Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act

C. Stephen Redhead
Specialist in Health Policy

Janet Kinzer
Information Research Specialist

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Introduction

Congress is deeply divided over implementation of the Patient Protection and Affordable Care Act (ACA), the health reform law enacted in March 2010.[1] Since the ACA's enactment, lawmakers opposed to specific provisions in the ACA, or to the entire law, have debated implementation of the law on numerous occasions and considered multiple bills to repeal, defund, delay, or otherwise amend the law. Most of the legislative activity on these ACA-related bills has taken place in the House. The legislation includes stand-alone bills as well as provisions in broader, often unrelated measures that would (1) repeal the ACA in its entirety and, in some cases, replace it with new law; (2) repeal, or by amendment restrict or otherwise limit, specific provisions in the ACA; (3) eliminate appropriations provided by the ACA and rescind all unobligated funds;[2] (4) replace the mandatory appropriations for one or more ACA programs with authorizations of (discretionary) appropriations, and rescind all unobligated funds; and (5) block or otherwise delay implementation of specific ACA provisions. A few bills containing provisions to amend the ACA that have attracted sufficiently broad and bipartisan support have been approved in both the House and the Senate and signed into law.

Some lawmakers also have used the annual appropriations process in an effort to eliminate funding for the ACA and address other concerns they have with implementation of the law. ACA-related provisions have been included in enacted appropriations acts in each of the last four years (i.e., FY2011-FY2014). In the most recent appropriations cycle, disagreement between the House and the Senate over the inclusion of various ACA provisions in the FY2014 continuing resolution (CR) temporarily shut down programs and activities across the federal government.

Congress took up consideration of the FY2014 CR in September 2013, having failed to complete legislative action on any of the annual appropriations acts for the new fiscal year. The House repeatedly attached provisions to the CR to defund or delay ACA implementation, which the Senate rejected. With no agreement in place at the start of the fiscal year (i.e., October 1, 2013), the resulting lapse in discretionary funding led to a partial shutdown of government operations. Lawmakers finally reached agreement on legislative language on October 16, and the President signed the Continuing Appropriations Act, 2014 (P.L. 113-46) the following day to reopen the government.[3] P.L. 113-46, which funded the federal government through January 15, 2014, did

[1] The 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 the ACA. All references to the ACA in this report refer to the law as amended by HCERA.

[2] Appropriations bills provide agencies with budget authority, which is the legal authority to incur financial obligations (e.g., hire employees, purchase services, award grants, or sign contracts) that result in immediate or future government expenditures (or outlays). Budget authority is generally made available for obligation during a specified time period, typically the upcoming fiscal year. Once budget authority reaches the end of that time period, it "expires," meaning that it is no longer available for obligation. A rescission is a provision of law that cancels budget authority prior to when it would otherwise expire, making it unavailable for future obligation. For further explanations of these terms, see GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, pp. 85-86, available at http://www.gao.gov.

[3] P.L. 113-46, 127 Stat. 558. For more analysis of the various legal and procedural considerations arising from the use of the appropriations process to delay or defund the ACA, see CRS Report R43246, *Affordable Care Act (ACA) and the Appropriations Process: FAQs Regarding Potential Legislative Changes and Effects of a Government Shutdown*, coordinated by C. Stephen Redhead.

not include any provisions to defund or delay ACA implementation. Instead, it required the Secretary of Health and Human Services (HHS) to certify to Congress that the ACA health insurance exchanges are verifying the eligibility of individuals applying for subsidies to help cover the cost of purchasing insurance coverage. In January 2014, Congress completed action on the FY2014 appropriations process by approving the Consolidated Appropriations Act, 2014 (P.L. 113-76).

This report summarizes legislative and other actions taken to repeal, defund, delay, or otherwise amend the ACA since the law's enactment. The information is presented in four appendices. **Table A-1** in **Appendix A** summarizes the authorizing legislation to amend the ACA that has been approved by both chambers and enacted into law. **Table B-1** in **Appendix B** summarizes the ACA provisions in authorizing legislation that passed the House in the 112th Congress (2011-2012) but was not approved by the Senate. It also lists the ACA-related legislation that the House has passed to date in the 113th Congress (2013-2014), but which has not been taken up by the Senate. **Table C-1** in **Appendix C** summarizes the ACA-related provisions in enacted annual appropriations acts for each of FY2011 through FY2014. Also included is a brief overview of all the ACA-related provisions added to appropriations bills considered, and in most cases reported, by the House and Senate Appropriations Committees since FY2011. Finally, **Table D-1** in **Appendix D** summarizes various administrative decisions taken by HHS and the Department of the Treasury to delay implementation of specific ACA requirements by one year. Other recent announcements by the Administration that address ACA implementation are also listed.

To help provide context for the information presented in the appendices, the report continues with some background on the core provisions of the ACA. That is followed by an overview of the law's impact on federal spending. This report is updated periodically to reflect legislative and other developments.

Background on the Affordable Care Act[4]

Among its many provisions, the ACA reforms the private health insurance market and sets minimum standards for health coverage. The law creates competitive private health insurance marketplaces—or exchanges—in each state through which individuals and small employers will be able to shop for, select, and enroll in qualified health plans. The exchanges began open enrollment on October 1, 2013. Insurance coverage bought through the exchanges takes effect on or after January 1, 2014. Plans offered through the exchanges, and certain other plans, must meet essential health benefit standards requiring them to cover emergency services, hospital care, physician services, preventive care, prescription drugs, and mental health and substance use disorder treatment, among other specified services.

Refundable tax credits will be available to certain individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) to help offset the cost of purchasing insurance coverage through the exchanges. In addition, certain individuals and families receiving the

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[4] The information provided in this section is drawn from CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead. While a detailed examination of the ACA is beyond the scope of this report, numerous CRS products that provide more in-depth information on the many new programs and activities authorized and funded by the law are available at http://www.crs.gov/pages/subissue.aspx?cliid=3746&parentid=13&preview=False.

premium credit will be eligible for a subsidy to lower their cost-sharing (i.e., out-of-pocket costs such as deductibles and co-pays).

The ACA also establishes new federal requirements for private health insurance, some of which have already taken effect. For example, health plans may not deny coverage to children up to age 19 based on a preexisting condition, young adults up to age 26 generally must be allowed to remain on their parents' health plans, and plans must cover preventive services and immunizations recommended by various specified entities without any cost-sharing. The remaining health insurance requirements take effect in 2014, when health plans will be required to sell and renew policies to all individuals, and may not deny coverage for preexisting conditions at any age or otherwise discriminate based on health status. Premiums may vary by limited amounts, but only based on age, family size, geographic area, and tobacco use.[5]

Also beginning in 2014, most U.S. citizens and legal residents will be required to have health insurance. Those who remain uninsured may have to pay a penalty. As plans will no longer be able to restrict coverage of individuals with health problems, the ACA's individual insurance mandate is intended to ensure that healthy individuals participate in the insurance market rather than waiting until they need health care services. Increasing the number of healthy persons in the risk pool helps spread the risk and reduce premiums.

