IN THE UNITED STATES COURT OF FEDERAL CLAIMS

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	No. 16-744C Judge Charles F. Lettow

PLAINTIFF'S REPLY IN SUPPORT OF CROSS-MOTION FOR JUDGMENT ON THE ADMINISTRATIVE RECORD ON COUNTS II-V

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PLAINTIFF'S REPLY IN SUPPORT OF CROSS-MOTION FOR JUDGMENT ON THE ADMINISTRATIVE RECORD ON COUNTS II-V

Plaintiff, Land of Lincoln Mutual Health Insurance Company (Lincoln), pursuant to Rule 52.1(c) of the RCFC, and the Court's Order of October 18, 2016, replies in support of its cross-motion for judgment on the Administrative Record on Counts II-V of its Complaint.

INTRODUCTION

The Government filed yet another lengthy brief in opposition to Lincoln's cross-motion, this time 34 pages. Its own motion to dismiss and for judgment on Count I was 45 pages, its reply on that motion was 25 pages, and its response to Lincoln's motion for judgment was 27 pages. In total, the Government has filed 131 pages of briefing to try to avoid paying now what the relevant money-mandating statute plainly states it "shall pay" – Lincoln's risk corridors payments for calendar years 2014 and 2015. The Government now even refuses to acknowledge any liability for the remaining 2014 payment in an amount it approved (and partially paid), taking the baseless position that a later general appropriations law absolves it of any liability for an obligation it had already incurred. It advances the same argument for Lincoln's 2015 risk corridors payment.

THE GOVERNMENT'S ARGUMENTS

The Government's 131 pages of argument boil down to this: because the Government did not appropriate enough money in 2014 for Calendar Year 2015 payments or in 2015 for Calendar Year 2016 payments, the Government claims it does not have to pay the full amount of the risk corridors obligations it incurred in 2014 and 2015. The Government also claims that because HHS decided, contrary to its own prior pronouncements and in reaction to insufficient funding, to operate the risk corridors program as "budget neutral" and to pay over a three-year cycle, not annually, the Government has no current obligations and, again, does not have to pay.

Yet, the undisputed administrative record shows that the very agency charged with administering the ACA and its risk corridors program:

- Admits risk corridors is intended for the government to "share risk" with QHPs;
- Admits risk corridors is not statutorily required to be budget neutral (of course not; if it were budget neutral, there would be no risk sharing);
- Admits that even though it could only make a partial payment in 2015 for 2014 risk corridors, the full amount is required to be paid and is an ongoing obligation of the Government;
- Admits even though it can pay nothing for 2015 risk corridors in 2016, full payment is an ongoing obligation of the Government and such payment is "due."

The Government – represented here through the Department of Justice – is at direct odds with own agency. Its legal positions are also at direct odds with clear precedent that:

- The Government's obligations are not determined by its appropriations; *see, e.g.*, GAO, Principles of Federal Appropriations Law, Ch. 2 (4th Ed. 2016) at 2-5 ("a failure or refusal by Congress to make the necessary appropriations would not defeat the obligation, and the party entitled to payment would most likely be able to recover in a lawsuit"); at 2-63 ("a failure to appropriate in this type of situation will prevent administrative agencies from making payment, but, as in *Langston* and *Vulte*, is unlikely to prevent recovery by way of a lawsuit"); *See also*, the Government's own Brief in *United States v. Burwell*, District of D.C., No. 14-1967, Doc. 55-1 at 20 ("the absence of appropriations would not prevent the insurers from seeking to enforce that statutory right through litigation".)
- A general appropriations act – substantively and procedurally – does not change existing law unless clearly manifested in that act and unless enacted in accordance with special procedures according to specific House and Senate rules.

Notably, the Government cannot and does not dispute that: Lincoln was a QHP and did incur the coverage risks and losses under section 18062 of the ACA; that the remaining amount owed for 2014 is correct; and that the amount submitted as owed for 2015 has not been contested by HHS.

THE OBLIGATIONS LINCOLN INCURRED

Lincoln entered a contractual "QHP agreement" in September 2013 to be a QHP on the Federal Exchange for 2014 and could not terminate that coverage in calendar year 2014. Lincoln Mo.App. at A-22. When it signed that agreement, the Government had appropriated $3.6 billion to the CMS Program Management (PM) fund that could be used, *inter alia*, to make risk corridors payments. That appropriations law provided those funds were available through September 2019. Only after Lincoln had complied with Section 1342 of the ACA for calendar year 2014 and complied with its QHP agreement in 2014 (and incurred tens of millions of dollars of coverage risk and expense), did Congress pass a general appropriations law, in December 2014, that restricted future funds, other than user fees, from going into the CMS PM account to be used for risk corridors payments.

