning no later than January 1, 2012, to test a payment incentive and service delivery model that uses physician- and nurse practitioner-directed primary care teams to provide home-based services to chronically ill patients. The Secretary must submit a plan, no later than January 1, 2016, for expanding the program if it is determined that such expansion would improve the quality of care and reduce spending. Requires the Secretary to transfer from the Medicare Part A and Part B trust funds $5 million for each of FY2010 through FY2015 for administering and carrying out the demonstration, to remain available until expended.[a] Total amount = $30 million. [CMS]	No public information located on funding obligations. [For a fact sheet on the independence at home demonstration, administered by CMMI, see http://www.innovations.cms.gov/initiatives/Independence-at-Home/index.html.]

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
3026	New authority	**Community-based care transitions program.** Requires the Secretary to establish a five-year program, beginning January 1, 2011, to provide funding to eligible hospitals and community-based organizations that provide evidence-based transition services to Medicare beneficiaries with multiple chronic conditions who are at high risk for hospital readmission. Requires the Secretary to transfer from the Medicare Part A and Part B trust funds $500 million for the period FY2011 through FY2015, to remain available until expended.[a] [CMS]	No public information located on funding obligations. [This program is being administered by CMMI, as part of its Partnership for Patients initiative. See http://www.innovations.cms.gov/initiatives/Partnership-for-Patients/index.html.]
3027(b)	Amends DRA Sec. 5007	**Medicare gainsharing demonstration program.** CMS is supporting two projects that allow hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred as a result of collaborative efforts to improve overall quality and efficiency. ACA appropriates $1.6 million for FY2010, to remain available through FY2014 or until expended, for carrying out the demonstration. [CMS]	No public information located on funding obligations.
3113	New authority	**Diagnostic laboratory test demonstration program.** Requires the Secretary to conduct a two-year demonstration program beginning July 1, 2011, with a subsequent report to Congress, to test the impact of direct payments for certain complex laboratory tests on Medicare costs and quality of care. Payments are to be made from the Part B trust fund and may not exceed $100 million. Transfers $5 million from the Medicare Part B trust fund, to remain available until expended, for carrying out the demonstration program and preparing the subsequent report. [CMS]	Payments under the demonstration began in January 2012. [See http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/TCCDLT_FactSheet.pdf.]
3306	Amends MIPPA Sec. 119	**Outreach and assistance for Medicare low-income programs.** Transfers a total of $45 million from the Medicare Part A and Part B trust funds for the period FY2010 through FY2012 to extend funding for the following beneficiary outreach and education activities for Medicare low-income programs: (1) State Health Insurance Counseling and Assistance Programs (SHIPs), $15 million; (2) Area Agencies on Aging (AAAs), $15 million; (3) Aging and Disability Resource Centers (ADRCs), $10 million; and (4) the National Center for Benefits Outreach and Enrollment (NCBOE), $5 million. Funds are to remain available until expended.[c] Note: P.L. 112-240 appropriates $25 million for FY2013 for these programs: (1) SHIPs, $7.5 million; (2) AAAs, $7.5 million; (3) ADRCs, $5 million; and (4) NCBOE, $5 million. [AoA, CMS; CFDA 93.518]	HHS announced grant awards totaling $45 million in September 2010.
3403	New SSA Sec. 1899A	**Independent Payment Advisory Board (IPAB).** Creates an independent, 15-member advisory board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. Appropriates $15 million for FY2012 to support the board's activities. For each subsequent fiscal year, appropriates the amount from the previous fiscal year adjusted for inflation. Sixty percent of the appropriation is to be derived by transfer from the Medicare Part A trust fund, and 40% is to be derived by transfer from the Medicare Part B trust fund. Note: P.L. 112-74 rescinds $10 million of IPAB's $15 million appropriation for FY2012; see **Appendix C**.	IPAB members have yet to be appointed.

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
4202(b)	New authority	**Medicare prevention and wellness evaluation.** Transfers $50 million from the Medicare Part A and Part B trust funds, to remain available until expended, to fund an evaluation of community-based prevention and wellness programs and, based on the findings, develop a plan to promote healthy lifestyles and chronic disease self-management among Medicare beneficiaries.[a] [CMS]	No public information located on funding obligations.
4204(e)	New authority	**Medicare vaccine coverage.** Appropriates $1 million for FY2010 for a GAO report on the impact of Medicare Part D vaccine coverage on access to those vaccines among beneficiaries.	Report released in December 2011 (GAO-12-61).
10323(a)	New SSA Sec. 1881A	**Environmental health hazards.** Extends Medicare eligibility to individuals with specified health conditions linked to environmental exposures, who have resided for specified times in an area subject to a Superfund public health emergency declaration. Requires the Secretary to establish a pilot program, with appropriate reimbursement methodologies, to provide comprehensive, coordinated, and cost-effective care to such individuals. Transfers such sums as may be necessary from the Medicare Part A and Part B trust funds to carry out the pilot program.[a] [CMS]	No public information located on funding obligations.
10323(b)	New SSA Sec. 2009	**Environmental health hazards.** Appropriates $23 million for the period FY2010 through FY2014, and $20 million for each five-year period thereafter, for grants to state and local government agencies, health care facilities, and other entities to (1) provide screening for specified lung diseases and other environmental health conditions to individuals who have resided for specified times in an area subject to a Superfund public health emergency declaration; and (2) disseminate public information about the availability of screening, the detection and treatment of environmental health conditions, and the availability of Medicare benefits to certain individuals diagnosed with such conditions, pursuant to new SSA Sec. 1881A (as added by ACA Sec. 10323(a)). [CMS; CFDA 93.534]	$5 million [Funding provided for an asbestos health screening program in Libby, Montana.]
Fraud and Abuse			
6402(i) & HCERA Sec. 1303(a)	Amends SSA Sec. 1817(k)	**Health Care Fraud and Abuse Control (HCFAC) Account.** Applies a permanent inflation adjustment to the annual appropriation (provided under SSA Sec. 1817(k)) for the HCFAC account. Appropriates from the Medicare Part A trust fund the following supplemental amounts for the HCFAC account: $10 million for each of FY2011 through FY2020; plus an additional $95 million for FY2011, $55 million for FY2012, $30 million for each of FY2013 and FY2014, and $20 million for each of FY2015 and FY2016. Funds are to remain available until expended. Total amount = $350 million. [CMS]	No public information located on funding obligations.
Health Centers and the National Health Service Corps			
4101(a)	New authority	**School-based health centers (SBHCs).** Appropriates $50 million for each of FY2010 through FY2013, to remain available until expended, for a grant program to fund the construction and renovation of school-based health centers. Total amount = $200 million. [HRSA; CFDA 93.501]	$142 million [In December 2012, HRSA announced a third round of awards to SBHCs totaling $80 million. See http://bphc.hrsa.gov/about/schoolbased/index.html.]