In addition to expanding access to private health insurance coverage, the 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 FPL. The federal government will initially cover 100% of the expansion costs, phasing down to 90% of the costs by 2020. Moreover, Medicaid law authorizes the HHS Secretary to withhold existing federal Medicaid matching funds if states refuse to comply with the expansion. However, in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court found that the Medicaid expansion unconstitutionally coerced the states by threatening them with the loss of their existing federal Medicaid matching funds.[6] The Court precluded the HHS Secretary from penalizing states that choose not to participate in the Medicaid expansion, a decision that effectively makes Medicaid expansion an option for states.[7]

How ACA Implementation Affects Federal Spending

Implementation of the ACA is having an impact on both mandatory and discretionary spending. Mandatory spending—also referred to as direct spending—is controlled through authorizing laws.[8] It includes spending on entitlement programs such as Medicare and Social Security. Such

[5] For more information, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

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

[7] For more information, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

[8] An authorization may generally be described as a statutory provision that defines the authority of the government to act. It can establish or continue a federal agency, program, policy, project, or activity. Further, it may establish policies and restrictions and deal with organizational and administrative matters. It may also explicitly authorize subsequent congressional action to provide appropriations. For further information, see CRS Report R42098, *Authorization of* (continued...)

spending may be funded through provisions in the authorizing law that provide temporary or permanent appropriations for that purpose. Alternatively, when the authorizing law contains no appropriations, such mandatory programs are funded through the annual appropriations process. This is sometimes referred to as "appropriated mandatory" or "appropriated entitlement" spending.[9] Discretionary spending is both controlled and funded through the annual appropriations process. It typically covers the routine costs of running federal agencies and offices, including wages and salaries.[10]

Federal spending on ACA implementation can be grouped into three categories: (1) mandatory spending to expand insurance coverage through the exchanges and Medicaid, (2) other mandatory spending provided in the ACA, and (3) discretionary spending on administering and enforcing the ACA.

Mandatory Spending on Expanding Insurance Coverage

The first category, which accounts for most of the federal spending under the ACA, includes the exchange subsidies (i.e., premium tax credits and cost-sharing subsidies), the federal government's share of the costs of Medicaid expansion, and tax credits for small employers. The Congressional Budget Office's (CBO's) estimate of the budgetary impact of the ACA projected that those costs would be offset by revenues from new taxes and fees established in the law, and by savings from the law's changes to Medicare payments that are designed to slow the growth in future spending on this program.[11]

Mandatory Spending for Other Programs

The ACA included numerous appropriations that provide billions of dollars of mandatory funding to support grant programs and other activities authorized by the law.[12] For example, the ACA provided funding for several temporary insurance programs for targeted groups, including a temporary high-risk pool for uninsured individuals with preexisting conditions, and a reinsurance program to reimburse employers for a portion of the health insurance claims' costs for their 55- to 64-year-old retirees. It provided funding for grants to states to plan and establish health insurance exchanges. The ACA also provided a permanent appropriation, available for 10-year periods, for the Center for Medicare & Medicaid Innovation (CMI), within the Centers for Medicare & Medicaid Services (CMS), to test and implement innovative health care payment and service delivery models.

(...continued)

Appropriations: Procedural and Legal Issues, by Jessica Tollestrup and Brian T. Yeh.

[9] For further information on direct spending, see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

[10] For further information on discretionary spending, see CRS Report R42388, *The Congressional Appropriations Process: An Introduction*, by Jessica Tollestrup.

[11] For more analysis of the ACA's projected impact on federal direct spending and revenues, including details of CBO's budgetary estimates, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

[12] For a summary of all the ACA's mandatory appropriations, and the status of obligation of those funds, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead.

In addition, the ACA created four special funds and appropriated amounts to each one. First, the Community Health Center Fund (CHCF) is providing $11 billion over five years to help support community health center operations and the National Health Service Corps. Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) is supporting comparative effectiveness research through FY2019 with a mix of appropriations, fees on health plans, and transfers from the Medicare trust funds. Third, the Prevention and Public Health Fund (PPHF), for which the ACA provided a permanent annual appropriation, is intended to support prevention, wellness, and other public health-related programs and activities. Finally, the Health Insurance Reform Implementation Fund (HIRIF), for which the ACA appropriated $1 billion, is helping cover the administrative costs of implementing the law.

Discretionary Spending

While implementation of the ACA is having a significant impact on mandatory spending, the law is having a more modest effect on discretionary spending, which is controlled through the annual appropriations process. The ACA is affecting discretionary spending in two ways. First, the law created numerous new discretionary grant programs and provided most of them with an authorization of appropriations. To date, however, few of these programs have received discretionary funding, though several of them have been supported with mandatory funds from the PPHF.[13]

Second, the two agencies largely responsible for the ACA's implementation—CMS and the Internal Revenue Service (IRS)—are incurring substantial costs in connection with administering and enforcing the law. To date, the agencies have used a mix of discretionary funds from agency accounts (e.g., CMS Program Management, IRS Operations Support) and transfers from other HHS agency accounts, as well as ACA mandatory funds (e.g., HIRIF, PPHF) to support implementation activities.

CMS and the IRS both requested additional discretionary funding for ACA-related activities in their FY2013 and FY2014 budgets. For FY2013, CMS requested an additional $1 billion in its Program Management account for ACA implementation, primarily to establish the federally facilitated exchange in states that elect not to run their own exchanges and to engage in consumer education and outreach.[14] The IRS requested an additional $360 million for FY2013 to administer and enforce the ACA's tax-related provisions.[15] The Full-Year Continuing Appropriations Act, 2013 (P.L. 113-6, Division F) did not provide these requested funds for ACA implementation. In

[13] The ACA also reauthorized funding for many *existing* discretionary grant programs authorized under the PHSA; notably, the federal health workforce programs administered by the Health Resources and Services Administration (HRSA). The authorization of appropriations for many of these programs expired prior to the ACA's enactment, though they continued to receive an annual appropriation. The ACA also permanently reauthorized appropriations for the federal health centers program and for programs and services provided by the Indian Health Service (IHS). Congressional appropriators have in general continued to provide discretionary funding for these long-standing programs, though typically at funding levels below the amounts authorized by the ACA. For more details on all the authorizations (and reauthorizations) of discretionary funding in ACA, including the FY2011-FY2013 funding levels for programs that received an appropriation, see CRS Report R41390, *Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

[14] U.S. Department of Health and Human Services, *Budget in Brief, FY2013*, at http://www.hhs.gov/budget/fy2013/budget-brief-fy2013.pdf.