The same is true for Lincoln's 2015 risk corridors payment. Lincoln entered another QHP Agreement with CMS in October 2014 (Lincoln Mo. App. at A-28) for coverage year 2015 that it, again, could not terminate and it had to perform and provide coverage on the Exchange for all of calendar year 2015. Congress passed the 2016 general appropriations act in December 2015, well after Lincoln had already performed and incurred approximately $100 million in risk corridors losses for calendar year 2015.[1]

The Government argues Congress "clearly indicated" it intended to modify the ACA and limit risk corridors "payments out" to risk corridors "payments in." The Government relies on general appropriations laws for fiscal years 2015 and 2016 that failed to provide additional funding, effectively limiting funding for risk corridors in those years to risk corridor "payments in." The Government's argument is contrary to law and the admissions of the very agency it

[1] This same fact pattern also applies to Lincoln's 2016 QHP Agreement. Lincoln Mo.App. at A-40 (executed in October 2015).

represents here. A general appropriations law is not general legislation and does not change existing law, unless such intent is clear and manifest and the only permissible justification is that the old and new laws are irreconcilable by a clear positive repugnancy between them. *TVA v. Hill,* 437 U.S. 153, 190 (1978). It could not change Lincoln's vested right to its risk corridors payments after the fact. *Cherokee Nation*, 543 U.S. at 645 ("a statute that retroactively repudiates the Government's contractual obligation may violate the Constitution [*citing, inter alia, Winstar*, 518 U.S. at 876-876] and noting "such an interpretation is disfavored.").

The House and Senate Rules also do not permit the procedure the Government now advocates. *See* Rules of the House of Representatives, Rule XXI 2(a)(2)(b) ("a provision changing existing law may not be reported in a general appropriation bill...") (Reply App. A-16); and Senate Rule XVI(4) ("no amendment offered by any other Senator which proposes general legislation shall be received to any general appropriation bill...."). (Reply App. A-14). *See* discussion of these rules in *TVA v. Hill*, 437 U.S. 155, 190 (1978), superseded by statute on other grounds, rejecting an argument that a funding limitation in a general appropriations law modified substantive law. The Court also rejected evidence of a legislative committee's statements about the effect of an appropriations law, ruling it cannot be equated with statutes enacted by Congress. The Government's citation to after-the-fact explanatory statements from a Congressional committee (Gov. Resp. pp. 7-8) here is thus not probative on the effect of the 2014 general appropriations act.

Further, Congress itself well knows when and how it can modify prior substantive law. It has tried repeatedly to overturn the entire ACA and failed. It has had modest success in repealing certain provisions of the ACA. *See* Congressional Research Service Report 43289, February 5, 2016, "Legislative Actions to Repeal, Defund, or Delay the ACA," Reply App.A-18-

42. Congress has never voted to repeal or modify the risk corridors program or even brought a bill to the floor on that subject.

Even Senator Rubio and his cohorts know the 2015 General Appropriations Act (passed by P.L. 113-235 on December 16, 2014) that limited funding for the risk corridors program did not change the substantive law requiring such payments. *See* CRS Report 44100, October 7, 2016, "Use of the Annual Appropriations Process to Block Implementation of the ACA," Reply App. A-43-65 at A-59. He introduced Senate Bill 359 on February 4, 2015 to limit risk corridors payments to risk corridors collections. Reply App. A-67-68. The exact same bill was introduced that same day in the House as HR 724. Reply App. A-70-71. They were each referred to Committee and have never left either Committee since. Of course, such bills would not be necessary had Congress already changed the law via the 2015 Appropriations Act. It had not.

That Congress' action in limiting funding did not abrogate the Government's obligations that it shall pay full risk corridors losses is confirmed not only by HHS' repeated admissions to that effect (previously cited in each of Lincoln's briefs) but also by the Congressional Research Service's advice to the House Energy and Commerce Committee on January 23, 2014 (Reply App. A-73-75). There the CRS confirmed that risk corridors are a method of sharing gains or losses. It noted that "[u]nder § 1342(b)(1) if a plan's allowable costs exceed the total premium received (less administrative costs), the Secretary is required to pay the plan a percentage of the shortfall in premiums." Reply App. A-73 (emphasis added). The CRS went on to debunk the very argument the Government makes here that its obligation to pay is somehow limited by appropriations, quoting the plain language of § 18062:

> 'If ... a participating plan's allowable costs for any plan year are more than [specified thresholds] the Secretary shall pay to the plan an amount equal to [the statutory formula].' 42 U.S.C. § 18062(b)(1). It should also be noted that the question of whether

> an appropriation is available to make these payments is separate from the question of whether insurance plans meet the eligibility requirements for a payment under § 1342(b)(1). A qualified health plan may have a legal claim to the payments by operation of the statutory formula, but that alone does not constitute an appropriation for which that claim may be paid.

Reply App. A-74.

The Department of Justice is acting here (and in all the companion risk corridors cases) solely to delay payment of a clear legal obligation. But the Government is the People. Of the People. By the People. For the People. Lincoln is a legal "person" of the United States, as are its investors and insureds. As Judge Smith noted in connection with the *Winstar* litigation, "It is the obligation of the United States to do right" and the United States has an obligation to act in a manner that "respects the life, liberty and property of its citizens," and not to interpose delay simply because the dollars at stake appear to be so large. *California Federal Bank v. United States*, 39 Fed. Cl. 753, 754-55 (1997), *rev'd in part on other grounds*, 535 F.2d 1348 (Fed. Cir. 2008). Where the Government refuses to do right we must ask the Court to force it to do so.