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
10503(b)(1)	New authority	**Community Health Center Fund (CHCF).** Transfers from the CHCF the following amounts for health center operations, to remain available until expended: FY2011 = $1 billion; FY2012 = $1.2 billion; FY2013 = $1.5 billion; FY2014 = $2.2 billion; and FY2015 = $3.6 billion. Total amount = $9.5 billion. [HRSA; CFDA 93.527]	In FY2011 and FY2012, HRSA awarded a total of approximately $1.1 billion in ACA grants to support health center operations and related activities. [See http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf.]
10503(b)(2)	New authority	**National Health Service Corps (NHSC).** Transfers from the CHCF the following amounts for NHSC operations, scholarships, and loan repayments, to remain available until expended: FY2011 = $290 million; FY2012 = $295 million; FY2013 = $300 million; FY2014 = $305 million; and FY2015 = $310 million. Total amount = $1.5 billion. [HRSA; CFDA 93.547]	According to the President's FY2013 budget, obligations are as follows: FY2011 = $289 million; FY2012 (est.) = $296 million; FY2013 (est.) = $300 million.
10503(c)	New authority	**Health center construction and renovation.** Appropriates $1.5 billion, to be available for the period FY2011 through FY2015, and to remain available until expended, for health center construction and renovation. [HRSA; CFDA 93.526]	$1.509 billion
Health Workforce			
5507(a)	New SSA Sec. 2008	**Health workforce demonstration programs.** Requires the Secretary to establish two demonstration projects. The first is to award health profession opportunity grants to states, Indian tribes, institutions of higher education, and local workforce investment boards to help low-income individuals obtain education and training in health care jobs that pay well and are in high demand. Funds may be used to provide financial aid and other supportive services. The second project is to provide states with grants to develop core training competencies and certification programs for personal and home care aides. Appropriates $85 million for each of FY2010 through FY2014, of which $5 million in each of FY2010 through FY2012 is to be used for the second project. Total amount = $425 million. [ACF, HRSA; CFDA 93.093, 93.512]	$195 million: Health Profession Opportunity Grant (HPOG) $13 million: Personal and Home Care Aide State Training (PHCAST) program [See http://www.acf.hhs.gov/programs/ofa/programs/hpog and http://bhpr.hrsa.gov/nursing/grants/phcast.html.]
5507(b)	Amends SSA Sec. 501(c)	**Family-to-family health information centers.** Renews funding for the family-to-family information centers, which assist families of children with disabilities or special health care needs and the professionals who serve them, by appropriating $5 million for each of FY2010 through FY2012, to remain available until expended. Total amount = $15 million. Note: P.L. 112-240 appropriates $5 million for FY2013. [HRSA; CFDA 93.504]	$5 million (FY2012) [See http://mchb.hrsa.gov/programs/familytofamily/index.html.]
5508(c)	New PHSA Sec. 340H	**Teaching health centers.** Appropriates such sums as may be necessary, not to exceed $230 million, for the period FY2011 through FY2015 to make payments for direct and indirect graduate medical education (GME) costs to qualified teaching health centers (THCs). [HRSA; CFDA 93.530]	$30 million [See http://bhpr.hrsa.gov/grants/teachinghealthcenters/.]
5509	New authority	**Medicare graduate nurse education demonstration program.** Appropriates $50 million for each of FY2012 through FY2015, to remain available until expended, for a Medicare demonstration program under which up to five eligible hospitals will receive reimbursement for providing advanced practice nurses with clinical training in primary care, preventive care, transitional care, and chronic care management. Total amount = $200 million. [CMS/CMMI]	CMMI, which is administering this program, has selected the five participating hospitals and begun making reimbursement payments. [See http://innovations.cms.gov/initiatives/GNE/index.html.]

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
10502	New authority	**Health care facility construction.** Appropriates $100 million for FY2010, to remain available for obligation until Sept. 30, 2011, for debt service on, or construction or renovation of, a hospital affiliated with a state's sole public medical and dental school. [HRSA; CFDA 93.502]	$100 million [Funding awarded to Ohio State University.]
Community-Based Prevention and Wellness			
4002	New authority	**Prevention and Public Health Fund (PPHF).** Establishes a PPHF and originally provided a permanent annual appropriation to the fund, as follows: FY2010 = $500 million; FY2011 = $750 million; FY2012 = $1 billion; FY2013 = $1.25 billion; FY2014 = $1.5 billion; FY2015 and each year thereafter = $2 billion. Requires the Secretary to transfer amounts from the fund to HHS accounts to increase funding, over the FY2008 level, for PHSA-authorized prevention, wellness, and public health activities, including prevention research and health screenings. Authorizes House and Senate appropriators to transfer monies from the PPHF to eligible activities. Note: P.L. 112-96 subsequently reduced the annual appropriations to the PPHF over the period FY2013-FY2021, as follows: FY2013 through FY2017 = $1 billion; FY2018 and FY2019 = $1.25 billion; FY2020 and FY2021 = $1.5 billion; FY2022 and each year thereafter = $2 billion. [OS, CDC, HRSA, SAMHSA, ACL; CFDA 93.507, 93.521, 93.522, 93.523, 93.524, 93.531, 93.533, 93.538, 93.539, 93.540, 93.542.]	PPHF funds are annual appropriations that must be obligated during the fiscal year in which they are made available. For a complete list of all PPHF obligations for FY2010 and FY2011, see the GAO report, *Prevention and Public Health Fund: Activities Funded in Fiscal Years 2010 and 2011* (GAO-12-788), at http://www.gao.gov/assets/650/648310.pdf. For a summary of the activities and programs, by agency, that were supported with FY2012 PPHF funds, see http://www.hhs.gov/open/recordsandreports/prevention/index.html. [This website was mandated by P.L. 112-74; see **Appendix C**.] Note: The listed CFDA programs do not capture all the uses of PPHF funding. PPHF funds have also been integrated into existing programs that do not mention PPHF.
Maternal and Child Health			
2951	New SSA Sec. 511	**Maternal, infant, and early childhood home visiting program.** Appropriates the following amounts for grants to states, U.S. territories, and Indian tribes to develop and implement early childhood home visiting programs that adhere to evidence-based models of service delivery: FY2010 = $100 million; FY2011 = $250 million, FY2012 = $350 million; FY2013 = $400 million; FY2014 = $400 million. Total amount = $1.5 billion. Programs must establish benchmarks to measure improvements for the participating families in maternal and newborn health; prevention of child abuse or neglect or child injuries; school readiness and achievement; reductions in crime or domestic violence; family economic self-sufficiency; and coordination and referrals for other community resources and supports. [HRSA, ACF; CFDA 93.505, 93.508]	$639 million [See http://mchb.hrsa.gov/programs/homevisiting/.]
2953	New SSA Sec. 513	**Personal Responsibility Education Program (PREP).** Establishes a state formula grant program to support evidence-based PREPs designed to educate adolescents about abstinence, contraception, and adulthood. Also, requires the Secretary to award grants to implement innovative youth pregnancy prevention strategies and to target services at high-risk populations. Appropriates $75 million for each of FY2010 through FY2014, of which $10 million each year is to be reserved for the youth pregnancy prevention grants. Funds are to remain available until expended. Total amount = $375 million. [ACF; CFDA 93.092]	$215 million [See http://www.acf.hhs.gov/programs/fysb/programs/adolescent-pregnancy-prevention/programs/prep-competitive.]