[15] U.S. Department of the Treasury, Internal Revenue Service, *Budget in Brief, FY2013*, at http://www.irs.gov/pub/newsroom/budget-in-brief-fy2013.pdf .

the absence of any new FY2013 discretionary funding for ACA implementation, HHS reportedly relied on the following alternative sources of funding:[16]

- $235 million in unobligated HIRIF funds carried over from FY2012;
- $454 million in FY2013 PPHF funds;
- $450 million from the non-recurring expenses fund (NEF);[17] and
- $116 million from the Secretary's authority to transfer funds from other HHS accounts.[18]

The President's FY2014 budget requested an additional $1.4 billion for CMS Program Management for ongoing ACA implementation activities,[19] and an additional $440 million for the IRS to administer the ACA's tax-related provisions, including the premium tax credits.[20] However, the Consolidated Appropriations Act, 2014 (P.L. 113-76) did not provide either agency with an increase in discretionary funding for FY2014. Moreover, P.L. 113-76 prohibited the HHS Secretary from transferring FY2014 PPHF funds to CMS for ACA-related activities. It also required the Secretary to provide in the department's FY2015 budget justification a detailed accounting of all the funds used to date to implement the ACA. Finally, the joint explanatory statement accompanying P.L. 113-76 instructed HHS to include in the FY2015 budget justification the amount of funding available for transfer to the NEF, and the amount of any such funding transferred to the NEF (see **Table C-1** in **Appendix C**).

[16] John Reichard, "HHS Using Several Sources to Fund Federal Health Insurance Exchange," *CQ Roll Call*, April 10, 2013.

[17] The non-recurring expenses fund, within the Department of the Treasury, was established by Division G, Section 223 of the Consolidated Appropriations Act, 2008 (P.L. 110-161, 121 Stat. 2188). The HHS Secretary may transfer to the NEF unobligated balances of expired annual discretionary funds up to five years after the fiscal year in which those funds were available for obligation. The amounts transferred to the fund are available until expended for use by HHS for "capital acquisition necessary for the operation of the Department, including facilities infrastructure and information technology infrastructure." Congressional appropriators must be notified in advance of any planned use of funds.

[18] Each year, the Labor-HHS-ED appropriations act provides the HHS Secretary with limited authority to transfer funds between appropriation accounts. No more than 1% of the funds in any given account may be transferred, and recipient accounts may not be increased by more than 3%. Congressional appropriators must be notified in advance of any transfer.

[19] U.S. Department of Health and Human Services, *Budget in Brief, FY2014*, at http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

[20] U.S. Department of the Treasury, Internal Revenue Service, *Budget in Brief, FY2014*, at http://www.irs.gov/PUP/newsroom/FY%202014%20Budget%20in%20Brief.pdf.

Appendix A. ACA Provisions in Enacted Authorizing Legislation in the 111th and 112th Congresses

Table A-1 summarizes the *authorizing* legislation enacted to date to amend the ACA. Each table entry includes the public law number and date of enactment, the original bill number and sponsor, and a brief description and explanation of the change(s) made to the ACA. The laws are listed in reverse chronological order beginning with the most recently enacted legislation and extending back to the first measure signed into law following enactment of the ACA and the accompanying package of amendments in the Health Care and Education Reconciliation Act.[21] In compiling the table, CRS made decisions about which laws—or specific provisions in a particular law—to include, and which ones to leave out. Generally, CRS included only those laws that amend, or make changes that relate to, *new* programs and activities that were established under the ACA. CRS excluded laws that amend or extend *established* programs and activities that predate the ACA and were amended or extended by it. For example, the ACA extended multiple existing Medicare and Medicaid program payments and activities that have since been further extended and/or modified by more recently enacted laws. None of those laws are included in **Table A-1**.

The following laws are referred to in **Table A-1** by their acronym:

- Health Care and Education Reconciliation Act (HCERA; P.L. 111-152)
- Internal Revenue Code (IRC)
- Medicare Improvements for Patients and Providers Act (MIPPA; P.L. 110-275)
- Social Security Act (SSA)

[21] See footnote 1.

Table A-1. Enacted Authorizing Legislation That Amends the ACA

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		112th Congress
P.L. 112-240 Jan. 2, 2013	H.R. 8 (Camp)	**American Taxpayer Relief Act of 2012.** Among its many provisions, P.L. 112-240: • Amended MIPAA Section 119 to provide a total of $25 million for FY2013 for the four outreach and assistance programs, which ACA Section 3306 funded through FY2012. • Amended SSA Section 501(c)(1)(A) to provide $5 million for FY2013 for the family-to-family information centers, which ACA Section 5507(b) funded through FY2012. • Transferred 10% of the remaining unobligated Consumer Operated and Oriented Plan (CO-OP) program funds to a new CO-OP contingency fund (to provide assistance and oversight to CO-OP loan recipients) and rescinded the other 90% of those funds (see entries for P.L. 112-10 and P.L. 112-74, which predate this act, in **Table C-1**).[a] • Repealed ACA Title VIII, the Community Living Assistance Services and Supports (CLASS) Act. • Repealed the ACA's appropriations for the National Clearinghouse for Long-Term Care Information and rescinded all unobligated funds.
P.L. 112-141 July 6, 2012	H.R. 4348 (Mica)	**Moving Ahead for Progress in the 21st Century Act, or "MAP-21".** Among its many provisions, P.L. 112-141 further modified the Medicaid disaster-recovery FMAP adjustment (see entry for P.L. 112-96, below) by changing the adjustment factor and the effective date.
P.L. 112-96 Feb. 22, 2012	H.R. 3630 (Camp)	**Middle Class Tax Relief and Job Creation Act of 2012.** Among its many provisions, P.L. 112-96: • Amended ACA Section 4002 to reduce the Prevention and Public Health Fund (PPHF) annual appropriations over the period FY2013-FY2021 by a total of $6.25 billion to help offset the cost of extending the payroll tax cut and other programs in P.L. 112-96. • Amended SSA Section 1923(f) to extend by one year the disproportionate share hospital (DSH) allotment reduction imposed by ACA Section 3203. • Amended SSA Section 1905(aa), as added by ACA Section 2006, to make a technical correction to the formula to phase down the Medicaid disaster-recovery Federal Medical Assistance Percentage (FMAP) adjustment as originally intended. [The purpose of the adjustment was to help Louisiana avoid a significant reduction in its federal Medicaid match (i.e., FMAP) in the aftermath of Hurricane Katrina. As written in ACA Section 2006, 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. 112-56 Nov. 21, 2011	H.R. 674 (Herger)	**3% Withholding Repeal and Job Creation Act.** Among its many provisions, P.L. 112-56 amended IRC Section 36B, as added by ACA Section 1401(a) (as amended), by modifying the calculation of Modified Adjusted Gross Income (MAGI) to include Social Security benefits. MAGI will be used to determine eligibility for exchange subsidies and Medicaid, beginning in 2014.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
P.L. 112-9 Apr. 14, 2011	H.R. 4 (Lungren)	**Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011.** Amended IRC Section 6041, as amended by ACA Section 9006, to repeal the 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 further amended IRC Section 36B, as added by ACA Section 1401(a), by modifying the amount of excess premium tax credits that individuals would have to repay based on household income (see entry for P.L. 111-309, below).
		111th Congress
P.L. 111-383 Jan. 7, 2011	H.R. 6523 (Skelton)	**Ike Skelton National Defense Authorization Act for Fiscal Year 2011.** Extended TRICARE coverage to dependent adult children up to age 26, to conform to the private health insurance requirements under the ACA.
P.L. 111-312 Dec. 17, 2010	H.R. 4853 (Oberstar)	**Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010.** Amended ACA Section 10909 to extend the nonrefundable adoption tax credit through tax year 2012. The adoption tax credit helps offset the cost of qualified adoption expenses. [Subsequently, P.L. 112-240 made the nonrefundable adoption tax credit permanent.]
P.L. 111-309 Dec. 15, 2010	H.R. 4994 (Lewis)	**Medicare and Medicaid Extenders Act of 2010.** To help offset the costs of the Medicare and Medicaid program extensions and the postponement of cuts in Medicare physician payments, P.L. 111-309 amended IRC Section 36B (as added by ACA Section 1401(a)) to modify the amount of excess premium tax credits that individuals would have to repay. The law created a sliding scale for such repayments based on household income. [Under the 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. The ACA placed limits on the amount of any premium credit overpayment that had to be repaid to the government.]
P.L. 111-226 Aug. 10, 2010	H.R. 1586 (Rangel)	**FAA Air Transportation Modernization and Safety Improvement Act.** Among its many provisions, P.L. 111-226 amended SSA Section 1927(k)(1)(B)(i)(IV) (as added by ACA Section 2503(a)(2)(B), as amended by HCERA Section 1101(c)) by modifying the definition of average manufacturer price (AMP) to include inhalation, infusion, implanted, or injectable drugs that are not generally dispensed through a retail community pharmacy.
P.L. 111-173 May 27, 2010	H.R. 5014 (Filner)	**[No title.]** Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided by the Department of Veterans Affairs constitutes minimal essential health care coverage as required by the ACA. [Beginning in 2014, the ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]
P.L. 111-159 Apr. 26, 2010	H.R. 4887 (Skelton)	**TRICARE Affirmation Act.** Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided under TRICARE, TRICARE for Life, and the Nonappropriated Fund Health Benefits program constitutes minimal essential health care coverage as required by the ACA. [Beginning in 2014, the ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]

