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

C. Stephen Redhead
Specialist in Health Policy

Janet Kinzer
Information Research Specialist

March 2, 2015

Congressional Research Service
7-5700
www.crs.gov
R43289

CRS REPORT
Prepared for Members and
Committees of Congress

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Introduction

Congress remains 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 the entire law have repeatedly debated its implementation and considered bills to repeal, defund, delay, or otherwise amend the law. To date, most of this legislative activity has taken place in the House, which reverted to Republican control in 2011. Over the past four years, the Republican-led House has passed numerous ACA-related bills, including legislation that would repeal the entire law. But there has been far less debate in the Senate, which remained under Democratic control through 2014. Most of the ACA legislation that passed the House during this period was not considered in the Senate. However, a few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support were approved by both the House and the Senate and signed into law. Now that Republicans control both chambers of Congress, opponents of the ACA see new opportunities to pass and send to the President legislation that would change the law.

In addition to considering ACA repeal or amendment in authorizing legislation, some lawmakers have used the annual appropriations process in an effort to eliminate funding for the ACA's implementation and address other concerns they have with the law. ACA-related provisions have been included in enacted appropriations acts each year since the ACA became law. In October 2013, disagreement between the House and Senate over the inclusion of ACA language in a temporary spending bill for the new fiscal year (i.e., FY2014) resulted in a partial shutdown of government operations that lasted 16 days.

This report summarizes legislative actions taken to repeal, defund, delay, or otherwise amend the ACA since it was signed into law. The report is divided into two sections. The first section focuses on authorizing legislation, and the second section discusses appropriations bills. While a detailed examination of the ACA itself is beyond the scope of this report, a brief overview of the ACA's core provisions and its impact on federal spending is provided.[2] This material is included to help provide context for the discussion of ACA legislative activity that follows. This report is updated periodically to reflect legislative and other developments.

A Brief Overview of the ACA

The ACA made significant changes to the way U.S. health care is financed, organized, and delivered. Its primary goal is to increase access to affordable health care for the medically uninsured and underinsured. To that end, the law included a complex set of interconnected provisions that address the private health insurance market.

[1] The ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended numerous provisions in the ACA. HCERA also included some new provisions related to the ACA. Several subsequently enacted bills—some of which are summarized in this report—made additional changes to selected ACA provisions. All references to the ACA in this report refer collectively to the law as amended and to the related HCERA provisions.

[2] Numerous CRS products that provide more in-depth information on the many new programs and activities authorized and funded by the ACA are available at http://www.crs.gov/pages/subissue.aspx?cliid=3746&parentid=13&preview=False.

First, the ACA requires health insurers to comply with a set of federal standards ("market reforms") to ensure that individuals may purchase, keep, and renew coverage that provides a minimum level of benefits and consumer protections, with some limits on costs. Second, the law establishes competitive private health insurance marketplaces—or exchanges—through which individuals and small employers are able to compare and enroll in qualified health plans. Exchanges operate in every state and the District of Columbia. They are administered by states or by the federal government, or through a partnership between the state and federal governments. Qualified individuals who enroll in exchange plans may receive financial assistance if they meet income and certain other requirements. Refundable tax credits are available to individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) to help pay the insurance premium. The premium tax credits are available upon enrollment so that eligible individuals and families can choose to receive the subsidy immediately rather than wait until they file taxes the following year. In addition, certain individuals and families receiving the tax credit may be eligible for cost-sharing subsidies to reduce their out-of-pocket costs (e.g., deductibles, copays) when receiving health services. Small employers with fewer than 25 full-time equivalent employees (FTEs) may also use the exchanges to purchase insurance coverage for their employees and may qualify for a tax credit to help cover the cost of providing that coverage.

Third, the ACA's "individual mandate" requires most U.S. citizens and legal residents to obtain coverage. Those who remain uninsured may have to pay a penalty unless they qualify for an exemption. The individual mandate is intended to encourage healthy individuals to participate in the insurance market and not wait until they get sick to buy coverage. Finally, the law requires larger employers with 50 or more FTEs to offer health coverage that meets affordability and adequacy standards for their full-time employees and those workers' dependents. Employers who do not comply with these requirements may be subject to a tax if one or more of their employees purchase coverage through an exchange and receive a subsidy. The purpose of the ACA's employer requirements is to encourage larger firms to maintain affordable and adequate coverage for their employees.

The ACA coupled its private insurance provisions with the requirement that states expand their Medicaid programs to cover all nonelderly individuals with incomes up to 138% FPL. Those with higher incomes, up to 400% FPL, may be eligible to get subsidized coverage through an exchange. In June 2012, the U.S. Supreme Court in *NFIB v. Sebelius* found the Medicaid expansion to be unconstitutionally coercive and prohibited the federal government from enforcing it.[3] The Court's decision made Medicaid expansion optional for states.