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
2954	Amends SSA Sec. 510	**Abstinence education grants.** Renews funding for the state formula grant program to support abstinence education programs by appropriating $50 million for each of FY2010 through FY2014. Total amount = $250 million. Funds are awarded to states based on the proportion of low-income children in each state compared to the national total, and may only be used for teaching abstinence. [ACF, CDC; CFDA 93.235]	$83 million (FY2010-FY2012) [See http://www.acf.hhs.gov/programs/fysb/resource/aegp-fact-sheet.]
10211-10214	New authority	**Pregnancy assistance grants.** Appropriates $25 million for each of FY2010 through FY2019 (total amount = $250 million) to establish a Pregnancy Assistance Fund for the purpose of awarding grants to states to assist pregnant and parenting teens and women. State grantees have the flexibility to make funds available to institutions of higher education, high schools and community service centers, and to the state attorneys general to improve services for pregnant women who are victims of domestic violence, sexual assault, or stalking. [OS; CFDA 93.500]	$72 million [See http://www.hhs.gov/ash/oah/oah-initiatives/paf/home.html.]
Long-Term Care			
2403	Amends DRA Sec. 6071(h)	**Medicaid Money Follows the Person (MFP) demonstration program.** Extends funding for the MFP demonstration through FY2016. The program authorizes the Secretary to award competitive grants to states to reduce their reliance on institutional care for people needing long-term care, and expand options for elderly people and individuals with disabilities to receive home and community-based long-term care services. Appropriates $450 million for each of FY2012 through FY2016, to remain available through FY2016. Total amount = $2.25 billion. [CMS; CFDA 93.791]	$293 million (FY2012 only) [See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html.]
2405	New authority	**State Aging and Disability Resource Centers (ADRCs).** Appropriates $10 million for each of FY2010 through FY2014 (total amount = $50 million) for ADRCs, authorized under OAA Sec. 202. ADRCs serve as a single, coordinated resource for consumer information on the range of long-term care options in community and institutional settings. Some ADRCs also serve as the entry point to publicly administered long-term care programs (e.g., Medicaid, OAA services, state assistance programs). AoA and CMS have invested more than $100 million in the ADRC program since 2003. ADRCs currently operate in over 350 community sites across 54 states and territories. See also the entry for ACA Sec. 3306, above. [AoA; CFDA 93.517]	$15 million [See http://www.aoa.gov/AoA_programs/HCLTC/ADRC/index.aspx.]
6201	New authority	**Background checks of long-term care providers.** Requires the Secretary to establish a nationwide program for background checks on direct patient access employees of long-term care facilities or providers, and to provide federal matching funds to states to conduct these activities. Requires the Treasury Secretary to transfer to HHS an amount, not to exceed $160 million, that is specified by the HHS Secretary as necessary to carry out the program for the period FY2010 through FY2012. Funds are to remain available until expended. [CMS; CFDA 93.506]	$48 million

ACA Section	Statutory Authority	Program	Obligations as of January 4, 2013, Based on TAGGS Unless Specified Otherwise
8002(d)	Amends DRA Sec. 6021(d)	**National Clearinghouse for Long-Term Care Information.** Appropriates $3 million for each of FY2011 through FY2015 for the National Clearinghouse for Long-Term Care Information, and requires the Clearinghouse to include information on the Community Living Assistance Services and Supports (CLASS) program, established under ACA Sec. 8002(a). Total amount = $15 million. [AoA]	No public information located on funding obligations. However, these are annual appropriations that must be obligated during the fiscal year in which they are made available. [See http://www.longtermcare.gov/LTC/Main_Site/index.aspx.]
Comparative Effectiveness Research			
6301(d)-(e)	New IRC Secs. 9511, 4375, & 4376. New SSA Sec. 1183	**Patient-Centered Outcomes Research Trust Fund (PCORTF).** Establishes a PCORTF to fund the new Patient-Centered Outcomes Research Institute (PCORI) and its comparative effectiveness research activities. Appropriates to the PCORTF $10 million for FY2010, $50 million for FY2011, and $150 million for each of FY2012 through FY2019, for a total of $1.26 billion over that 10-year period. For each of FY2013 through FY2019, the PCORTF is to receive additional appropriations equal to the net revenues from a new health insurance policy/plan fee,[d] as well as Medicare trust fund transfers.[e] Each fiscal year, 20% of the funds in the PCORTF are to be transferred to the Secretary, to remain available until expended. Of those transferred funds, 80% are to be provided to AHRQ. [OS, AHRQ]	In June 2012, PCORI announced pilot project grant awards totaling $30 million over two years. In December 2012, PCORI announced its first comparative effectiveness research grant awards totaling $41 million over three years. [See http://www.pcori.org/.]
Biomedical Research			
9023	New IRC Sec. 48D	**Therapeutic research and development tax credits and grants.** Creates a two-year tax credit program, subject to an overall cap of $1 billion, for small companies (250 or fewer employees) that invest in new therapies to prevent, diagnose, and treat cancer and other diseases. Companies may apply for one or more tax credits, each covering up to 50% of the cost of qualifying research investments made in 2009 and 2010. However, the total amount of tax credits any one company receives for the two years may not exceed $5 million. Companies may elect to receive one or more grants in lieu of tax credits, subject to the same restrictions (i.e., grants may cover up to 50% of the cost of qualifying investments made in 2009 and 2010; the total amount of grants any one company receives for the two years may not exceed $5 million). Appropriates such sums as may be necessary to carry out the grant program. [IRS]	According to the IRS: total grant awards = $970 million; total tax credits = $17 million. [See http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Qualifying-Therapeutic-Discovery-Project-Credits-and-Grants.]
ACA Implementation: Administrative Expenses			
HCERA Sec. 1005	New authority	**Health Insurance Reform Implementation Fund (HIRIF).** Appropriates $1 billion to the HIRIF for federal administrative expenses to carry out ACA. [OS; CFDA 93.528]	The HIRIF funds were projected to have all been obligated by the end of FY2012.