Source: Prepared by the Congressional Research Service based on the text of the public laws listed in the table.

a. P.L. 112-10 and P.L. 112-74 rescinded a total of $2.6 billion of the ACA's original $6 billion appropriation for the CO-OP program (see **Table C-1**). At the time P.L. 112-240 was enacted, according to HHS budget documents, the CO-OP program had an unobligated balance of $2.532 billion. P.L. 112-240 rescinded 90% of that amount (i.e., $2.279 billion), and transferred the remaining funds (i.e., $253 million) to the contingency fund. In all, Congress has rescinded $4.879 billion of the $6 billion CO-OP program appropriation.

Appendix B. ACA Provisions in Bills Approved by the House in the 112th and 113th Congresses

As noted earlier in this report, lawmakers opposed to specific provisions in the ACA, or to the entire law, have debated implementation of the law on numerous occasions and considered multiple bills to repeal, defund, delay, or otherwise amend the law. Most of this legislative activity has taken place in the House. However, a few bills containing provisions to amend the ACA that have attracted sufficiently broad and bipartisan support have been approved in both the House and the Senate and signed into law. Those laws are summarized in **Table A-1** in **Appendix A**.

Table B-1 below summarizes the ACA provisions in authorizing legislation that the House has passed to date in the 113th Congress, but which has not been taken up by the Senate. It also lists the ACA-related legislation that passed the House in the 112th Congress, but was not approved by the Senate. **Table B-1** includes only legislation that, if enacted, would have a direct impact on the ACA and its implementation; measures that would not have such an effect are not included. Thus, budget resolutions, which are concurrent resolutions and not eligible to become public law, are not included.[22]

[22] Both the House and the Senate have taken multiple votes on amendments to, and passage of, budget resolutions that expressed support for a full repeal of the ACA, or the repeal or amendment of specific provisions in the law. However, budget resolutions are concurrent resolutions that apply only to the Congress. They are not presented to the President for his signature and do not have the force of law. In the 112th Congress, for example, the House voted on several ACA-related amendments to, and passage of, the FY2012 and FY2013 budget resolutions (H.Con.Res. 34 and H.Con.Res. 112, respectively).

Table B-1. ACA Provisions in Bills Approved by the House in the 112th and 113th Congresses

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
113th Congress	
H.R. 3362 (Lee)	**Exchange Information Disclosure Act.** Passed the House by a vote of 259-154 on January 16, 2014. H.R. 3362 would require the HHS Secretary to submit to Congress and make public a detailed weekly report, through March 2015, on (1) consumer interactions with healthcare.gov (or subsequent sites) and efforts undertaken to remedy problems that impact consumers; and (2) calls to the federal consumer service call center, including the number of calls received by the call center, problems identified by users, and referrals of those calls. The Secretary also would be required to make public a list (with contact information) of all navigators and certified application counselors trained and certified by exchanges, and a list of all agents and brokers trained and certified by the federally facilitated exchange. Both lists would have to be updated weekly through March 2015.
H.R. 3811 (Pitts)	**Health Exchange Security and Transparency Act of 2014.** Passed the House by a vote of 291-122 on January 10, 2014. H.R. 3811 would require the HHS Secretary to notify affected individuals within two business days of a breach of their personally identifiable information maintained by an exchange.
H.R. 3350 (Upton)	**Keep Your Health Plan Act of 2013.** Passed the House by a vote of 261-157 on November 15, 2013. H.R. 3350 would permit health insurance companies to continue selling policies in 2014 that were in existence in the individual market on January 1, 2013, even though such plans may not meet the ACA's essential health benefit standards and other market reforms that take effect in 2014. [Note: This legislation was prompted by the decision of insurers to send cancellation notices to individuals and small businesses with health plans in the individual and small group markets. The Administration also has taken steps to address this issue. On November 14, 2013, it announced a transitional policy under which insurers may choose, subject to the approval of state insurance regulators, to renew noncompliant health plans that have been cancelled, or are slated for cancellation. Under the ACA, insurers are not permitted to sell noncompliant coverage to new enrollees. H.R. 3350, however, would allow insurers to sell such coverage in the individual market during 2014. See **Appendix D**.]
H.R. 2009 (Price)	**Keep the IRS Off Your Health Care Act of 2013.** Passed the House by a vote of 232-185 on August 2, 2013. H.R. 2009 would prohibit the Internal Revenue Service (IRS) from implementing or enforcing any provisions of the ACA.
H.R. 2668 (Young)	**Fairness for American Families Act.** Passed the House by a vote of 251-174 on July 17, 2013. H.R. 2668 would delay the ACA individual mandate by one year, and shift by one year the schedule of penalties for individuals who do not comply with the mandate. It also incorporated the provisions in H.R. 2667 (see above) to delay the employer mandate and related reporting requirements.
H.R. 2667 (Griffin)	**Authority for Mandate Delay Act.** Passed the House by a vote of 264-161 on July 17, 2013. H.R. 2667 would delay for one year certain ACA reporting requirements for insurers and employers as well as the penalties for employers who do not offer affordable coverage. [Note: H.R. 2667 would essentially codify the Administration's announcement on July 2, 2013, that it was delaying the ACA employer mandate and related reporting requirements. See **Table D-1**.]
H.R. 45 (Bachmann)	**A bill to repeal the Patient Protection and Affordable Care Act.** Passed the House by a vote of 229-195 on May 16, 2013. H.R. 45 would repeal the ACA in its entirety and restore the provisions of law amended or repealed by the ACA as if it had not been enacted.
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H.R. 6079 (Cantor)	**Repeal of Obamacare Act.** Passed the House by a vote of 244-185 on July 11, 2012. H.R. 6079 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 436 (Paulsen)	**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. 5652 (Ryan)	**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 disproportionate share hospital (DSH) allotment reduction imposed by the ACA; and (6) repealed the ACA's Medicaid maintenance of effort requirements.
H.R. 4628 (Biggert)	**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 in **Table A-1** in **Appendix A**). The provision in H.R. 4628 to repeal the PPHF and rescind all unobligated funds was not included in MAP-21.]
H.R. 5 (Gingrey)	**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. 1173 (Boustany)	**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 Title VIII of the ACA, the Community Living Assistance Services and Supports (CLASS) Act. [Note: P.L. 112-240, enacted January 2, 2013, included a repeal of the CLASS Act; see **Table A-1** in **Appendix A**.]
H.R. 358 (Pitts)	**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 the 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. 1216 (Guthrie)	**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. 1214 (Burgess)	**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. 1213 (Upton)	**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.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 1217 (Pitts)	**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. 2 (Cantor)	**Repealing the Job-Killing Health Care Law Act.** Passed the House by a vote of 245-189 on January 19, 2011. It was 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 the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.