In addition to expanding access to insurance coverage, the ACA contains hundreds of other provisions that address health care access, costs, and quality. They include new programs to test alternative ways of delivering and paying for health care. The law also includes new taxes and fees as well as adjustments to Medicare payments to hospitals and other health care providers. These provisions are designed to offset spending on exchange subsidies and Medicaid expansion.

[3] *NFIB v. Sebelius*, No. 11-393, slip op. (June 28, 2012), http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. For more information, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

Impact on Federal Spending

Implementation of the ACA is affecting both mandatory and discretionary spending. *Mandatory spending*—also referred to as direct spending—is controlled through authorizing laws.[4] It includes spending on entitlement programs such as Medicare and Social Security. Authorizing laws may provide permanent or temporary appropriations or other forms of budget authority for such spending. When the authorizing law contains no appropriations, mandatory programs may be funded through the annual appropriations process. This is sometimes referred to as "appropriated mandatory" or "appropriated entitlement" spending.[5] *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.[6]

Federal spending on ACA implementation can be grouped into the following three categories:

- **Mandatory Spending on Expanding Insurance Coverage.** This category accounts for most of the federal spending under the ACA. It 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 (CBO) projected that this spending, along with other ACA mandatory spending (discussed in the second category), would be fully offset by (1) revenues from the ACA's new taxes and fees, and (2) savings from the law's adjustments to Medicare provider payments that are projected to slow the rate of growth of Medicare spending.[7]
- **Mandatory Spending on Other Programs.** The ACA authorized new Medicare and Medicaid spending. For example, it phased out the Medicare prescription drug benefit "donut hole" through a combination of subsidies and manufacturer discounts, and it increased Medicare payments for primary care services and medical education. The ACA also included numerous appropriations that are providing billions of dollars of mandatory funding to support grant programs and other activities authorized by the law.[8] For example, the law funded temporary insurance programs for targeted groups prior to the exchanges becoming operational, and it provided funding for grants to states to plan and establish health insurance exchanges. The ACA included 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.

[4] Authorizing legislation generally refers to substantive legislation, reported by a committee (or committees) of jurisdiction other than the House or Senate Appropriations Committees, that establishes or continues the operation of a federal program or agency either indefinitely or for a specific period.

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

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

[7] 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.

[8] 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 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) has provided almost $11 billion over five years (FY2011-FY2015) to help support community health center operations and the National Health Service Corps. Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) is supporting patient-centered comparative clinical 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, helped cover the initial administrative costs of implementing the law.

- **Discretionary Spending.** The ACA is affecting discretionary spending in two ways. First, the law created numerous new discretionary grant programs and provided each of them with an authorization of appropriations. To date, however, few of these programs have received discretionary funding through annual appropriations acts, though several of them have been supported with mandatory funds from the PPHF.[9] Second, the two agencies largely responsible for the ACA's implementation—CMS and the Internal Revenue Service (IRS)—are incurring significant costs in connection with administering and enforcing the law. Both agencies requested an increase in funding in each of the past three years (FY2013-FY2015) to help pay for ACA implementation. But congressional appropriators did not provide either agency with any additional discretionary funds (see discussion under "ACA Provisions in Appropriations Acts"). CMS has instead relied on discretionary fund transfers from other accounts and on ACA mandatory funds (i.e., HIRIF, PPHF) to support its ACA implementation activities. CMS also has transferred HIRIF funds to the IRS.

ACA Provisions in Authorization Legislation

Table A-1 in **Appendix A** summarizes the authorizing legislation to amend the ACA that has been signed into law since the ACA's enactment in March 2010. During the 111th Congress, when the House was still under Democratic control, a number of clarifications and technical adjustments to the law were enacted. In the 112th and 113th Congresses, several more substantive ACA amendments that garnered bipartisan support were signed into law. For example, Congress repealed Title VIII of the ACA—the Community Living Assistance Services and Supports (CLASS) Act—which would have established a voluntary, long-term care insurance program to

[9] The ACA also reauthorized funding for many *existing* discretionary grant programs authorized under the Public Health Service Act; notably, the federal health workforce programs administered by the Health Resources and Services Administration (HRSA). The authorizations of appropriations for many of these programs expired prior to the ACA's enactment, though most of them were still receiving annual appropriations. 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-FY2014 funding levels for programs that received an appropriation, see CRS Report R41390, *Discretionary Spending Under the Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

pay for community-based services and supports for individuals with functional limitations. Lawmakers also repealed a tax-filing provision (IRS Form 1099) that had been included in the ACA, and they reduced the PPHF annual appropriation over the period FY2013-FY2021 by a total of $6.25 billion.

