CRS Insights

Congress Faces Calls to Address Expiring ACA Appropriations

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The Affordable Care Act (ACA), enacted in March 2010, appropriated billions of dollars of mandatory funds to support grant programs and other activities authorized by the law. For example, it appropriated a total of $16 billion to support three temporary health care programs for targeted groups prior to the exchanges becoming operational, and provided an open-ended amount for state grants through 2014 to plan and establish exchanges. The ACA also appropriated five years of funding for home visitation and other maternal and child health (MCH) programs. And it included $11 billion over five years for the Federal Health Centers program and the National Health Service Corps (NHSC).

The Primary Care "Cliff"

Advocates for the nation's primary care system are urging Congress to extend ACA funding for health centers and the NHSC. Those funds expire this year (i.e., FY2015), setting up what the advocates are calling a "primary care cliff" that will result in a significant drop in funding for primary care programs that deliver services, place primary care providers in underserved areas, and train future providers.

The Health Centers and NHSC programs are cornerstones of the government's efforts to expand access to primary care. The Health Centers program helps support more than 1,300 community-based health centers operating over 9,200 delivery sites across the country. Health centers provide care to medically underserved populations regardless of their ability to pay. The NHSC program awards scholarships and loan repayment to certain health professionals who agree to practice in shortage areas, often at health centers.

The ACA established the Community Health Center Fund (CHCF) to help support the Health Centers and NHSC programs, and gave it a total of $11 billion in annual appropriations over the five-year period FY2011-FY2015. CHCF funding was intended to supplement the discretionary funds that the two programs receive through the regular appropriations process. However, the CHCF has partially replaced the Health Center program's annual discretionary appropriations, which have been reduced since FY2010 (see **Table 1**). In FY2014, CHCF funding represented about 60% of the Health Center program's funding. In the case of the NHSC program, Congress eliminated its annual discretionary appropriation entirely. Since FY2012 the program has relied solely on CHCF funding (see **Table 1**).

Table 1. Health Centers and NHSC Funding

(Millions of Dollars, by Fiscal Year)

	2010	2011	2012	2013	2014	2015
Health Centers						
Discretionary	2,141	1,481	1,472	1,391	1,400	TBD
CHCF	NA	1,000	1,200	1,465	2,145	3,600
% CHCF	0%	40.3%	48.3%	51.3%	60.5%	TBD
NHSC						
Discretionary	141	25	0	0	0	TBD
CHCF	NA	290	295	285	283	287
% CHCF	0%	92.1%	100%	100%	100%	TBD

Source: Prepared by CRS based on HHS budget documents.

Notes: FY2013, FY2014, and FY2015 (NHSC only) amounts reflect sequestration. NA = not applicable. TBD = to be determined.

A bipartisan group of lawmakers has addressed the upcoming funding "cliff" in a letter to congressional leaders. Advocates for the Health Center and NHSC programs have also sent a letter to the congressional leadership signed by numerous national stakeholder groups. In addition to these two programs, both letters mention the ACA's Teaching Health Center (THC) program, for which the ACA appropriated $230 million. THCs are community-based outpatient facilities that train medical or dental residents in primary care. The ACA's THC funds, which also expire in FY2015, help cover the costs of training residents.

Though not addressed by advocates, another ACA provision is set to expire at the end of calendar year 2014 that may affect primary care access for Medicaid beneficiaries. The law provided higher Medicaid reimbursement rates to certain primary care providers who serve Medicaid patients; these payments will revert to their pre-ACA levels on January 1, 2015. ACA also included higher primary care payments for Medicare providers, though these payment rates are in place through January 1, 2016.

Congress Has Extended and Rescinded ACA Appropriations

Congress has already acted on three separate occasions—in P.L. 112-240, P.L. 113-67, and P.L. 113-93—to extend ACA funding for a number of MCH and health workforce programs. Other time-limited ACA funding has been allowed to expire (e.g., school-based health center grants).

For the advocates of health centers and the NHSC, the loss of ACA mandatory funds at the end of FY2015 is compounded by the fact that Congress has reduced—and, in the case of the NHSC, eliminated—annual discretionary funding for these longstanding programs. If lawmakers choose not to extend mandatory funding for the two programs, congressional appropriations may try to make up the difference with discretionary funds. But that may prove challenging under the discretionary spending limits currently in place.

Lawmakers opposed to specific ACA appropriations have succeeded in getting some of the funding rescinded. Language added to appropriations acts for each of the past four years (i.e., FY2011-FY2014) has rescinded funding for the ACA's Consumer Operated and Oriented Plan (CO-OP) program and the Independent Payment Advisory Board (IPAB). In addition, the Middle Class Tax Relief Act of 2012 (P.L. 112-96) reduced funding for the Prevention and Public Health Fund (PPHF), which was established by the ACA to support prevention, wellness, and other public health programs and activities. The ACA provided the PPHF with a permanent annual appropriation that increased from $0.5 billion in FY2010 to $2 billion in FY2015 and each year thereafter. P.L. 112-96 reduced the annual appropriations to the PPHF over the period FY2013-FY2021 by a total of $6.25 billion.

To date, the other longer-term and permanent appropriations in the ACA have not been modified by Congress. Those appropriations include (1) 10 years of funding—through a mix of annual appropriations, fees on health plans, and transfers from the Medicare trust funds—for the Patient-Centered Outcomes Research Trust Fund to support patient-centered comparative clinical effectiveness research; and (2) a permanent appropriation, available for 10-year periods, for the Center for Medicare & Medicaid Innovation to test and implement innovative health care payment and service delivery models.