Source: Prepared by the Congressional Research Service based on the text of the bills listed in the table.

Appendix C. ACA Provisions in Appropriations Acts (FY2011-FY2014)

Numerous ACA-related provisions were added to appropriations bills considered, and in some instances reported, by the House and Senate Appropriations Committees for FY2011-FY2014. These provisions were incorporated in the Departments of Labor, Health and Human Services, Education, and Related Agencies ("Labor-HHS-ED") Appropriations Act, which funds the Centers for Medicare & Medicaid Services (CMS), and the Financial Services and General Government ("Financial Services") Appropriations Act, which funds the Internal Revenue Service (IRS). They include language prohibiting the use of discretionary funds provided in the bill to implement specific ACA provisions or the entire law, as well as broader legislative language that would, for example, repeal, restrict, or rescind mandatory spending for specific ACA provisions. While none of the discretionary funding prohibitions survived, a few of the other provisions were incorporated into the final appropriations legislation agreed to by both chambers and enacted into law. They include provisions that rescind specific ACA mandatory funds, or place restrictions on their use, and language requiring the HHS Secretary to provide a detailed accounting of certain ACA-related spending.

Table C-1 summarizes the ACA-related provisions in enacted annual appropriations acts for each of FY2011 through FY2014. It also provides a brief summary of the legislative actions taken by the House and Senate Appropriations Committees on both the Labor-HHS-ED and the Financial Services appropriations acts each year, prior to agreement on the final version of the legislation, and lists the ACA-related provisions included in these committee bills.

Table C-1. ACA-Related Provisions in Appropriations Acts, FY2011-FY2014

Public Law and Date of Enactment	Summary of Provisions
	FY2014
P.L. 113-76 Jan. 17, 2014	**Consolidated Appropriations Act, 2014.** Division H of P.L. 113-76—the FY2014 L-HHS-ED Appropriations Act—includes the following ACA-related provisions: • Rescinds $10 million of the FY2014 appropriation for the Independent Payment Advisory Board (IPAB), which was authorized and funded by ACA Section 3403. [Note: The same rescission was included in both the FY2012 and FY2013 appropriations acts; see below.] • Requires the HHS Secretary to transfer the FY2014 PPHF funds to the accounts specified, in the amounts specified, and for the activities specified in a table included in the explanatory statement to accompany P.L. 113-76 (Congressional Record, January 15, 2014, p. H1041). Prohibits the Secretary from making further transfers. [Note: The requirement to transfer PPHF funds in accordance with the allocations specified in an accompanying table was included in each of the FY2011, FY2012, and FY2013 L-HHS-ED appropriations bills reported by the Senate Appropriations Committee, but these provisions were not included in the final enacted appropriations legislation; see below.] • Requires the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program and by state. [Note: A similar, but less detailed, provision was included in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6; see below.] • Prohibits the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: This provision first appeared in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6; see below.] • Authorizes the HHS Secretary to transfer up to $305 million from the Medicare trust funds to the CMS Program Management account for Medicare operations, but prohibits the use of such transferred funds for ACA implementation. • Requires the HHS Secretary to include in the FY2015 budget justification and on the HHS website a detailed breakdown of the ACA programs and activities receiving funds appropriated to implement the law, including the number of full-time equivalents (FTEs), for FY2014 and for each of the past four fiscal years (i.e., FY2010-FY2013). • Requires the HHS Secretary to include in the FY2015 budget justification a detailed breakdown of all funds used to date by CMS for the exchanges, including the proposed use of such funds in FY2015. • Requires the HHS Secretary to include in the FY2016 budget justification an analysis of how the ACA requirement that health plans cover recommended immunizations and other preventive services without any cost-sharing will impact eligibility for HHS discretionary programs. In addition, the explanatory statement to accompany P.L. 113-76, submitted by the House Appropriations Committee Chairman (Congressional Record, January 15, 2014, p. H1034), instructs HHS to include in the FY2015 budget justification the amount of expired unobligated balances available for transfer to the non-recurring expenses fund (NEF), and the amount of any such balances transferred to the NEF. Section 4 of P.L. 113-76 states that the explanatory statement is to be treated as if it were a joint explanatory statement of the conference committee. Division E of P.L. 113-76—the FY2014 Financial Services Appropriations Act—includes the following ACA-related provision: • Requires the IRS Commissioner to allocate $92 million in general program funds among the agency's appropriations accounts for various specified activities (e.g., improve delivery of services to taxpayers), but prohibits the use of such funds for ACA implementation.