ARGUMENT

HHS has failed to make timely risk corridors payments to Lincoln as mandated by statute. The Administrative Record supports judgment for Lincoln on all counts and each of them individually. The Government claims to dispute various allegations of the Complaint and claims to need discovery on each of Counts II-V. Yet, it cites no facts in the Administrative Record showing any disputed material question of fact on any essential element of Counts II-V that the Court could not itself resolve as part of its resolution of Lincoln's motion for judgment on the administrative record. It also identifies no specific discovery it needs to rebut any material fact of Counts II-V or how such discovery may lead to relevant or admissible evidence on that issue beyond what is already part of the record. It cannot because Lincoln's motion is based

entirely on the Administrative Record and the parties' actions under the relevant statute as shown in the Administrative Record. Those facts show:

1. What the ACA expressly provides with respect to risk corridors – the Government "shall pay" on an annual basis per plan year for 2014, 2015 and 2016, and risk corridors payments in and out are not tied or required to be budget neutral. Further, HHS "shall base" the risk corridors program on the Medicare Part D program which makes annual risk corridors payments and does not limit such payments to risk corridors collections;

2. Issuers have to be QHPs to provide coverage on the Federal Exchange and enter into QHP agreements to so qualify;

3. The QHPs are contracts and provide:

    a. QHPs must provide coverage for the entire plan year;

    b. There will be setoffs against risk corridors (*ergo*, risk corridor payments must be "due");

    c. There will be exchanges between HHS and issuers of "user fees" – and HHS considers such "user fees" to include risk corridors payments to issuers;

    d. If there is a change in applicable law or regulation HHS will provide notice to QHP issuers and allow them to terminate – no such notices were ever provided to Lincoln; and

    e. HHS can terminate a QHP issuer if it does not comply with its contractual obligations and/or applicable regulations – again, no such notices were ever provided to Lincoln.

4. The Government appropriated $3.6 billion in 2014 for use through September 2019, including to pay risk corridors.

5. Risk corridors amounts owed to Lincoln for 2014 and 2015 are not disputed by any facts in the Administrative Record and enough money was appropriated to pay those amounts for those years.

Lincoln's Motion for Judgment on Counts II-V is based on the exact same core of undisputed operative facts as Count I. The Government cites no new or different facts in opposition. The Court can determine the legal effect of those facts under Rule 52.1 and can also

make underlying factual determinations from the Administrative Record, if necessary. No case or procedural rule precludes review of Counts II-V on the Administrative Record and the Government cites none. It promotes judicial economy to consider these all at one time when they are based on the exact same record.

The Government's intent is clear from the plain language of the ACA in section 1342 (41 U.S.C § 18062). It is also clear that the law was designed to cause issuers like Lincoln to become QHPs. It is also clear the risk corridors program was designed to support QHP issuers by having the Government share the risks they undertook in the early years of the program.

I. The Government's Statement of the Case Is Incomplete

Lincoln has previously outlined the undisputed facts in its Statement of the Case in its own Motion for Judgment at pp. 3-8, and in its Response and Cross-Motion to the Government's Motion for Judgment at pp. 2-5.

The Government's Statement of the Case is once again incomplete and misleading. It states "nothing in the text or legislative history [of the ACA] suggests that as part of its reforms, participating insurers would become Federal contractors providing health coverage for private individuals on the Government's behalf." Gov. Resp. 3. Actually, it does. As the Government admits on the very next page of its Response, it requires issuers to enter QHP agreements (*i.e.*, contracts) in order to provide insurance in the federally-regulated exchange and HHS manages and oversees that exchange. QHPs on the Federal Exchange must sign contracts in order to participate in the risk corridors. Gov. Resp. 4.[2]

[2] Whether issuers in state run exchanges also had to sign agreements is irrelevant here. Lincoln had to in order to participate in the Federal Exchange.

The Government says in Response, p. 4, it "mitigates" pricing risks through the 3Rs. It does not just mitigate. It shares loss with issuers via risk corridors. In order to share loss, risk corridors cannot be budget neutral.

The Government says "there are no risk corridor contracts." Gov. Resp. 5. QHPs on the Federal Exchange must sign contracts in order to participate in risk corridors. Its own admissions conclusively show there are such agreements. While the Government admits Section 1342 directed HHS to establish a risk corridors program, it left out the key statutory language:

- The Secretary "shall pay" the risk corridor amounts calculated;
- "HHS shall ... administer" the risk corridors program for "Calendar Years 2014, 2015 and 2016"; and
- That annual program "shall be based" on the Medicare Part D program which requires annual risk corridors payments and is not budget neutral.