As discussed in the introduction to this report, the Republican-controlled House approved numerous other ACA bills during the 112th and 113th Congresses, none of which became law. Two of these bills were considered by the Democratic-led Senate. The legislation included stand-alone bills as well as provisions in broader, often unrelated measures that would have (1) repealed the ACA in its entirety and, in some cases, replaced it with new law; (2) repealed, or by amendment restricted or otherwise limited, specific provisions in the ACA; (3) eliminated appropriations provided by the ACA and rescinded all unobligated funds;[10] (4) replaced the mandatory appropriations for one or more ACA programs with authorizations of (discretionary) appropriations, and rescinded all unobligated funds; and (5) blocked or otherwise delayed implementation of specific ACA provisions.

Table B-1 in **Appendix B** summarizes all the House-passed ACA bills in the 112th and 113th Congresses. Many of the entries in the table include a brief explanation of the ACA provisions that the bill addresses to help provide some legislative context for the reader. During this period the House voted on three separate occasions to repeal the ACA in its entirety. Other House-approved bills included measures that would have amended or delayed implementation of the ACA's private insurance coverage provisions—including delaying the individual mandate and the employer requirements—and rescinded certain ACA appropriations. Some of the bills passed with Democratic support.

Outlook for the 114th Congress

The ACA legislation approved by the House during the previous Congress provides a menu of policy options for the new Republican-controlled Congress. Several of the ACA bills that passed the House in the 113th Congress have been reintroduced and the House has already voted on and passed four of them, including a full-repeal bill. These bills, which have been referred to the Senate, are listed in **Table B-1**.

Now that Republicans control both chambers, opponents of the ACA are taking action to pass legislation to repeal or otherwise amend the ACA and send it to the President. In the Senate, however, Republicans do not have a filibuster-proof majority. Thus, they would need to secure some Democratic support for any ACA bills they wish to consider in order to gain the 60 votes needed to pass the legislation if the Democrats decide to filibuster. A bill that would repeal or make other substantive changes to the ACA's core provisions would almost certainly draw a presidential veto. Both the House and the Senate would then require a two-thirds vote—290 House votes and 67 Senate votes—to override the veto and allow the bill to become law.

[10] 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.

Faced with these procedural hurdles, lawmakers opposed to the ACA may look for areas of compromise and consider legislative changes to the ACA that gain significant bipartisan support.

ACA Provisions in Appropriations Acts

The ACA's opponents in Congress have used the annual appropriations process in an effort to block agency spending on its implementation and address other concerns they have with the law. Language that addresses the ACA has been included in enacted appropriations acts in each of the past five years (i.e., FY2011-FY2015).

The House Appropriations Committee has added numerous ACA-related provisions to annual appropriations acts since the Republicans regained control of the House in 2011. Most of these provisions were included in the Departments of Labor, Health and Human Services, Education, and Related Agencies ("Labor-HHS-ED") Appropriations Act, which funds CMS. A few were incorporated in the Financial Services and General Government ("Financial Services") Appropriations Act, which funds the IRS. By comparison, the Labor-HHS-ED and Financial Services appropriations bills drafted by the Senate Appropriations Committee, which was under Democratic control over the past four years, were largely free of any ACA-related provisions with one key exception. Each year the Senate Labor-HHS-ED appropriations bill included instructions on the allocation of PPHF funding.

Congressional appropriators have used a number of legislative options available to them through the appropriations process in an effort to defund, delay, or otherwise address implementation of the ACA. First, they have denied CMS and the IRS any new funding to cover the administrative costs of ACA implementation. CMS requested substantial increases in funding for its Program Management account in the FY2013, FY2014 and FY2015 budgets. These new funds were to help support operation of the federally facilitated exchanges and other ACA-related activities. Congress, however, did not provide any additional discretionary funds for CMS in the Labor-HHS-ED appropriations acts for FY2013-FY2015. Similarly, the IRS requested additional discretionary funds for each of those three years to support administration and enforcement of the ACA's tax provisions, including the premium tax credits and the individual mandate penalties. Again, congressional appropriators did not give the IRS the extra funds it requested.[11] Both agencies have asked for additional ACA funding in the FY2016 budget.