Public Law and Date of Enactment	Summary of Provisions
P.L. 113-46 Oct. 17, 2013	**Continuing Appropriations Act, 2014.** P.L. 113-46 provided continuing appropriations for the federal government through January 15, 2014, generally at FY2013 post-sequestration funding levels. It included the following ACA-related provisions: • Required the HHS Secretary to certify in a report to Congress, due by January 1, 2014, that the health exchanges are verifying the eligibility of individuals applying for premium tax credits and cost-sharing subsidies consistent with the requirements of the ACA. • Required the HHS Inspector General to report to Congress not later than July 1, 2014, on the effectiveness of procedures and safeguards provided under the ACA for preventing exchange applicants from submitting inaccurate or fraudulent information.

Legislative activity prior to enactment of P.L. 113-76. On September 20, 2013, in the absence of any enacted appropriations bills for FY2014, the House approved a continuing resolution (CR; H.J.Res. 59) to provide temporary funding for the federal government through December 15. H.J.Res. 59, as passed by the House, incorporated language that would have prohibited the use of any federal funds—mandatory or discretionary—to carry out the ACA. The Senate amendment to H.J.Res. 59 did not incorporate the House ACA defunding language. On September 29, the House amended the Senate amendment with language that would have (1) repealed the ACA's medical device tax, and (2) delayed the law's implementation by one year, but the Senate tabled both of these amendments. On September 30, the House further amended the Senate amendment by adding language to (1) delay the ACA's individual insurance mandate by one year, and (2) expand the ACA's requirement for Members of Congress and their staff to obtain health coverage through the exchanges to include the President, Vice President, and political appointees, and prohibit any premium contribution by the government. Once again, the Senate tabled the House amendments. With the House and Senate unable to agree on the CR, the Administration on October 1, 2013, commenced a partial shutdown of the federal government. The government resumed full operations on October 17, 2013, after House and Senate lawmakers reached an agreement on a temporary funding measure, and the Continuing Appropriations Act, 2014, was signed into law (see above).

Earlier in the summer of 2013, the House and Senate Appropriations Committees took the following actions on FY2014 appropriations. The Senate Appropriations Committee reported its FY2014 Labor-HHS-ED appropriations bill (S. 1284) on July 11, 2013. For the fourth year in a row, the Senate's L-HHS-ED appropriations bill would have instructed the HHS Secretary to allocate the PPHF funds to the programs specified, and in the amounts specified in a table included in the accompanying committee report (S.Rept. 113-71). S. 1284 also would have prohibited the Secretary from making any further transfers of PPHF funds. In addition, the bill would have required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds. S. 1284 would have provided CMS with its requested $1.4 billion increase in discretionary funds for ACA implementation in FY2014.

The Senate Appropriations Committee reported its FY2014 Financial Services appropriations bill (S. 1371, S.Rept. 113-80) on July 25, 2013. S. 1371 would have provided some but not all of the requested $440 million increase in IRS funding for ACA implementation.

The House Appropriations Committee reported its version of the FY2014 Financial Services appropriations bill (H.R. 2786, H.Rept. 113-172) on July 23, 2013. The measure did not provide any of the new IRS funds requested in the President's FY2014 budget for ACA implementation. H.R. 2786, as reported, would have prohibited the IRS from using any of the discretionary funds provided in the bill to implement the individual mandate, and would have prohibited transfers from HHS to IRS to implement the ACA. The House Appropriations Subcommittee on Labor-HHS-ED did not report a FY2014 appropriations bill.

Public Law and Date of Enactment	Summary of Provisions
	FY2013
P.L. 113-6 Mar. 26, 2013	**Consolidated and Further Continuing Appropriations Act, 2013.** Division F, Title V of P.L. 113-6 provided full-year continuing appropriations for Labor-HHS-ED for FY2013 generally at FY2012 levels, but with some spending adjustments—reductions and increases—for specified programs. It included the following ACA-related provisions: • Rescinded $200 million of the $500 million transfer from the Medicare Part A and Part B trust funds for the 5-year Community-Based Care Transition Program, which was established and funded by ACA Section 3026. • Rescinded $10 million of IPAB's FY2013 appropriation. [Note: The same rescission was included in the FY2012 appropriations act; see below.] • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds. [Note: This provision first appeared in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6; see below.] • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: This provision first appeared in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6; see below.]
Legislative activity prior to enactment of P.L. 113-6. The House Appropriations Subcommittee on Labor-HHS-ED approved a draft bill for FY2013 on July 18, 2012, but no further action was taken. The measure did not provide CMS with any of the requested $1.0 billion increase in funding for FY2013 to help pay for ACA implementation and related activities, and it would have 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 that would have (1) rescinded the entire FY2013 appropriations for PPHF and IPAB, and rescinded the FY2013 base appropriation of $150 million for the Patient-Centered Outcomes Research Trust Fund (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 CMI 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 the 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 its FY2013 Financial Services appropriations bill (H.R. 6020, H.Rept. 112-550) on June 26, 2012. The measure did not include the IRS's requested funding increase of $360 million for FY2013 for ACA implementation. Moreover, H.R. 6020 would have 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 its version of the FY2013 Labor-HHS-ED appropriations bill (S. 3295) on June 14, 2012. The measure included about half of the funding increase requested by CMS for ACA implementation. As with the Senate's Labor-HHS-ED appropriations bills for the previous two fiscal years, S. 3295 would have instructed the HHS Secretary to allocate the PPHF funds for FY2013 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 would have 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 FY2013 Financial Services appropriations bill (S. 3301) on June 14, 2012. The measure did not include any ACA-related provisions. However, the accompanying committee report (S.Rept. 112-177) directed the IRS to submit a detailed table itemizing each fund transfer from the Health Insurance Reform Implementation Fund (HIRIF) to the IRS for the purpose of ACA implementation.	

Public Law and Date of Enactment	Summary of Provisions
	FY2012
P.L. 112-74 Dec. 23, 2011	**Consolidated Appropriations Act, 2012.** Division F of P.L. 112-74—the FY2012 Labor-HHS-ED Appropriations Act—included the following ACA-related provisions: • Rescinded $400 million of the remaining $3.8 billion for the Consumer Operated and Oriented Plan (CO-OP) program; see P.L. 112-10, below. • Rescinded $10 million of IPAB's FY2012 appropriation. • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds. • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes.
Legislative activity prior to enactment of P.L. 112-74. 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 that would have (1) rescinded the entire FY2012 appropriations for CHCF, PPHF, IPAB, the pregnancy assistance grants, the home visitation program, state Aging and Disability Resource Centers (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 the Center for Medicare and Medicaid Innovation (CMI) for the period FY2011-FY2019; and (4) prohibited using any of the discretionary funds provided in the bill to implement and administer the ACA until 90 days after all ACA legal challenges are complete. The House Appropriations Committee reported the FY2012 Financial Services appropriations bill (H.R. 2434, H.Rept. 112-136) on July 7, 2011. The measure included the following ACA-related provisions that would have (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 its version of the FY2012 Labor-HHS-ED appropriations bill (S. 1599) on September 22, 2011. Similar to the previous year's bill, S. 1599 would have instructed the HHS Secretary to allocate the PPHF funds for FY2012 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 its FY2012 Financial Services appropriations bill (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.	