II. Lincoln's Motion for Judgment on Counts II – V is Properly Brought

HHS, in its administrative capacity, has refused to make full risk corridors payments in timely fashion to Lincoln. Rule 52.1(c) permits a motion for judgment on the Administrative Record and does not limit the legal bases upon which the motion may be made, and the Government cites no rule or law that limits the application of Rule 52.1. The cases the Government cites in its Response, p. 10, *Holmes*, 98 Fed. Cl. 767, and *Advanced Data*, 216 F.3d 1054, involve APA reviews in the Court of Federal Claims specifically established by statute. This is not an APA review. It is a review of an agency action that is directly contrary to law and is considered by a preponderance of the evidence standard on the Administrative Record. *See*, *Palm Beach Isles Association v. United States*, 58 Fed. Cl. 657, 666-667 (2003), *aff'd*, 2005 U.S. App. LEXIS 4055 (Fed. Cir. 2005) (5 U.S.C. § 706 standard of review only applies if required

by statute; no such statute there so agency action reviewed on preponderance of evidence standard).

The Government also cites Judge Lettow's decision in *Montana Fish*, 91 Fed. Cl. 434, Resp. p. 10. The Court did not rule there, as the Government argues, that a party has a right to discovery before hearing on a Rule 52.1 motion on contract claims. It ruled only on a motion to supplement the record and noted discovery on the contract claims may be addressed whether or not part of the Administrative Record.

The Government has not made a motion here for discovery in order to respond to Lincoln's cross-motion, much less identified any specific discovery it needs or how it will lead to relevant or admissible evidence on the cross-motion. Instead, the Government simply concludes in its Resp. p. 11 the various allegations "have no support in the Administrative Record." They do. *See* Lincoln's Motion for Judgment, pp. 2-8, Reply, p. 3, and Response and Cross-Motion, pp. 3-5, 10-11, 13-15 and 31-47. The Government's argument is interposed only for delay.

The Court can decide facts on a Rule 52.1 motion and draw reasonable inferences from those facts as well. It is undisputed Lincoln entered into a QHP "agreement" with HHS. It is a reasonable inference it did so to become a QHP and thereby provide insurance on the Federal Exchange. The Government does not need discovery on this issue. No more evidence is needed to prove it.

As Lincoln became a QHP, it is also reasonable to infer it understood that as a QHP, it would get the benefits the ACA provides to QHPs. Why would a QHP turn down risk corridors payments? Yet, the Government claims there is no proof Lincoln "agreed to become a QHP" "based on Congress' statutory commitments set forth in the ACA." Gov. Resp. 11. There is.

And it is unrebutted. The QHP agreement and the statute. No other inference is reasonable and the Government provides none.

The rest of the Government's complaints fail for the same reasons. It ignores the administrative record, the QHP agreement and the plain dictates of the ACA. A representative example is at p. 12 its Response. It argues the Administrative Record does not "contain any evidence that Land of Lincoln complied with the terms of the alleged contract and in what amounts the alleged breach of this contract damaged Lincoln." Sure it does. Lincoln attached its three consecutive, annual QHP agreements with HHS to its motion (which the Government omitted from the Administrative Record). Those agreements provide HHS can terminate the agreement if Lincoln does not comply and provides for notice and a cure period for any such breaches. Lincoln Motion for Judgment, App. A-21-22. The Administrative Record contains no HHS notice letters of breach to Lincoln, no notices of termination and no notices that the laws or regulations governing QHPs under the agreements had changed (as the agreements require).

The Administrative Record also shows HHS approved Lincoln's 2014 risk corridors amounts and paid them in part (as limited by its appropriations—pro rata). AR 270. From these facts, the Court can reasonably infer Lincoln complied with its contract obligations. The record directly shows Lincoln's damages – the shortfall for 2014 risk corridors payments – $3,925,418.48. AR 270.

Likewise, Lincoln has submitted its 2015 risk corridors calculations in verified form in late July 2016, totaling $71,833,251. AR 1256. *Id.* The Administrative Record again contains no HHS letters in 2015 to Lincoln complaining about its actions as a QHP. HHS has had more than 30 days to consider Lincoln's submission. HHS has not disputed that submission. HHS has not paid. The Court can draw the reasonable inference that Lincoln complied with its QHP

contract obligations in 2015, its submitted risk corridors amounts for 2015 are correct, and it is damaged in those amounts because HHS has failed to timely pay.

III. Counts II-V Are Amply Supported By the Administrative Record

The Government's Response to Lincoln's Motion for Judgment on the Administrative Record as to Counts II-V is a redux of its motion to dismiss. Lincoln has already responded to that motion in its Response to Government Motion, pp. 31-46. Lincoln responds to the Government's new, additional arguments below.

A. Count II.

With respect to Count II, the QHP contracts each have references at ¶4, pg. 1 that an exchange of "payments of FFE user fees will be between CMS and QHPI." The Government claims they do not reference risk corridors payments but only "FFE user fees," as specifically defined in HHS regulations. Gov. Resp. 14-16. But the contract does not define them that way. Moreover, as the Government admits, HHS understood that Section 1342 "authorizes the collection of and payment of user fees to and from the QHPs". Lincoln Motion, App. 12 A-77-78, AR 1482-1483 (emphasis added). The QHP contract was created to allow Lincoln to "qualify" to offer insurance on the FFE exchange. The only "user fees" that would go to Lincoln were for reinsurance, risk adjustment and risk corridors. That contract specifically contemplated HHS would make risk corridors payments to Lincoln. That other "user fees" might be made by or to Lincoln does not change that.