Source: Prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), as amended.

a. Transfers from the two trust funds are in such proportion as the Secretary determines appropriate.

b. Of the amounts appropriated for the period FY2011-FY2019, and for each subsequent 10-year period, at least $25 million must be made available each fiscal year for the selection, testing, and evaluation of new payment and service delivery models.

c. Transfers from the two trust funds are in the same proportion as the Secretary determines under SSA Sec. 1853(f).

d. The health insurance fee is to equal $2 multiplied by the average number of covered lives in a policy/plan year ($1 in the case of a policy/plan year ending during FY2013), updated annually by the rate of medical inflation beginning in FY2015.

e. The trust fund transfers are to equal $2 ($1 in FY2013) multiplied by the average number of individuals entitled to benefits under Part A or enrolled under Part B in a given fiscal year, updated annually by the rate of medical inflation beginning in FY2015.

Table 2. ACA Appropriations and Fund Transfers by Fiscal Year

FY2010-FY2019

ACA Section	Program	Appropriation (or Fund Transfer) in $ millions										Total[a]
		FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	
Private Health Insurance												
1002	Health insurance consumer information	30[b]	(Note: This section also authorizes to be appropriated SSAN for FY2011 and each fiscal year thereafter.)									30
1003	Review of health insurance premium rates	250	—	—	—	—	—	—	—	—	—	250
1101	Temporary high-risk health insurance pools	5,000[b]	—	—	—	—	—	—	—	—	—	5,000
1102	Early retiree reinsurance program	5,000[b]	—	—	—	—	—	—	—	—	—	5,000
1311	Health insurance exchange planning and establishment	Appropriates amounts necessary for grants each fiscal year, as determined by the Secretary; no grant awards after Jan. 1, 2015						—	—	—	—	TBD[c]
1322	Consumer operated and oriented plans (CO-OPs)	6,000[d]	—	—	—	—	—	—	—	—	—	6,000
1323	Health insurance exchange subsides (U.S. territories)	—	—	—	—	$1 billion total for CY2014 through CY2109[e]						1,000
Medicaid and Children's Health Insurance Program (CHIP)												
2701	Medicaid adult health quality measures	60	60	60	60	60	—	—	—	—	—	300[f]
2707	Medicaid emergency psychiatric demonstration	—	75[g]	—	—	—	—	—	—	—	—	75
2801	Medicaid and CHIP Payment and Access Commission	11[h]	(Note: This section also authorizes to be appropriated SSAN for FY2011 and each fiscal year thereafter.)									11
4108	Medicaid prevention and wellness incentives	—	$100 million total for CY2011 through CY2015[f]					—	—	—	—	100
4306	CHIP childhood obesity demonstration	$25 million total for FY2010 through FY2014					—	—	—	—	—	25
10203(d)	CHIP annual appropriation[i]	—	—	—	—	19,147	21,061	—	—	—	—	40,208
10203(d)	CHIP outreach and enrollment grants	Increases total funding from $100 million to $140 million and extends funding period through FY2015						—	—	—	—	40

ACA Section	Program	Appropriation (or Fund Transfer) in $ millions										Total[a]
		FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	
Medicare												
3014	Medicare quality and efficiency measures	20[j]	20	20	20	20	—	—	—	—	—	100
3021(a)	Center for Medicare and Medicaid Innovation	5	plus $10 billion total for FY2011 through FY2019, and $10 billion for each subsequent 10-year period									10,005[f]
3024	Medicare independence at home demonstration	5[j]	5	5	5	5	5	—	—	—	—	30
3026	Community-based care transition services	—	$500 million total for FY2011 through FY2015[j]					—	—	—	—	500
3027(b)	Medicare gainsharing demonstration	2	—	—	—	—	—	—	—	—	—	2[f]
3113	Diagnostic laboratory test demonstration	5[k]	—	—	—	—	—	—	—	—	—	5
3306	Outreach and assistance for low-income beneficiaries	$45 million total for FY2010 through FY2012[l]			25[l]	—	—	—	—	—	—	70
3403	Independent Payment Advisory Board	—	—	5[m]	For FY2013 and each subsequent fiscal year, appropriates previous year's amount adjusted for inflation; funds derived from the Medicare trust funds.							TBD[c]
4202(b)	Prevention and wellness evaluation	50[j]	—	—	—	—	—	—	—	—	—	50
4204(e)	GAO study of Medicare vaccine coverage	1	—	—	—	—	—	—	—	—	—	1
10323(a)	Environmental health pilot program	SSAN[j]										TBD[c]
10323(b)	Environmental health screening and education	$23 million total for FY2010 through FY2014					$20 million total for FY2015 though FY2019, and for each 5-year period thereafter					43[f]
Fraud and Abuse												
6402(i) & HCERA 1303(a)	Health Care Fraud and Abuse Control (HCFAC) Account	—	105	65	40	40	30	30	10	10	10	350[n]
Health Centers and the National Health Service Corps (NHSC)												
4101(a)	School-based health center establishment grants	50	50	50	50	—	—	—	—	—	—	200[f]

ACA Section	Program	Appropriation (or Fund Transfer) in $ millions										
		FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	Total[a]
10503(b)(1)	Community Health Centers Fund, patient services	—	1,000	1,200	1,500	2,200	3,600	—	—	—	—	9,500[f]
10503(b)(2)	Community Health Centers Fund, NHSC	—	290	295	300	305	310	—	—	—	—	1,500[f]
10503(c)	Community health center construction and renovation	—	$1.5 billion total for FY2011 through FY2015					—	—	—	—	1,500[f]
Health Workforce												
5507(a)	Health workforce demonstration grants	85	85	85	85	85	—	—	—	—	—	425
5507(b)	Family-to-family health information centers	5	5	5	5[o]	—	—	—	—	—	—	20[f]
5508(c)	Teaching health centers, GME payments	—	SSAN for FY2011 through FY2015, not to exceed $230 million					—	—	—	—	≤230
5509	Medicare graduate nurse education demonstration	—	—	50	50	50	50	—	—	—	—	200[f]
10502	Health care facility construction	100	—	—	—	—	—	—	—	—	—	100[p]
Community-Based Prevention and Wellness												
4002	Prevention and Public Health Fund	500	750	1,000	1,000	1,000	1,000	1,000	1,000	1,250	1,250	9,750[q]
Maternal and Child Health												
2951	Maternal, infant, and early childhood home visitation	100	250	350	400	400	—	—	—	—	—	1,500
2953	Personal responsibility education program grants	75	75	75	75	75	—	—	—	—	—	375[f]
2954	Abstinence education state grants	50	50	50	50	50	—	—	—	—	—	250
10214	Pregnancy assistance grants	25	25	25	25	25	25	25	25	25	25	250
Long-Term Care												
2403	Medicaid money follows the person demonstration	—	450	450	450	450	450	450	—	—	—	2,700