Public Law and Date of Enactment	Summary of Provisions
	FY2011
P.L. 112-10 Apr. 15, 2011	**Department of Defense and Full-Year Continuing Appropriations Act, 2011.** Division B, Title VIII of P.L. 112-10 provided full-year continuing appropriations for Labor-HHS-ED for FY2011 generally at FY2010 levels, but with numerous spending reductions for specified agencies and programs. It included the following ACA-related provisions: • Permanently canceled $2.2 billion of the $6 billion appropriation for CO-OP program, which was established and funded by ACA Section 1322. • Repealed the free choice voucher program, established by ACA Section 10108, which would have required certain employers to provide vouchers to qualified employees for purchasing coverage through a health insurance exchange. • Prohibited transfers from the Public Health and Social Services Emergency Fund to support the U.S. Public Health Sciences Track, pursuant to ACA Section 5315. • Removed the maintenance of effort requirement for use of monies in the Community Health Center Fund (CHCF), which was established and funded by ACA Section 10503 (as amended by HCERA Section 2303). • Mandated a Government Accountability Office (GAO) study of the costs and processes of ACA implementation, and a Medicare actuarial analysis of the impact of the ACA's private insurance reforms on employer-sponsored health insurance premiums.
Legislative activity prior to enactment of P.L. 112-10. The Senate Appropriations Committee reported its version of the FY2011 Labor-HHS-ED appropriations bill (S. 3686) on August 2, 2010. The measure would have instructed the HHS Secretary to allocate the PPHF funds for FY2011 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-ED 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.	

Source: Prepared by the Congressional Research Service based on the text of the public laws listed in the table.

Appendix D. Administrative Actions to Delay Implementation of Specific ACA Provisions

The Department of Health and Human Services (HHS) and the Department of the Treasury have taken a number of administrative decisions to delay by one year various ACA mandates and other requirements. These decisions are listed in **Table D-1** in reverse chronological order beginning with the most recent one.

In addition, the Administration has made a number of announcements in the past few months that address the law's implementation. These announcements, which are briefly summarized below, are excluded from the table because none represents a one-year delay of an ACA statutory or regulatory requirement.

- On October 28, 2013, the Centers for Medicare & Medicaid Services (CMS) announced that it would exempt from the individual mandate penalty those individuals who wait until after February 15, 2014, to enroll in a health plan offered through an exchange during the initial enrollment period.[23]
- On November 14, 2013, the Administration established a transitional policy, which it encouraged state insurance commissioners to adopt. Under the policy, insurers may choose to renew noncompliant health plans that have been cancelled, subject to approval by state insurance regulators. The intent of the policy is to allow Americans whose insurance companies cancelled their insurance coverage for 2014 to remain in their plans. The policy was prompted by the decision of insurers to send cancellation notices to individuals and small businesses with health plans in the individual and small group markets that do not meet the ACA's new standards for health insurance coverage.[24] On December 19, 2013, CMS issued further clarification of the options available to consumers with cancelled policies, explaining that they may be eligible for a hardship

[23] Beginning in 2014, the ACA requires most U.S. citizens and legal residents to maintain minimum essential health coverage. Individuals without coverage for three consecutive months will have to pay a penalty unless they qualify for one of the statutory exemptions. In its ACA rulemaking, CMS specified that the initial open enrollment period for individuals to enroll in coverage through the exchanges would extend from October 1, 2013, through March 31, 2014. HHS also specified the coverage effective dates. For individuals who sign up for coverage between the 1st and 15th of a given month, the coverage effective date is the first day of the immediately following month. However, for those who sign up between the 16th and end of a given month, the coverage effective date is the first day of the second following month. Thus, an individual who signs up on February 16, 2014, would not be insured until April 1, 2014. That individual would be uninsured for the first three months of 2014 and would have to pay a fine, unless otherwise exempt. On October 28, 2013, CMS exercised its authority under IRC Section 5000A (as added by ACA Section 1501(b)) to establish a hardship exemption in order to provide relief for such individuals who wait until after February 15, 2014, to enroll. For more information, see http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf. Note: On November 22, 2013, HHS announced that individuals will have until December 23, rather than the December 15, to sign up for coverage that begins on January 1, 2014. This exception to the policy for coverage effective dates applies only to the month of December.

[24] Under the ACA, health plans that consumers had at the time the law was enacted in 2010 were "grandfathered" in and have existed largely unchanged since the law's enactment. Grandfathered plans do not have to adopt many of the ACA's new requirements for health insurance, including coverage of essential health benefits and other consumer protections that took effect at the beginning of 2014. However, new plans purchased since the law's enactment have to meet all the ACA requirements. For more information, see http://www.whitehouse.gov/the-press-office/2013/11/14/fact-sheet-new-administration-proposal-help-consumers-facing-cancellatio.

exemption from the individual mandate penalty and eligible to purchase a catastrophic plan if one is offered in their area.[25]

- On November 22, 2013, HHS announced that it would delay by one month the open enrollment period for plan years that begin in 2015. The open enrollment period for 2015 will begin November 15, 2014, instead of October 15, 2014, and conclude January 15, 2015.[26]
- On January 14, 2014, HHS announced that individuals enrolled in the Pre-Existing Condition Insurance Plan (PCIP) who have not yet found new health insurance coverage may keep their PCIP coverage for two additional months, through March 31, 2014. Earlier, on December 12, 2013, HHS had announced that the PCIP, which was originally scheduled to terminate on January 1, 2014, would be extended through the end of January 2014.[27]

The following laws are referred to in **Table D-1** by their acronym:

- Internal Revenue Code (IRC)
- Public Health Service Act (PHSA)

[25] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Options Available for Consumers with Cancelled Policies," December 19, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf.

[26] The dates for the 2015 open enrollment period were included in the HHS proposed rule that sets out various parameters and standards for the 2015 benefit year. U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2015; Proposed Rule," 78 *Federal Register* 72321, December 2, 2013.

[27] The ACA instructed the HHS 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 the District of Columbia (DC); the remaining states administer their own PCIP programs. The ACA appropriated $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. The federally-run PCIP and state-run PCIPs stopped accepting new enrollees on February 16, 2013, and March 2, 2013, respectively, because of the finite amount of available funding. Under the law, PCIP coverage was to end on January 1, 2014, and the Secretary was instructed to develop procedures for transitioning individuals enrolled in PCIP into qualified health plans offered through the exchanges. However, the ACA gave the Secretary the authority to extend PCIP coverage, if necessary, to avoid a lapse in coverage for such individuals. For more information, see https://www.pcip.gov/.