The Government also argues that the contract does not obligate HHS to make payments in excess of other user fees. Gov. Resp. 17. Sure it does. It contemplates HHS will pay Lincoln risk corridors in accordance with the statutory requirement to pay "user fees" that, as HHS has

admitted, are not required to be budget neutral and for which HHS repeatedly admits it is obligated to pay in full, regardless of risk corridors receipts.

The Government also argues, Resp. 17, fn. 11, that the risk corridors is an open-ended indemnity agreement contrary to law, citing *Hercules*, 516 U.S. 417 and *Rick's Mushroom*, 521 F.3d 1338. In both those cases, there was no contractual or statutory provision for any indemnity, much less one providing for a limited statutory based risk-sharing formula, as here. They do not apply.

The Government goes on to try to stretch *Rick's Mushroom* to support its argument that "because the QHP agreements do not incorporate Section 1342 as contract terms or provide for money damages the Court lacks jurisdiction over Count II." Gov. Resp. 18. The Government is wrong on both points. The QHP agreement specifically contemplates risk corridors payments will be made to Lincoln (for which Section 1342 provides). The statute is money-mandating and therefore provides for money damages to support jurisdiction. The Government's own cited case, *ARRA Energy Co. I,* 97 Fed. Cl. 12, 45-46 (2011), distinguished *Rick's Mushroom* on that very basis. *See also, Holmes v. United States,* 657 F.3d 1303, 1314 (Fed. Cir. 2011) (there is a general presumption that money damages are an available remedy upon breach of express and implied in fact contracts).

The Government Response, p. 20, fn. 14 cites a Murphy article in its appendix as somehow showing the absence of a contractual undertaking to pay risk corridors. The article does not address that issue at all. But it does confirm that the Government would share in either profit or loss with the QHP and specifically that "this risk-sharing mechanism [risk corridors] is not designed to be revenue-neutral and, in theory, every plan could get paid." Gov. Resp. A-60.

The Government also cites an October 2013 article from the Society of Actuaries attached in its appendix for the proposition that Lincoln's QHP Agreement of September 2013 with HHS could not be a contract because the Society said the definition of which plans qualify for risk corridors was still unknown. But the Society did not know of Lincoln's specific QHP Agreement signed the previous month with HHS, and that Agreement was never amended, as on its face, is required. *See* Lincoln Motion App. at A 23, § V.C. The article is not probative on that issue. Nevertheless, the Government's own attachment confirms there is a risk corridors "arrangement" between QHPs and the Government and other important facts with respect to risk corridors. It states:

> 1) The risk corridors program "temporarily dampens gains and losses in a risk-sharing arrangement between issuers and the federal government. Since the protection is only available for QHPs, it also provides a strong incentive for issuers to participate in the health insurance exchange as set up by the ACA." Gov. Resp. A-49 (emphasis added);
>
> 2) "If all of the plans in a market (or even just the most popular ones) end up pricing their products too low and so suffer losses, the Government will end up needing to fund this program, and the required funds could be substantial." *Id.* at A-50; and
>
> 3) HHS acknowledges in the Federal Register "that the program is not statutorily required to be budget neutral and that payments will be made regardless of the balance between receipts and payments." (*Id.* at A-50) and "HHS has clarified that it is conscious of the risk corridors program's non-symmetric nature and states in the March 1 regulations that funds will be paid out regardless of the balance between payments and receipts." *Id.* at A-53.

Further, the industry did not expect the risk corridors program would be budget neutral, but rather that full risk corridors payments would be made. *See* American Action Forum ("AAF"), "The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment," January 9, 2015 (Reply App. A-1-12 at A-11) at 10 (HHS announcement it would operate risk corridors in budget neutral way "likely represented a significant departure from the health plans' expectations when they incorporated the impact of the risk corridors

program into premiums. Ultimately, HHS acknowledged through regulation that while it believes the program will be budget neutral, it recognizes the requirement ... to provide payment in-full to issuers....").

B. Count III.

With respect to Count III, the Government ignores that it is properly plead in the alternative to Count II. If Count II is not read to encompass an obligation to comply with the ACA and make full, timely risk corridors payments, but rather, as the Government posits, is limited to compliance with HHS electronic "systems and processes," then there is no express contract as to risk corridors and no such express contract precludes formation of an implied-in-fact contract. The QHP agreement is still relevant, however, because it indisputably shows Lincoln and HHS intended for Lincoln to be a QHP and for each to comply with all applicable requirements as to QHPs. In turn, it is at least implicit that HHS will provide to QHPs what that same law and those same regulations require. That includes, of course, full risk corridors payments.