Second, House appropriators repeatedly have added limitations (often referred to as riders) to the Labor-HHS-ED and Financial Services appropriations bills. Limitation provisions within appropriations measures are provisions that restrict the use of discretionary funds provided by the bill. They do this either by capping the amount of funding that may be used for a particular purpose or by prohibiting the use of any funds for a specific purpose. For example, appropriators on multiple occasions added language prohibiting an agency from using any of the discretionary funds in its appropriations bill for ACA implementation activities. Limitation provisions also may be used to restrict the availability of funds for transfer.[12] To date, the ACA limitation provisions

[11] For more discussion on the budget requests for, and sources of, funding to cover the administrative costs of implementing the ACA, see CRS Report R41390, *Discretionary Spending Under the Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

[12] For more discussion and analysis of limitation provisions, including the relevant House and Senate rules and the procedural issues that arise during floor consideration of general appropriations measures that include such provisions, see CRS Report R41634, *Limitations in Appropriations Measures: An Overview of Procedural Issues*, by Jessica (continued...)

added by House appropriators have been removed during negotiations with the Senate. None of them have been incorporated into the final appropriations legislation agreed to by both chambers and signed into law.

Third, House appropriators have incorporated legislative language in the Labor-HHS-ED appropriations bills. Unlike limitations, legislative provisions have the effect of making new law or changing existing law.[13] As an example, appropriators included language to rescind (i.e., cancel) certain mandatory funding provided by the ACA. House rules prohibit legislative provisions in appropriations acts, while the rules of the Senate allow exceptions under some circumstances. However, special rules in the House (approved by the Rules Committee) and unanimous consent agreements in the Senate can be used to set aside each chamber's rules, including those that relate to legislating in appropriations measures.

Finally, congressional appropriators have added to recent Labor-HHS-ED appropriations acts several reporting and other administrative requirements regarding implementation of the ACA. These include instructing the HHS Secretary to establish a website with information on the allocation of PPHF funds, and provide an accounting of administrative spending on ACA implementation.

Table C-1 in **Appendix C** summarizes the ACA-related legislative and other provisions that were incorporated in the enacted Labor-HHS-ED and Financial Services appropriations acts for each of FY2011-FY2015. For each fiscal year the table also provides a brief overview of any legislative action taken by the House and Senate Appropriations Committees on their respective versions of the two appropriations bills prior to the two chambers reaching agreement on the final version of the legislation. This discussion lists all the ACA language added to the bills by the committees. As already noted, none of the ACA limitations added by the House appropriators were included in the enacted Labor-HHS-ED and Financial Services appropriations acts.

Government Shutdown

Disagreement between the Republican-controlled House and the Democrat-led Senate on whether to include ACA provisions in the FY2014 continuing resolution (CR) shut down programs and activities across the federal government in October 2013. Congress took up consideration of the FY2014 CR to ensure continued funding for the government at the start of the new fiscal year (i.e., October 1) after lawmakers failed to complete legislative action on any of the FY2014 annual appropriations acts. The House tried three times to attach provisions to the CR to defund or delay ACA implementation. Each time the Senate rejected the House language. With no agreement in place at the start of FY2014, 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, the following day to reopen the government.[14]

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[13] CRS Report R41634 (see footnote 2) discussed the differences between limitations and legislative provisions in appropriations measures, and how to distinguish between the two.

[14] 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* (continued...)

The measure funded the federal government through January 15, 2014, and did not include any provisions to defund or delay ACA implementation. Instead, it required the HHS Secretary to certify to Congress that the ACA health insurance exchanges were 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, which included all 12 annual appropriations acts for FY2014.[15]

Outlook for the 114th Congress

Republican leaders in the House and Senate have indicated that they plan to use the appropriations process in the 114th Congress to address ACA implementation.[16] With majorities in both chambers, House and Senate appropriators may find it easier to coordinate their efforts to include ACA limitations and other legislative language in the appropriations bills, which must be enacted each year to fund government operations.

Senate Republicans may still need to persuade a handful of Democrats to join them to get to the 60 votes needed to debate and pass appropriations bills if the Democrats decide to filibuster the legislation. An appropriations bill that contains limitations or other language intended to defund or otherwise impede ACA implementation is likely to be vetoed by the President. In that case each chamber would require a two-thirds vote to override the veto.

Another option would be to use the threat of a government shutdown at the beginning of the new fiscal year as leverage to try and get ACA limitations and other legislative provisions included in appropriations measures. However, that option appears less likely in the 114th Congress. Republican leaders in both chambers have made it clear that they will not support another shutdown, like the one that occurred in 2013, suggesting that lawmakers on both sides of the issue may have to find areas of compromise.[17]

(...continued)

Appropriations Process: FAQs Regarding Potential Legislative Changes and Effects of a Government Shutdown, coordinated by C. Stephen Redhead.

[15] P.L. 113-76, 128 Stat. 5.