Table D-1. Administrative Delays in ACA Implementation

Source and Date	Summary of Delay
U.S. Department of Health and Human Services, "A Direct New Path to SHOP Marketplace Coverage," blog posted November 27, 2013, http://www.hhs.gov/healthcare/facts/blog/2013/11/direct-new-path-to-shop-marketplace.html.	**Small Business Health Options Program (i.e., SHOP) Exchanges.** On November 27, 2013, the Administration announced that the federally-facilitated SHOP exchange will not accept online enrollments for one year, until November 2014. In the meantime, small businesses can enroll in plans listed on the exchange through an insurance agent or broker, or directly with the insurance carrier. [Note: This announcement represents the third delay in launching the online SHOP exchange, which was originally expected to be fully functional at the beginning of October 2013. See, also, the SHOP exchange transitional policy, which is described below.]
U.S. Department of Health and Human Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits for Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing: Exchanges: Eligibility and Enrollment," Final Rule, 78 *Federal Register* 42160-42322, July 15, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.	**Exchange Applicant Eligibility and Verification; Electronic Notices.** The July 15, 2013, final rule on health insurance exchange eligibility and enrollment included the following one-year delays: • State-based exchanges will not be required until 2015 to verify applicants' information regarding possible employer coverage in order to determine eligibility for premium tax credits. During 2014 the exchanges may accept an applicant's attestation without further verification. [Under IRC Section 36B(c)(2)(C), as added by ACA Section 1401(a), individuals whose employer offers a health plan that is affordable (i.e., the employee's share of the premium does not exceed 9.5% of the employee's household income) and provides minimum value (i.e., the plan's share of the total allowed costs of benefits provided under the plan is at least 60%) are not eligible for a premium tax credit through the exchange.] • While the government initially proposed an audit of each exchange applicant who reported an income that was at least 10% below the amount indicated by Internal Revenue Service (IRS) and Social Security Administration (SSA) records, the final rule permits state-based exchanges during 2014 to audit less than 100% of all such individuals provided the sample size used is statistically significant. [Under IRC Section 36B(b), as added by ACA Section 1401(a), individuals and families who enroll in qualified health plans (QHPs) offered through an exchange are eligible for refundable premium tax credits if their income is between 100% and 400% of the federal poverty level.] • The federal government has delayed until 2015 a requirement that state Medicaid agencies provide notices electronically to beneficiaries. Between October 1, 2013, and January 1, 2015, state Medicaid agencies must give individuals the choice to receive notices in electronic format or by regular mail. Agencies must ensure that an individual's choice to receive electronic notices is confirmed by regular mail, and must inform the individual of his or her right to switch to receiving notice through regular mail. [42 C.F.R. 435.918] Note that exchanges must also provide required notices by regular mail or, if an individual elects, electronically, provided that the specifications for electronic notices in 42 C.F.R. 435.918 are met. However, exchanges may choose to delay until 2015 the requirement in 42 C.F.R. 435.918(b)(1) that individuals who choose to receive electronic notices receive confirmation by mail. (45 C.F.R. 155.230(d))

Source and Date	Summary of Delay
U.S. Department of the Treasury, "Continuing to Implement the ACA in a Careful, Thoughtful Manner," July 2, 2013, http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx.	**Employer Mandate and Insurer Reporting.** Exercising its authority under IRC Section 7805(a) to grant transition relief, the Administration has delayed until 2015 the ACA requirement that employers with at least 50 full-time equivalent employees provide health coverage for their full-time workers (and children under age 26) or risk paying a penalty. It also has delayed until 2015 the requirement for employers and insurers to report certain information to the IRS. [IRC Section 6055, as added by ACA Section 1502(a), requires reporting by insurers, self-insuring employers, and other parties that provide health coverage. IRC Section 6056, as added by ACA Section 1514(a), requires certain employers to report on the health coverage they offer to their full-time employees.]
U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program," Final Rule, 78 *Federal Register* 33233-33240, June 4, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-06-04/pdf/2013-13149.pdf.	**SHOP Exchanges.** The June 4, 2013, SHOP exchanges final rule includes a transitional policy that delays until 2015 a requirement that SHOP exchanges provide qualified employers the option to offer employees a choice of QHPs. For plan years beginning in 2014, federally facilitated SHOP exchanges will only allow employers to select one QHP to offer to their employees, while state-based SHOP exchanges may allow employers to choose one or more QHPs to offer to their employees.
Letter from Kathleen Sebelius, Secretary of Health and Human Services, to Senator Maria Cantwell, March 22, 2013, http://www.cantwell.senate.gov/public/_cache/files/43cebb4b-424a-4960-b88b-d0d9e0bf3692/Senator%20Cantwell%20final%20response%20on%20the%20Basic%20Health%20Plan.pdf.	**Basic Health Plan Option.** The Administration has delayed implementing the Basic Health Program until 2015. [ACA Section 1331, as amended, permits states to establish a Basic Health Program in which states would contract with private-sector and cooperative health plans to provide health insurance coverage for certain low-income individuals not eligible for the state's Medicaid program with incomes between 133% and 200% of the federal poverty level. States that decide to offer the Basic Health Option receive federal funding equal to 95% of the value of the premium tax credits and cost-sharing subsidies that eligible individuals would have received had they purchased coverage through the exchange.]
U.S. Department of Labor, "FAQs about Affordable Care Act Implementation Part XII," February 20, 2013, http://www.dol.gov/ebsa/faqs/faq-aca12.html.	**Limitations on Group Health Plan Cost-Sharing.** PHSA Section 2707(b), as added by ACA Section 1201, requires group health plans to ensure that any annual cost-sharing (e.g., deductibles) imposed under the plan for a plan year beginning on or after January 1, 2014, does not exceed the limitations established under ACA Section 1302(c)(1) and (c)(2). The Administration has provided a one-year grace period to insurers that use more than one benefits administrator that will allow them to apply the separate out-of-pocket limits to each set of benefits under the various administrators. Under this policy, for example, many group health plans will be able to maintain separate out-of-pocket limits for hospital and doctors' services and for prescription drug coverage.
Internal Revenue Service, "Employer-Provided Health Coverage Information Reporting Requirements: Questions and Answers," updated December 19, 2013, http://www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements:-Questions-and-Answers.	**W-2 Reporting of Employer-Sponsored Health Coverage.** IRC Section 6051(a), as amended by ACA Section 9002, generally requires the cost of employer-sponsored health coverage to be reported on Form W-2 (Wage and Tax Statement). This reporting requirement applies to taxable years beginning after December 31, 2010. The IRS provided transitional relief to employers by giving them additional time to make any necessary changes to payroll systems and procedures in order to comply with the W-2 reporting requirement. First, it made reporting on the 2011 W-2, which is typically provided to employees in January 2012, optional. Second, while employers are generally required to report the cost of health benefits on the W-2 for 2012 and subsequent years, the IRS provided transition relief for certain employers and with respect to certain types of coverage. Employers covered by the transition relief are not required to report until future guidance is issued.

Source: Prepared by the Congressional Research Service based on a review of the documents cited in the table.

Author Contact Information

C. Stephen Redhead
Specialist in Health Policy
credhead@crs.loc.gov, 7-2261

Janet Kinzer
Information Research Specialist
jkinzer@crs.loc.gov, 7-7561