ACA Section	Program	Appropriation (or Fund Transfer) in $ millions										
		FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	Total[a]
2405	State Aging and Disability Resource Centers	10	10	10	10	10	—	—	—	—	—	50
6201	Background checks of long-term care providers	Up to $160 million total for FY2010 through FY2012			—	—	—	—	—	—	—	≤160[r]
8002(d)	National Clearinghouse for Long-Term Care Information	—	3	3	3	3	3	—	—	—	—	15
Comparative Effectiveness Research												
6301(d)	Patient-Centered Outcomes Research Trust Fund, Medicare transfers	—	—	—	For each of FY2013-FY2019, transfers amounts from the Medicare trust funds as determined by a formula							TBD[s]
6301(e)	Patient-Centered Outcomes Research Trust Fund, appropriations	10	50	150	For each of FY2013-FY2019, appropriates $150 million plus an amount equal to the net revenue from a fee levied on insurance policies and health plans							TBD[t]
Biomedical Research												
9023(e)	Grants for investment in new therapeutics	SSAN	—	—	—	—	—	—	—	—	—	≤1[u]
PPACA Implementation												
HCERA 1005	Health Insurance Reform Implementation Fund	1,000	—	—	—	—	—	—	—	—	—	1,000

Source: Prepared by the Congressional Research Service based on the text of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), as amended.

Notes: Funds are provided from the Treasury unless otherwise noted. A dash means that ACA does not appropriate or transfer funds for the fiscal year(s) noted.

a. Total represents the cumulative amount of appropriations or fund transfers over the 10-year period FY2010-FY2019. Note that in several instances the 10-year total is yet to be determined (TBD); see table entries for ACA Secs. 1311, 3403, 6301(d) & (e), 9023(e), and 10323(a). In addition, four provisions provide annual or multiple-year appropriations beyond FY2019. The total shown in the table for three of these provisions represents the cumulative amount appropriated through FY2019; see table entries for ACA Secs. 3021(a), 4002 (discussed in table note "q" below), and 10323(b). Finally, the total for ACA Sec. 6402(i) includes an amount appropriated in FY2020 (see table note "n" below).

b. Funds are to remain available without fiscal year limitation.

c. To be determined.

d. ACA Sec. 1322 appropriated $6 billion for the CO-OP program. Subsequently, Division B, Title VIII, Sec. 1857 of P.L. 112-10 canceled $2.2 billion of that appropriation; Division F, Title V, Sec. 524 of P.L. 112-74 rescinded an additional $400 million; and Sec. 644 of P.L. 112-240 rescinded all but 10% of the remaining unobligated funds. See **Appendix C**.

e. Of this total amount, $925 million is for Puerto Rico, and the remaining $75 million is for the other U.S. territories in amounts as specified by the Secretary.

f. Funds are to remain available until expended.

g. Funds are to remain available for obligation through Dec. 31, 2015.

h. Of this total amount, $9 million is appropriated, and the remaining $2 million is a transfer from CHIP funding for FY2010. Funds are to remain available until expended.

i. Prior to enactment of ACA, the CHIP program was funded through FY2013.

j. The Secretary is required to transfer amounts from the Medicare Part A and Part B trust funds each fiscal year in such proportion as the Secretary determines appropriate. Funds are to remain available until expended.

k. The Secretary is required to transfer the $5 million from the Medicare Part B trust fund, to remain available until expended.

l. The Secretary is required to transfer amounts from the Medicare Part A and Part B trust funds in the same proportion as the Secretary determines under SSA Sec. 1853(f). Funds are to remain available until expended. Note: Sec. 610 of P.L. 112-240 appropriated $25 million for FY2013 for the four outreach and assistance programs funded under ACA Sec. 3306. See **Table 1** and **Appendix C**.

m. Division F, Title V, Sec. 525 of P.L. 112-74 rescinded $10 million of IPAB's appropriation for FY2012. See **Appendix C**.

n. Funds are to be appropriated from the Medicare Part A trust fund. Note: the total amount appropriated (i.e., $350 million) includes a final appropriation of $10 million for FY2020.

o. Sec. 624 of P.L. 112-240 appropriated $5 million for FY2013 for this program.

p. Funds are to remain available for obligation until Sept. 30, 2011.

q. ACA Sec. 4002 originally provided a permanent annual appropriation to the Prevention and Public Health Fund, as follows: FY2010 = $500 million; FY2011 = $750 million; FY2012 = $1 billion; FY2013 = $1.25 billion; FY2014 = $1.5 billion; FY2015 and each year thereafter = $2 billion. Subsequently, P.L. 112-96 reduced the annual appropriations to the PPHF over the period FY2013-FY2021, as follows: FY2013 through FY2017 = $1 billion; FY2018 and FY2019 = $1.25 billion; FY2020 and FY2021 = $1.5 billion; FY2022 and each year thereafter = $2 billion. Thus, appropriations to the fund now total $9.750 billion over the period FY2010-FY2019.

r. The HHS Secretary is required to notify the Treasury Secretary of the amount necessary to carry out activities under this section for the period of FY2010 through FY2012, but not to exceed $160 million. The Treasury Secretary must then transfer the amount specified from the Treasury to the HHS Secretary. Funds are to remain available until expended.

s. To be determined. ACA Sec. 6301(d) provided the following formula for the transfer of funds from the Medicare Part A and Part B trust funds to the Patient-Centered Outcomes Research Trust Fund: (1) for FY2013, an amount from each respective Medicare trust fund equal to $1 multiplied by the average number of individuals entitled to Part A benefits, or enrolled in Part B during that period; and (2) for each of FY2014-FY2019, an amount from each respective Medicare trust fund equal to $2 multiplied by the average number of individuals entitled to Part A benefits, or enrolled in Part B during that fiscal year. Beginning in FY2015, amounts are subject to adjustment for increases in health care spending.

t. To be determined. In addition to the amounts transferred to the Patient-Centered Outcomes Research Trust Fund under ACA Sec. 6301(d), described in the preceding table note, ACA Sec. 6301(e) appropriated to the Fund a specified amount for each of FY2010-FY2019, plus an additional amount for each of FY2013 through FY2019 equal to the net revenues received from a fee imposed on health insurance policies and self-insured plans. The fee equals $2 multiplied by the average number of covered lives in a policy/plan year ($1 in the case of policy/plan years ending during FY2013). Beginning in FY2015, amounts are subject to adjustment for increases in health care spending.

u. To be determined. ACA Sec. 9023(e) created a two-year tax credit program, subject to an overall cap of $1 billion, for small companies that invest in new therapies to prevent, diagnose and treat cancer and other diseases. The total amount of tax credits any one company can receive for the two years may not exceed $5 million. Companies may elect to receive one or more grants—for which SSAN are appropriated—in lieu of tax credits. Grant applications must be received before Jan. 1, 2013.