[16] Tamar Hallerman, "Republicans Could Use Spending Bills to Challenge Obama," *CQ Roll Call*, November 6, 2014.

[17] Carl Hulse and Jeremy W. Peters, "Boehner Uses New Mandate to Muffle Talk of a Shutdown," *New York Times*, November 30, 2014; Paul Kane, "McConnell's Promise of No Shutdowns Will Be Tested by Senate's Staunch Conservatives," *Washington Post*, November 15, 2014.

Appendix A. ACA Provisions in Enacted Authorizing Legislation in the 111th, 112th, and 113th 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.[18] 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 acronyms:

- 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)

[18] 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
		113th Congress
P.L. 113-93 Apr. 1, 2014	H.R. 4302 (Pitts)	**Protecting Access to Medicare Act of 2014.** Among its many provisions, P.L. 113-93: • Eliminated paragraph (2) of ACA Section 1302(c), which capped deductibles for small group health plans at $2,000 for singles and $4,000 for families (indexed after 2014 to average per capita premium costs). [Insurers were finding it difficult staying within the deductible cap while covering all essential health benefits and meeting the 60% actuarial value (AV) level for bronze plans. In fact, CMS had already agreed to waive the deductible cap if a plan could not "reasonably reach" the AV level without exceeding the cap.]
		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.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
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.
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 amended IRC Section 36B, as added by ACA Section 1401(a), by further modifying the sliding scale that determines the amount of excess premium tax credits that individuals 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 ACA created a sliding scale for such repayments based on household income. P.L. 111-309 modified the sliding scale. [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.]

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
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, 113th, and 114th Congresses

As discussed 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 passed the House in the 112th and 113th Congresses (2011-2014), but saw little if any further legislative action. Two of these bills, both of which passed the House in the 113th Congress, were taken up and approved by the Senate though neither measure ended up getting enacted into law. The bills are listed in reverse chronological order beginning with the most recently passed one. **Table B-1** also summarizes the ACA legislation that has passed the House to date in the 114th Congress. Generally, the table only lists 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 only binding on certain matters before the Congress, are not included.[19]

On July 30, 2014, the House approved a simple resolution (H.Res. 676) that authorized the Speaker John Boehner to sue the Obama Administration on behalf of the House of Representatives over implementation of the ACA's private health insurance provisions. The House filed a lawsuit in federal district court on November 21, 2014, seeking to invalidate two actions taken by the Administration. First, the lawsuit claims that HHS abused its authority by delaying enforcement of the ACA's employer mandate. Second, it argues that Congress has never appropriated funds for the ACA's cost-sharing subsidies.[20]

[19] The House has 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 Congress. They are not presented to the President for his signature and do not have the force of law. The House approved the FY2012 and FY2013 budget resolutions (H.Con.Res. 34 and H.Con.Res. 112, respectively) during the 112th Congress and passed the FY2014 and FY2015 budget resolutions (H.Con.Res. 25 and H.Con.Res. 96, respectively) during the 113th Congress. Each of these four budget resolutions included language addressing full repeal of the ACA.

[20] *United States House of Representatives v. Burwell*, 1:14-cv-01967 (D.D.C. 2014), http://www.speaker.gov/sites/speaker.house.gov/files/HouseLitigation.pdf.

Table B-1. ACA Provisions in Bills Approved by the House in the 112th, 113th, and 114th Congresses