Lincoln does not rely, as the Government argues, solely on the statute and regulations. It relies on both parties' course of conduct. Lincoln entered these consecutive, annual QHP agreements. It complied with all applicable QHP requirements. It provided coverage under the Federal Exchange, incurred risk and attendant costs, claims and losses. It submitted proper forms for risk corridors payments. HHS received and processed those for 2014, approved them and paid them pro rata, to the limits of its appropriations. It also repeatedly admits, as late as September 2016, long after this litigation was filed, that it is obligated to make full risk corridors payments regardless of appropriation amounts. There is a reasonable inference from these undisputed facts to support each required element for an implied contact-in-fact.

The Government's citations, once again, do not apply on their facts. In *Baker*, 50 Fed. Cl. 483 (Gov. Resp. 20), the putative plaintiff applied for a discretionary government FHA loan where specific terms had yet to be negotiated if the application were accepted. There was no money-mandating statute, as here, nor any consideration provided by the applicant, as here, where Lincoln undertook to insure 50,000 Illinois residents through the Federal Exchange.

In *National Railway*, 470 U.S. 451 (Gov. Resp. 20), the agency created a new non-government entity that contracted with the plaintiff, so no direct contract with the agency itself could be implied. Here, Lincoln interacted directly with HHS, not a third party non-government entity. The citation in Gov. Resp. 21 to *Hanlin*, 316 F.3d 1325 is distinguishable on the same basis.

The Gov. Resp. 21 again cites to *AAA Pharmacy*, 108 Fed. Cl. 321 and *ARRA Energy*, 97 Fed. Cl. 21. Lincoln distinguished those in its cross-motion, p. 38, because they do not address right to payment issues. They still do not apply on their substantive facts anyway. *AAA Pharmacy* involved revocation of a plaintiff provider's billing privileges under Medicare where the provider attempted to claim an implied contract the Government would follow Medicare Act procedures to terminate such privileges. Here, there is no dispute Lincoln was a qualified QHP or that it is entitled to risk corridors payments because it provided consideration. In *AAA Pharmacy*, there was no consideration for the proposed implied contract. Further, it did not involve a money-mandating statute requiring the agency "shall pay" and "shall establish" a risk corridors program.

ARRA Energy involved a plaintiff seeking a reimbursement grant under a statute where it bought energy equipment. It was a grant. There was no consideration; no *quid pro quo* to support an implied in-fact contract. Here, again, Lincoln provided ample consideration – it

insured 50,000 United States and Illinois citizens and incurred the attendant costs, risks and claims for doing so.[3]

Despite the overwhelming and undisputed evidence to the contrary, the Government argues Lincoln did not provide a *quid pro quo* for its participation on the exchange because "the United States did not receive anything in return" (Gov. Resp. 23) and because risk corridors payments "are not compensatory in nature." *Id.* Both statements are false. The Government shared risk with Lincoln through the risk corridors program. Lincoln took on health insurance risks for over 50,000 citizens. It could not reject enrollees. It could not limit coverage for those enrollees for pre-existing conditions. When the Government pays risk corridors it is reimbursing and thereby compensating Lincoln for some of the losses it incurred. Providing coverage to United States citizens at lowered premiums is consideration to the United States. The Government cites no plausible argument nor case holding it is not.

The Government in its Response, p. 23, fails to distinguish Lincoln's citations to *Radium Mines*, *Aycock-Lindsey*, or *New York Airways*. It attempts to invoke *National Railways*, 470 U.S. 465 and *Stanwyck*, 127 Fed. Cl. 1308 as later precedent overruling those cases. Those later cases do not even mention, much less overrule Lincoln's citations. *National Railway*, once again, involved a contract with a separate non-government entity and no money-mandating statute. In *Stanwyck*, the plaintiff tried to construe a bankruptcy regulation as creating a contractual right to attorneys' fees. It did not involve, as here, a money-mandating statute.

The Government's "absence of authority" and Anti-Deficiency Act arguments in its Response, pp. 25-27, were raised in its motion to dismiss. They have no factual or legal basis here as shown in Lincoln's Response and Cross Motion, pp. 41-43. *See also, Salazar*, 132 S.Ct.

[3] It should be noted, however, that *ARRA Energy* rejected the Government's jurisdiction argument advanced here finding an obligation to pay under the statute satisfied the necessary jurisdictional basis under the Tucker Act. 97 Fed. Cl. 38.

2193 (Anti-Deficiency Act does not affect rights of citizens honestly contracting with the Government; appropriations act as limits upon a Government's agent but an insufficiency does not pay the Government's debts nor cancel its obligations).

The undisputed Administrative Record shows Lincoln had express or implied annual agreements with HHS for calendar years 2014, 2015 and 2016, and the statute authorized HHS—indeed directed it—to have risk corridors programs for each of those calendar years. Moreover, appropriations were authorized for each of those years (though not enough). The Government's Anti-Deficiency Act argument is specious.

C. Count IV.

Lincoln's Count IV was plead in the alternative to Counts II and III. Even if there is no express or implied-in-fact contract to timely pay full risk corridors payments, under the undisputed course of conduct between the parties, as evidenced by the Administrative Record, Lincoln reasonably expected to be paid full risk corridors payments and HHS has not paid.