Appendix A. Acronyms Used in the Report

The following laws and federal agencies are referred to in this report by their acronym:

AoA	Administration on Aging
ACF	Administration for Children and Families
AHRQ	Agency for Healthcare Research and Quality
BBEDCA	Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177)
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005 (P.L. 109-171)
HCERA	Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
HRSA	Health Resources and Services Administration
OS	HHS Office of the Secretary
IRC	Internal Revenue Code
IRS	Internal Revenue Service
MIPPA	Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)
OAA	Older Americans Act
PHSA	Public Health Service Act
PPACA	Patient Protection and Affordable Care Act (P.L. 111-148)
SSA	Social Security Act

Appendix B. ACA-Related Authorizing Legislation in the 112th Congress

Lawmakers opposed to specific provisions in ACA, or to the entire law, introduced numerous bills in the 112th Congress to modify or repeal the law. Most of the legislative activity on these bills took place in the House. The ACA-related legislation included bills that would have (1) repealed the law in its entirety and, in some instances, replaced it with new law; (2) repealed or amended specific provisions in the law; (3) eliminated certain mandatory appropriations in ACA (discussed in this report) and rescinded all unobligated funds;[19] (4) replaced the mandatory appropriations for one or more ACA programs with authorizations of appropriations, and rescinded all unobligated funds; and (5) blocked or otherwise delayed ACA implementation. A few provisions, with sufficiently broad and bipartisan support were approved in both the House and the Senate and signed into law.

This appendix summarizes the ACA-related provisions in authorization legislation enacted during the 112th Congress. It also provides a brief overview of each of the ACA-related bills that were passed by the House, but which were not approved by the Senate. **Appendix C** summarizes the ACA-related provisions in annual appropriations acts for the period FY2011-FY2013.

Enacted Legislation

P.L. 112-9 (April 14, 2011; H.R. 4), Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011. P.L. 112-9 repealed the ACA requirement that businesses file an information report (IRS Form 1099) whenever they pay a vendor more than $600 for goods in a single year. To pay for the 1099 repeal, P.L. 112-9 raised the limits on the amount of excess premium tax credits that individuals would have to repay. [Note: Under ACA, the amount received in premium credits is based on income as reported on tax returns. These amounts are reconciled the following year, which could result in an overpayment of credits if income increases. ACA placed limits on the amount of any premium credit overpayment that had to be repaid to the government.]

P.L. 112-56 (November 21, 2011; H.R. 674), 3% Withholding Repeal and Job Creation Act. Among its many provisions, P.L. 112-56 amended the calculation of Modified Adjusted Gross Income (MAGI) to include Social Security benefits. MAGI will be used to determine eligibility for health insurance exchange subsidies and Medicaid, beginning in 2014.

P.L. 112-96 (February 22, 2012; H.R. 3060), Middle Class Tax Relief and Job Creation Act of 2012. Among its many provisions, P.L. 112-96: (1) reduced ACA's annual appropriations to the PPHF over the period FY2013-FY2021 by a total of $6.25 billion to help offset the costs of the law's extension of the payroll tax cut; (2) extended by one year the disproportionate share hospital (DSH) allotment reduction imposed by ACA; and (3) corrected the formula to phase down ACA's Medicaid disaster-recovery FMAP adjustment as originally intended. [Note: The purpose of the adjustment was to help Louisiana avoid a significant reduction in its federal Medicaid match (i.e., Federal Medical Assistance Percentage, or FMAP) in the aftermath of

[19] Of the total amount of funding available for obligation, the unobligated balance represents the funds that an agency has not yet awarded or otherwise made a legal commitment to provide as payment for goods or services.

Hurricane Katrina. As written in ACA, the formula for the disaster-recovery FMAP adjustment unintentionally caused the FMAP adjustment to increase, rather than phase down, each year the state qualifies for the adjustment.]

P.L. 112-141 (July 6, 2012; H.R. 4348), Moving Ahead for Progress in the 21st Century Act, or "MAP-21". Among its many provisions, P.L. 112-141 included a further adjustment to ACA's Medicaid disaster-recovery provision (see entry for P.L. 112-96, above).

P.L. 112-240 (January 2, 2013; H.R. 8), American Taxpayer Relief Act of 2012. Among its many provisions, P.L. 112-240: (1) provided $25 million for FY2013 for the four outreach and assistance programs that were funded by ACA Sec. 3306 through FY2012; (2) provided $5 million for FY2013 for the family-to-family information centers, which ACA Sec. 5507(b) funded through FY2012; and (3) repealed the Community Living Assistance Services and Supports (CLASS) program.

House-passed Bills

H.R. 2, Repealing the Job-Killing Health Care Law Act. Passed the House by a vote of 245-189 on January 19, 2011; offered as an amendment during Senate floor debate on an unrelated bill (S. 223) and rejected on a procedural motion by a vote of 47-51. H.R. 2 would have repealed ACA in its entirety and restored the provisions of law amended or repealed by ACA as if it had not been enacted.

H.R. 5, Protecting Access to Healthcare Act. Passed the House by a vote of 223-181 on March 22, 2012. Title II of H.R. 5 would have repealed the authority and appropriations for the Independent Payment Advisory Board (IPAB).

H.R. 358, Protect Life Act. Passed the House by a vote of 251-172 on October 13, 2011. H.R. 358 would have prohibited using any funds authorized or appropriated by ACA to pay for an abortion or to pay for any part of the costs of a health plan that covers abortions, except if the pregnancy is the result of rape or incest, or the life of the pregnant female is at risk unless an abortion is performed. It would have required insurers that offer plans through the exchanges that cover abortion services to offer identical plans that do not cover abortion services. It also would have prohibited federal, state or local government programs that receive ACA funding from discriminating against health care entities that refuse to provide abortion services or abortion training.

H.R. 436, Health Care Cost Reduction Act of 2012. Passed the House by a vote of 270-146 on June 7, 2012. H.R. 436 would have (1) repealed ACA's 2.3% excise tax on medical devices; (2) repealed the law's restrictions on using tax-preferred accounts to pay for over-the-counter drugs; (3) allowed individuals to recoup up to $500 of unused funds remaining in their flexible spending account (FSA) after the end of the plan year; and (4) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount.

H.R. 1173, Fiscal Responsibility and Retirement Security Act of 2012. Passed the House by a vote of 267-159 on February 1, 2012. H.R. 1173 would have repealed the Community Living Assistance Services and Supports (CLASS) program.