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
	114th Congress
H.R. 596 (Byrne)	**A bill to repeal the Patient Protection and Affordable Care Act.** Passed the House by a vote of 239-186 on February 3, 2015. H.R. 596 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. It also instructs four House Committees (Education & Workforce, Energy & Commerce, Judiciary, and Ways & Means) each to report health reform legislation that addresses various issues specified in the bill. [Note: This is the fourth time the House has passed a full-repeal bill.]
H.R. 33 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act.** Passed the House by a vote of 401-0 on January 12, 2015. H.R. 33 would exclude the hours worked by volunteer firefighters and emergency medical responders from being counted toward the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. The IRS has ruled that it will not require volunteer emergency responders to count towards these ACA requirements. The House passed the same measure in 2014; see H.R. 3979 below.]
H.R. 30 (Young, T.)	**Save American Workers Act of 2014.** Passed the House by a vote of 252-172 on January 8, 2015. H.R. 30 would amend the ACA's definition of full-time employees to those who work on average at least 40 hours a week. [Note: The ACA requires employers with at least 50 full-time equivalent employees (FTEs) to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Full-time employees are defined as those who work on average at least 30 hours a week. The House passed the same measure in 2014; see H.R. 2575 below.]
H.R. 22 (Davis, R.)	**Hire More Heroes Act of 2014.** Passed the House by a vote of 412-0 on January 6, 2015. H.R. 22 would exclude employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count. [Note: The House passed a similar measure in 2014; see H.R. 3474 below.]
	113th Congress
H.R. 3522 (Cassidy)	**Employer Health Care Protection Act of 2014.** Passed the House by a vote of 247-167 on September 11, 2014. H.R. 3522 would have permitted health insurance companies to continue to offer group coverage that was in effect on any date during 2013, even if the coverage does not meet the ACA's essential health benefit standards and other market reforms that took effect at the beginning of 2014. Insurers could offer such coverage to existing or new enrollees through December 31, 2018, but could not offer the coverage through health insurance exchanges. [Note: The House passed a comparable measure in 2013; see H.R. 3350 below.]
H.R. 4414 (Carney)	**Expatriate Health Coverage Clarification Act of 2014.** Passed the House by a vote of 268-150 on April 29, 2014. H.R. 4414 would have exempted from certain ACA requirements expatriate health care plans offered to individuals working outside the United States. These plans are often used by corporate executives, nongovernmental organization employees, foreign aid workers, contractors, and others working abroad. U.S. insurance companies offering these plans are required to comply with the ACA whereas foreign insurance companies are not. [Note: A modified version of this legislation was enacted into law as Division M of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235); see **Table C-1** in **Appendix C**.]
H.R. 4194 (Issa)	**Government Reports Elimination Act of 2014.** Passed the House by voice vote on April 28, 2014. Among its provisions, H.R. 4194 would have modified the ACA's requirement for periodic reviews and evaluations of all federal disease prevention and health promotion programs. Instead of joint reviews conducted by the HHS and GAO, the reviews would be conducted by HHS alone. *H.R. 4194 subsequently passed the Senate, amended, by unanimous consent on September 16, 2014.*