The Government baited Lincoln (and the other QHPs) into complying with the QHP program, entering the Exchange and incurring billions of dollars of losses, but then refused to make required full risk corridors payments. *See, e.g., Precision Pine & Timber, Inc. v. United States*, 596 F.3d 817, 829 (Fed. Cir. 2010) (implied covenant cases "typically involve some variation on the old bait and switch. First, the government enters into a contract that awards a significant benefit in exchange for consideration. Then, the government eliminates or rescinds that contractual provision or benefit through a subsequent action directed at the existing contract."); and *Barsebak Kraft AB v. United States*, 36 Fed. Cl. 691, 706 (1996) (implied covenant "limits the manner in which a party who is vested with discretion under the contract may exercise it by requiring that party to exercise that discretion reasonably and with proper

motive ... [not in] a manner inconsistent with the reasonable expectations of the parties."). As in the cases cited in *Precision Pine*, Congress targeted risk corridors obligations specifically in its later appropriations acts. This violated the Government's existing obligations to fully pay risk corridors and was illegal and unconstitutional.

D. Count V.

Finally, as to Count V, Lincoln is not seeking an entitlement or benefit. It seeks a vested property right to risk corridors payments it earned by complying with a statute that mandates such payments, for which it insured over 50,000 United States citizens, thereby incurring tens of millions of dollars of health insurance costs, risks and losses. In that circumstance, which is not addressed in the Government's cited cases, Lincoln respectfully submits it has a legally recognized property interest that the Government is taking without compensation.

CONCLUSION

Justice delayed is justice denied. The Government continues to do everything in its power to delay and avoid payment under a clear, money-mandating statute. The Government should stop this charade and apply the law so Lincoln can be made whole and avoid the ongoing, pernicious effects the Government's refusal to pay is having on the State of Illinois, its other health insurers, health providers and citizens.[4]

Judgment on the Administrative Record should be entered for Lincoln against the United States for $75,758,669.48 and for its risk corridors payment for 2016 in the amount finally determined in 2017 on Count I and alternatively on Counts II, III, IV and V.

[4] *See* Plaintiff's Response to Defendant's Motion to Strike, Doc. 34, pp. 4-5. If the Lincoln estate does not get its full risk corridors payments, the State of Illinois will have to pass a projected $50-75 million shortfall on to other Illinois health insurers (resulting in further increases in Illinois health insurance premiums to Illinois citizens) and onto health providers and individual Illinois insureds.

Dated: November 2, 2016

Respectfully submitted,

s/ Daniel P. Albers

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that on this 2nd day of November 2016, a copy of the foregoing Plaintiff's Reply in Support of Cross-Motion for Judgment on the Administrative Record on Counts II-V with attached Appendix was filed electronically through the Court's Electronic Case Filing (ECF) system. As I understand, pursuant to RCFC Appendix E, V.12.(c), the Court's Notice of Electronic Filing satisfies the service requirement of RCFC 5 and the proof of service requirement of RCFC 5.3 via operation of the Court's ECF system.

s/ Daniel P. Albers

Daniel P. Albers

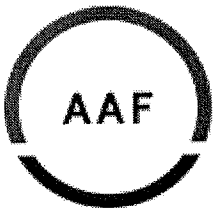
IN THE UNITED STATES COURT OF FEDERAL CLAIMS

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 16-744C Judge Charles F. Lettow

APPENDIX TO
PLAINTIFF'S REPLY IN SUPPORT OF CROSS-MOTION
FOR JUDGMENT ON THE ADMINISTRATIVE RECORD ON COUNTS II-V

Appendix 1	A-1-12	American Action Forum (AAF), "The ACA's Risk Spreading Mechanisms: A Primer On Reinsurance, Risk Corridors and Risk Adjustment", January 9, 2015
Appendix 2	A-13-14	Senate Rule XVI – Appropriations and Amendments to General Appropriations Bills
Appendix 3	A-15-17	Rules of the House of Representatives, Rule XXI 2(b), General Appropriations Bills and Amendments
Appendix 4	A-18-42	Congressional Research Service (CRS), Report R43289, February 5, 2016, "Legislative Actions to Repeal, Defend, or Delay the Affordable Care Act"
Appendix 5	A-43-65	CRS Report 44100, October 7, 2016, "Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act"
Appendix 6	A-66-68	Senate Bill 359, February 4, 2015
Appendix 7	A-69-71	House Bill H.R. 724, February 4, 2015
Appendix 8	A72-75	Congressional Research Service (CRS) Memorandum to House Energy and Commerce Committee, January 23, 2014, "Funding of Risk Corridor Payments Under ACA § 1342"

APPENDIX 1



Research

The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment

BRITTANY LA COUTURE, ANGELA BOOTH | JANUARY 9, 2015

BACKGROUND

The 2010 Affordable Care Act (ACA) health reform law established state-based health insurance exchanges to provide an individual market for qualified health insurance plans. The state exchanges sell insurance plans to any citizen, regardless of health status. Enrollees who purchase plans through an exchange can receive federal premium subsidies if their household income falls between 100 and 400 percent of the federal poverty level. This primer provides an overview of the ACA's risk mitigation provisions that apply to individual and/or small group market plans: reinsurance, risk corridors, and risk adjustment.