H.R. 1213, A bill to repeal ACA funding for health insurance exchanges. Passed the House by a vote of 238-183 on May 3, 2011. H.R. 1213 would have repealed the authority and

appropriations for state exchange planning and establishment grants and rescinded all unobligated funds.

H.R. 1214, A bill to repeal ACA funding for school-based health center (SBHC) construction. Passed the House by a vote of 235-191 on May 4, 2011. H.R. 1214 would have repealed the authority and appropriations for SBHC construction grants and rescinded all unobligated funds.

H.R. 1216, A bill to convert funding for graduate medical education (GME) in qualified teaching health centers (THCs) to an authorization of appropriations. Passed the House by a vote of 234-185 on May 25, 2011. H.R. 1216 would have replaced the appropriation for GME payments to THCs with an authorization of appropriations for each of FY2012 through FY2015, and rescinded all unobligated funds. It would have prohibited the GME funds from being used to provide abortions, except in cases of rape or incest or when the woman's life is in danger.

H.R. 1217, A bill to repeal the Prevention and Public Health Fund (PPHF). Passed the House by a vote of 236-183 on April 13, 2011. H.R. 1217 would have repealed the authority and appropriations for the PPHF and rescinded all unobligated funds.

H.R. 4628, Interest Rate Reduction Act. Passed the House by a vote of 215-195 on April 27, 2012. H.R. 4628 would have postponed by one year a scheduled increase in Stafford education loan rates and, to offset the costs of that adjustment, repealed the authority and appropriations for the PPHF and rescinded all unobligated funds. [Note: The one-year Stafford loan rate extension was incorporated as Division F, Title III of MAP-21, the surface transportation reauthorization bill (see entry for P.L. 112-141, above). The provision in H.R. 4628 to repeal PPHF and rescind all unobligated funds was not included in MAP-21.]

H.R. 5652, Sequester Replacement Reconciliation Act of 2012. Passed the House by a vote of 218-199 on May 10, 2012. H.R. 5652, which was introduced pursuant to the reconciliation instructions in the House FY2013 budget resolution (H.Con.Res. 112), would have replaced the FY2013 sequestration of discretionary spending (as required under the Budget Control Act of 2011) with a $19 billion reduction in the FY2013 discretionary cap, and would have implemented a series of mandatory program savings recommended by six House committees. Among its many provisions, H.R. 5652 would have (1) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount; (2) repealed the authority and appropriations for the exchange planning and establishment grants and rescinded all unobligated funds; (3) repealed the authority and appropriations for the PPHF and rescinded all unobligated funds; (4) rescinded all remaining unobligated funds for the Consumer Operated and Oriented Plan (CO-OP) program; (5) extended by one year the DSH allotment reduction imposed by ACA; and (6) repealed ACA's Medicaid maintenance of effort requirements.

H.R. 6079, Repeal of Obamacare Act. Passed the House by a vote of 244-185 on July 11, 2012. H.R. 6079 would have repealed all of ACA, except the authority for IPAB (see entry for H.R. 5, above), and restored the provisions of law amended or repealed by ACA as if it had not been enacted.

Appendix C. ACA Provisions in Appropriations Bills (FY2011-FY2013)

Numerous ACA-related provisions have been included in appropriations legislation introduced and enacted since passage of the health reform law. These provisions, often referred to as appropriations riders, generally are of two types: (1) appropriations restrictions that prohibit the use of discretionary funds provided in the bill to implement specific ACA provisions or the entire law; and (2) legislative language that amends or repeals specific ACA provisions.[20] This appendix summarizes the ACA provisions that were included in the enacted appropriations legislation for FY2011 and FY2012. It also provides for each of those years a brief overview of the ACA-related provisions that were added to both the Labor-HHS-Education and the Financial Services and General Government appropriations acts introduced and, in most cases, reported by the House and Senate Appropriations Committees. Only a few of those provisions were incorporated in the final omnibus appropriations bills for FY2011 and FY2012 that were signed into law.

The appendix also provides some discussion of the ACA provisions in FY2013 appropriations legislation. Congress has yet to complete action on any FY2013 appropriations bills. Currently, the federal government is operating under a six-month continuing resolution (P.L. 112-175); see discussion below under "FY2013 Appropriations".

FY2011 Appropriations

On April 15, 2011, the **Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10, H.R. 1473),** was signed into law, marking the completion of the FY2011 appropriations process more than six months after the beginning of the fiscal year. Prior to the enactment of P.L. 112-10, the President signed seven FY2011 interim continuing resolutions to fund the federal government. P.L. 112-10 included the FY2011 Department of Defense regular appropriations act and extended funding for the remaining 11 regular appropriations acts through the end of FY2011, generally at the annualized rate provided in FY2010, but with spending adjustments for numerous specified programs and activities.

Division B, Title VIII of P.L. 112-10 (Labor-HHS-Education) included the following ACA-related provisions: (1) canceled $2.2 billion of the original $6 billion appropriation for the CO-OP program; (2) repealed the free choice voucher program that would have required certain employers to provide vouchers to qualified employees for purchasing coverage through a health insurance exchange; (3) prohibited transfers from the Public Health and Social Services Emergency Fund to pay for the new U.S. Public Health Sciences Track; (4) removed the maintenance of effort requirement for use of the CHCF funds; and (5) mandated a GAO study of the costs and processes of ACA implementation, and a Medicare actuarial analysis of the impact of ACA's private insurance reforms on employer-sponsored health insurance premiums. [Note:

[20] House rules prohibit legislative language that establishes new law, or that amends or repeals current law, in regular appropriations bills and supplemental appropriations measures. However, they do not prohibit such provisions in continuing resolutions. These rules may be waived in a special rule adopted by the Rules Committee prior to floor consideration of the appropriations bill or conference report. A comparable rule in the Senate prohibits legislative language in both Senate Appropriations Committee amendments and non-committee amendments. For more information, see CRS Report R42388, *The Congressional Appropriations Process: An Introduction*, by Jessica Tollestrup.

The House passed but the Senate rejected an enrollment correction to H.R. 1473 (H.Con.Res. 35) that would have prohibited using any of the funds provided in P.L. 112-10 or in any previous act to implement ACA.]

Several months prior to the enactment of P.L. 112-10, on August 2, 2010, the Senate Appropriations Committee reported its version of the FY2011 Labor-HHS-Education appropriations bill (S. 3686). The measure instructed the HHS Secretary to allocate the PPHF funds for FY2011 (i.e., $750 million) to the programs specified, and in the amounts specified, in a table included in the accompanying committee report (S.Rept. 111-243). The House Appropriations Subcommittee on Labor-HHS-Education also approved a draft FY2011 bill, but the full committee took no further action on it. On February 19, 2011, the House by a vote of 235-189 passed its version of a full-year continuing resolution for FY2011 (H.R. 1). The bill included nine separate but overlapping provisions that would have prohibited using any of the discretionary funds provided in the bill to implement specific ACA provisions or the entire law. The Senate subsequently rejected H.R. 1 by a vote of 44-56 on March 9, 2011.