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 2575 (Young, T.)	**Save American Workers Act of 2014.** Passed the House by a vote of 248-179 on April 3, 2014. H.R. 2575 would have amended the ACA's definition of full-time employees to those who work on average at least 40 hours a week. [Note: The ACA requires employers with at least 50 full-time equivalent employees (FTEs) to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Full-time employees are defined as those who work on average at least 30 hours a week.]
H.R. 4015 (Burgess)	**SGR Repeal and Medicare Provider Payment Modernization Act of 2014.** Passed the House by a vote of 238-181 on March 14, 2014. H.R. 4015 would have replaced the Sustainable Growth Rate (SGR) formula, which determines the annual updates to Medicare's payment rates for physician services, with new systems for establishing those payment rates. To help pay for its cost, H.R. 4015 would have delayed enforcement of the ACA's individual mandate by five years by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2019. CBO estimated that this would result in 13 million fewer Americans with health insurance coverage in 2018 relative to current-law projections.
H.R. 3979 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act of 2014.** Passed the House by a vote of 410-0 on March 11, 2014. H.R. 3979 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted towards the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Prior to passage of H.R. 3979, the IRS ruled that it will not require volunteer emergency responders to count towards these ACA requirements.] *H.R. 3979 passed the Senate by a vote of 59-83 on April 7, 2014. The Senate added a five-month extension of unemployment benefits to the bill, among other things, and renamed it the Emergency Unemployment Compensation Act of 2014. H.R. 3979 subsequently became the legislative vehicle for the FY2015 National Defense Authorization Act (P.L. 113-291), which did not include the ACA provisions.*
H.R. 3474 (Davis, R.)	**Hire More Heroes Act of 2014.** Passed the House by a vote of 406-1 on March 11, 2014. H.R. 3474 would have permitted an employer to exclude employees who receive health care through the Department of Veterans Affairs or TRICARE from its FTE count.
H.R. 1814 (Schock)	**Equitable Access to Care and Health (EACH) Act.** Passed the House by voice vote on March 11, 2014. H.R. 1814 would have expanded the religious exemption in the ACA by exempting from the law's insurance mandate any individual who objects to purchasing health coverage because of sincerely held religious beliefs. [Note: The ACA's religious exemption applies only to religious sects that are recognized by the Social Security Administration as being conscientiously opposed to accepting insurance benefits (e.g., Amish).]
H.R. 4118 (Jenkins)	**Suspending the Individual Mandate Penalty Law Equals (SIMPLE) Fairness Act.** Passed the House by a vote of 250-160 on March 5, 2014. H.R. 4118 would have delayed enforcement of the ACA's individual mandate by one year by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2015. [Note: The House passed similar legislation in 2013; see H.R. 2668 below.]
H.R. 7 (Smith)	**No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2014.** Passed the House by a vote of 227-188 on January 28, 2014. H.R. 7 would have prohibited exchange applicants from obtaining premium tax credits or cost-sharing subsidies to help purchase health plans that cover elective abortions, and would have prohibited tax credits for health plans offered by an employer that include elective abortion coverage. Individuals would still be able to purchase separate abortion coverage, but would not be able to receive a tax credit or cost-sharing subsidy. H.R. 7 also would have prohibited OPM-contracted multi-state plans from including elective abortion coverage. [Note: The ACA permits exchange applicants to obtain premium tax credits and cost-sharing subsidies to help purchase health plans that cover elective abortions; however, the law prohibits the use of those federal funds to pay for abortion services and requires plans to collect an abortion surcharge from enrollees to pay for such services. The ACA also specifies that at least one multi-state plan offered in an exchange must not include elective abortion coverage.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
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 have required 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 have been 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 have required 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 have permitted health insurance companies to continue to offer individual coverage that was in effect as of January 1, 2013, even if the coverage did not meet the ACA's essential health benefit standards and other market reforms that took effect at the beginning of 2014. Insurers could offer such coverage to existing or new enrollees at any time during 2014, but could not offer the coverage through health insurance exchanges. [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 would allow insurers to sell such coverage in the individual market during 2014.]
H.R. 2775 (Black)	**No Subsidies Without Verification Act.** Passed the House by a vote of 235-191 on September 12, 2013. H.R. 2775 would have required the HHS Inspector General to certify to Congress that a program was in place to verify the household income of exchange applicants before making any premium tax credits or cost-sharing subsidies available. [Note: H.R. 2775 became the legislative vehicle for the FY2014 Continuing Appropriations Act, P.L. 113-46. That Act incorporated a modified version of the language in H.R. 2775; see **Table C-1** in **Appendix C**.]
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 have prohibited 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 have delayed enforcement of the ACA's individual mandate by one year by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2015. It also would have incorporated the provisions in H.R. 2667 (see below) 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 have delayed 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 have essentially codified the Administration's announcement on July 2, 2013, that it was delaying the ACA employer mandate and related reporting requirements.]
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 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
	112th Congress
H.R. 6684 (Cantor)	**Spending Reduction Act of 2012.** Passed the House by a vote of 215-209 on December 20, 2012. H.R. 6684 would have eliminated the FY2013 sequestration of direct defense spending (as required under the Budget Control Act of 2011), reduced the FY2013 overall discretionary cap by $19 billion, and implemented numerous other mandatory spending reductions. Among its provisions, H.R. 6684 would have (1) repealed the authority and appropriations for the exchange planning and establishment grants and rescinded all unobligated funds; (2) repealed the authority and appropriations for the PPHF and rescinded all unobligated funds; (3) rescinded all remaining unobligated funds for the Consumer Operated and Oriented Plan (CO-OP) program; and (4) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount.
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.
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 eliminated the FY2013 sequestration of direct defense spending (as required under the Budget Control Act of 2011), reduced the FY2013 overall discretionary cap by $19 billion, and 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 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.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
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.
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-FY2015)

Table C-1 summarizes the ACA-related provisions in enacted annual appropriations acts for each of FY2011 through FY2015. 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-FY2015

Public Law and Date of Enactment	Summary of Provisions
	FY2015
P.L. 113-235 Dec. 16, 2014	**Consolidated and Further Continuing Appropriations Act, 2015.** Division G of P.L. 113-235—the FY2015 L-HHS-ED Appropriations Act—includes the following ACA-related provisions: • Rescinds $10 million of the FY2015 appropriation for the Independent Payment Advisory Board (IPAB), which was authorized and funded by ACA Section 3403. [Note: The same rescission was included in the FY2012, FY2013, and FY2014 appropriations acts; see below.] • Requires the HHS Secretary to transfer the FY2015 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. 113-235 (Congressional Record, December 11, 2014, p. H9839). Prohibits the Secretary from making further transfers. [Note: The requirement to transfer PPHF funds in accordance with the allocations specified in an accompanying table has been included in each L-HHS-ED appropriations bill reported by the Senate Appropriations Committee since FY2011; however, the provision did not get included in the final enacted appropriations legislation until FY2014.] • Requires the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program or by state. [Note: The same provision was included in the FY2014 appropriations act; see below.] • Prohibits the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: The same provision was included in the FY2014 appropriations act; 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. [Note: The same provision was included in the FY2014 appropriations act; see below.] • Requires the HHS Secretary to include in the FY2016 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 FY2015 and for each of the past four fiscal years (i.e., FY2011-FY2014). [Note: The same provision was included in the FY2014 appropriations act; see below.] • Requires the HHS Secretary to include in the FY2016 budget justification a detailed breakdown of all funds used to date by CMS for the exchanges, including the proposed use of such funds in FY2016. Funding details must be provided for all the activities specified under the heading "Health Insurance Marketplace Transparency" in the explanatory statement to accompany P.L. 113-235 (Congressional Record, December 11, 2014, p. H9837). [Note: A less specific provision was included in the FY2014 appropriations act; see below.] • Prohibits risk corridor payments (authorized by ACA Section 1342) from the CMS Program Management appropriations account. The explanatory statement to accompany P.L. 113-235, submitted by the House Appropriations Committee Chairman and published in the December 11, 2014, Congressional Record, instructs HHS to include in the FY2016 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. In addition, the explanatory statement instructs the HHS Office of the Inspector General to (1) submit to Congress, within 60 days of enactment, a plan of how it will conduct health reform oversight activities; and (2) report to Congress (jointly with the Treasury Inspector General), no later than June 1, 2015, on the IRS's procedures for reconciling premium tax credits and reducing fraud and overpayments. [Note: Section 4 of P.L. 113-235 states that the explanatory statement is to be treated as if it were a joint explanatory statement of the conference committee.]

Public Law and Date of Enactment	Summary of Provisions
	Division E of P.L. 113-235—the FY2015 Financial Services Appropriations Act—does not include any ACA-related provisions. However, the explanatory statement to accompany P.L. 113-235 (discussed above) instructs the IRS to submit quarterly reports to Congress during FY2015 on actions taken to reconcile advance premium tax credit payments received in 2014 when 2014 tax returns are filed in 2015, and requires the Treasury Secretary to provide Congress an accounting each month of the number of individuals who had not paid the full amount of any premium owed for the preceding month for health coverage obtained through an exchange. Division M of P.L. 113-235—the Expatriate Health Coverage Clarification Act of 2014—would exempt expatriate health plans offered to individuals working outside the United States from certain ACA requirements. Prior to enactment of this law, U.S. insurance companies offering these plans had to fully comply with the ACA, whereas foreign insurance companies did not. [Note: The House passed a similar bill, H.R. 4414, on April 29, 2014; see **Table B-1** in **Appendix B**.]
Legislative activity prior to enactment of P.L. 113-235**.** The House passed the FY2015 Financial Services appropriations bill (H.R. 5016, H.Rept. 113-508) on July 16, 2014. The measure did not include the $436 million increase in funding requested by the IRS for ACA implementation. Moreover, it would have (1) prohibited the IRS from using any of the discretionary funds provided in the bill to implement the individual mandate; (2) prohibited any transfers from HHS to the IRS for ACA implementation; and (3) required the Treasury Secretary to provide Congress an accounting each month of the number of individuals who had not paid the full amount of any premium owed for the preceding month for health coverage obtained through an exchange. Language in H.Rept. 113-508 would have directed the IRS to submit monthly status reports to Congress during FY2015 on actions taken to reconcile advance premium tax credit payments received in 2014 when 2014 tax returns are filed in 2015. The House Appropriations Subcommittee on Labor-HHS-ED did not report a FY2015 appropriations bill. The Senate Appropriations Subcommittee on Labor-HHS-ED approved a draft bill for FY2015 on June 10, 2014, but no further action was taken. The Senate Appropriations Subcommittee on Financial Services approved a draft bill for FY2015 on June 24, 2014, but no further action was taken.	

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—included the following ACA-related provisions: • Rescinded $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.] • Required 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). Prohibited 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 the provision was not included in the final enacted appropriations legislation for those years; see below.] • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program or 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.] • 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.] • Authorized the HHS Secretary to transfer up to $305 million from the Medicare trust funds to the CMS Program Management account for Medicare operations, but prohibited the use of such transferred funds for ACA implementation. • Required 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). • Required 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. • Required 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. The explanatory statement to accompany P.L. 113-76, submitted by the House Appropriations Committee Chairman and published in the January 15, 2014, Congressional Record, instructed 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. [Note: Section 4 of P.L. 113-76 stated that the explanatory statement was 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—included the following ACA-related provision: • Required 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 prohibited 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. 113-46**.** 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 by including the President, Vice President, and political appointees, and by prohibiting 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 the IRS to implement the ACA. The House Appropriations Subcommittee on Labor-HHS-ED did not introduce or 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. After it passed the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (H.R. 1473) on April 14, 2011, the House approved an accompanying concurrent resolution (H.Con.Res. 35). The resolution instructed the House clerk, during enrollment of the bill, to insert a provision that would have prohibited using any of the funds provided by H.R. 1473 or any previous Act to implement the ACA. The Senate rejected H.Con.Res. 35.
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.

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