FY2012 Appropriations

The **Consolidated Appropriations Act, 2012 (P.L. 112-74, H.R. 2055)**, which included nine FY2012 appropriations acts, was signed into law on December 23, 2011. Division F of P.L. 112-74 (Labor-HHS-Education) included the following ACA-related provisions: (1) rescinded $400 million of the remaining $3.8 billion for the CO-OP program; see P.L. 112-10, above; (2) rescinded $10 million of IPAB's $15 million appropriation for FY2012; (3) instructed the HHS Secretary to establish a website with detailed information on the allocation and use of FY2012 PPHF funds; and (4) prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes.

Prior to the enactment of P.L. 112-74, the House and Senate Appropriations Committees took the following actions on the FY2012 Labor-HHS-Education and the FY2012 Financial Services and General Government appropriations acts:

- The chairman of the House Appropriations Subcommittee on Labor-HHS-Education introduced a chairman's bill (H.R. 3070) on September 29, 2011, but the subcommittee did not mark up or report the measure to the full committee. The bill received no full committee action. H.R. 3070, as introduced, included the following ACA-related provisions: (1) rescinded the entire FY2012 appropriations for CHCF, PPHF, IPAB, the pregnancy assistance grants, the home visitation program, state ADRCs, and the health workforce demonstration grants; (2) rescinded all the remaining CO-OP funds (i.e., $3.8 billion); (3) rescinded $1.862 billion of the $10 billion appropriation for CMMI for the period FY2011-FY2019; and (4) prohibited using any of the discretionary funds provided in the bill to implement and administer ACA until 90 days after all ACA legal challenges are complete.
- The House Appropriations Committee reported the Financial Services and General Government Appropriations Act, 2012 (H.R. 2434, H.Rept. 112-136) on July 7, 2011. The measure included the following two ACA-related provisions: (1) prohibited the IRS from using any of the discretionary funds provided in the bill to implement the ACA individual mandate; and (2) prohibited the transfer of any ACA funds to the IRS.

- The Senate Appropriations Committee reported the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2012 (S. 1599) on September 22, 2011. Similar to the previous year's bill, S. 1599, as reported, instructed the HHS Secretary to allocate the PPHF funds for FY2012 (i.e., $1 billion) to the programs specified, and in the amounts specified, in a table included in the accompanying committee report (S.Rept. 112-84). In addition, S.Rept. 112-84 included language directing the HHS Secretary to submit a detailed report on all the recipients of PPHF funding.
- The Senate Appropriations Committee reported the Financial Services and General Government Appropriations Act, 2012 (S. 1573) on September 15, 2011. The measure did not include any ACA provisions. However, the accompanying committee report (S.Rept. 112-79) directed the IRS to submit a detailed table itemizing each fund transfer from HHS to the IRS for the purpose of ACA implementation.

FY2013 Appropriations

The President's FY2013 budget requested more than $1 billion in new discretionary funding for CMS and the IRS to pay for ongoing ACA administrative costs. It remains unclear, however, whether congressional appropriators will provide those funds. Prior to FY2013, federal administrative costs associated with ACA implementation were supported with mandatory funds from the $1 billion Health Insurance Reform Implementation Fund (HIRIF); see the HIRIF entries in **Table 1** and **Table 2.** The HIRIF funds were projected to have all been obligated by the end of FY2012.

Congress has yet to complete action on any of the FY2013 appropriations bills. Instead, it has passed, and the President has signed, a continuing resolution to provide temporary funding for the first six months of FY2013. The **Continuing Appropriations Resolution, 2013 (P.L. 112-175, H.J.Res. 117)** funds government operations for most discretionary programs at an estimated annualized rate of $1.047 trillion, which equals the FY2013 discretionary spending cap set by the BCA. It increases funding for most federal agencies and programs by 0.612% over the FY2012 levels.[21] P.L. 112-175 does not incorporate any of the new ACA funding that was requested in the President's FY2013 budget.

In the 112th Congress, the House and Senate Appropriations Committees took the following actions on the FY2013 Labor-HHS-Education and the FY2013 Financial Services and General Government appropriations acts:

- The House Appropriations Subcommittee on Labor-HHS-Education approved a draft bill for FY2013 on July 18, 2012, but no further action was taken. The measure did not include any of the new CMS funds requested in the President's FY2013 budget for ACA implementation, and it prohibited using any of the discretionary funding provided in the bill to support CMS's Center for Consumer Information and Insurance Oversight (CCIIO). The draft bill also included the following ACA-related provisions: (1) rescinded the entire FY2013

[21] For more information, see CRS Report R42782, *FY2013 Continuing Resolution: Analysis of Components and Congressional Action*, by Jessica Tollestrup.

appropriations for PPHF and IPAB, and rescinded the base appropriation of $150 million for PCORTF; (2) rescinded $3 billion of the remaining $3.4 billion for the CO-OP funds (see P.L. 112-74, above); (3) rescinded $1.590 billion of the $10 billion appropriation for CMMI for the period FY2011-FY2019; (4) rescinded $300 million of the $1.5 billion CHCF appropriation in FY2013 for community health centers; (5) prohibited using any of the discretionary funds provided in the bill to implement and administer ACA; (6) instructed the HHS Secretary to establish a website with detailed information on the allocation and use of FY2013 PPHF funds; and (7) prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes.

- The House Appropriations Committee reported the Financial Services and General Government Appropriations Act, 2013 (H.R. 6020, H.Rept. 112-550) on June 26, 2012. The measure did not include any of the new IRS funds requested in the President's FY2013 budget for ACA implementation. H.R. 6020 prohibited the IRS from using any of the discretionary funds provided in the bill to carry out the transfer of ACA funds to the agency.
- The Senate Appropriations Committee reported the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2013 (S. 3295) on June 14, 2012. Again, similar to the bills for the previous two fiscal years, S. 3295, as reported, instructed the HHS Secretary to allocate the PPHF funds for FY2013 (i.e., $1 billion, reflecting the rescission in P.L. 112-96) to the programs specified, and in the amounts specified, in a table included in the accompanying committee report (S.Rept. 112-176). In addition, the bill directed the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds.
- The Senate Appropriations Committee reported the Financial Services and General Government Appropriations Act, 2013 (S. 3301) on June 14, 2012. The measure did not include any ACA provisions. However, the accompanying committee report (S.Rept. 112-177) directed the IRS to submit a detailed table itemizing each HIRIF fund transfer to the IRS for the purpose of ACA implementation.

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