While the exchanges are implemented and administered by either the state or the federal government, the qualified health plans offered are sold by private insurance companies and designed to be in compliance with the ACA regulations. For insurers, offering a plan on the exchange is very different than offering a plan on the pre-ACA individual market or to a group purchaser such as a large company. For one, the issuer offering their first exchange plan in 2014 had no way of knowing the health status or previous claims history of the applicants; some exchange enrollees may have been uninsured for many years and have a long list of unmet medical needs. Secondly, the applicant must be charged the same premium as everyone else in their age band, and the oldest applicants cannot be charged more than three times the rate of the youngest. And finally, insurance companies are selling a new insurance product, with newly mandated benefits, and limits on cost-sharing, but they have no control

over how many, or how few, individuals enroll.

Issuers priced their products according to their best projections. However, for the reasons listed above, uncertainty about risk pools is larger than for a mature market. In order to improve the incentives for insurers to participate, the ACA includes three risk spreading mechanisms: temporary reinsurance, temporary risk corridors, and permanent risk adjustment, all of which address potential risk pool issues by limiting the amount an insurance company can lose by participating in the marketplace. Risk adjustment is designed to spread risk among plans to prevent adverse selection, reinsurance helps plans with individuals who have unexpectedly high medical costs, and risk corridors protect both health plans and the federal government against uncertainty in pricing during the initial years of the ACA's market reforms. These mechanisms allow insurance companies to price their products more competitively, as any significant losses will be partially offset.

REINSURANCE

Reinsurance provides a safeguard against individuals with high medical costs – known as "high risk" – during the first three years of the ACA's insurance market reforms (2014-2016). All ACA-compliant, non-grandfathered plans on the individual market, both inside and outside the exchanges are eligible for reinsurance payments.[1] The legislative language left the determination of a high risk individual vague, noting that it could be based on diagnoses or another method. Through regulation, the Department of Health and Human Services (HHS) has determined that a high risk determination will be based on the cost of actual medical claims. For 2014, a health plan becomes eligible for reinsurance payments when an enrollee reaches medical costs of $45,000 (the so-called "attachment point") which was adjusted downward from the previous proposed regulation of $60,000.[2] The reinsurance attachment point for 2015 is $70,000.[3] Reinsurance payments stop when an individual's medical claims reach a cap, which is $250,000 in 2014 and 2015. The federal government will reimburse the plan for at least 80 percent of the claims cost between the attachment point and the cap in 2014, and 50 percent for claims in 2015.[4] For example, if an enrollee incurred $300,000 in medical claims during the 2014, the health plan would be responsible for the first $45,000, the reinsurance program would reimburse the plan at least $164,000 (80 percent of the amount between the attachment point and the cap), and the health plan would be pay the $50,000

above the cap.

Reinsurance programs can be implemented by each state, using a non-profit entity to collect and distribute reinsurance funds. Or, states can defer implementation to the federal government. In 2014, only Maryland and Connecticut elected to operate their own reinsurance programs.[5]

The reinsurance program is funded through fees levied on all health insurance plans, including self-insured plans that use a third-party administrator for core health care services. A rule finalized in early 2014 exempted self-insured, self-administered plans from paying the fee in 2015 and 2016.[6] The reinsurance fee is statutorily required to equal a specific amount for reinsurance payments, a specific amount paid to the U.S. Treasury, and a variable amount for administrative expenses. Each insurer's portion is calculated based on their enrollment. The funds available for reinsurance payments will total $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016; additional payments to the U.S. Treasury will be $2 billion in 2014 and 2015 and drop to $1 billion in 2016. This translates to $63 per person for the 2014 benefit year, [7] $44 per person for 2015, and $27 per person in 2016. The Center for Medicare and Medicaid Services (CMS) estimates[8] that these contribution amounts will be sufficient to collect the statutorily-required amounts for 2014 and 2015.

A CMS regulatory impact analysis estimated that the reinsurance protection allowed insurers to price their premiums 10-15 percent lower in 2014 than what prices would have been otherwise.[9]

Table 1: Reinsurance Program Funds Collected 2014-2016

Year	Reinsurance Payments	Payments to the US Treasury	Administrative Expenses	Per-Enrollee Cost Levied on Each Insurer*
2014	$10 Billion	$2 Billion	Variable	$63/ per person (HHS Estimate)

2015	$6 Billion	$2 Billion	Variable	$44/ per person (HHS Estimate)
2016	$4 Billion	$1 Billion	Variable	$27 2016 Notice of Proposed Payment Parameters[10]

*Note: All self-insured plans would contribute in 2014; the latest proposed rule exempts self-insured, self-administered plans from the reinsurance fee in 2015 and 2016.

RISK CORRIDORS

The risk corridors program is a temporary program from 2014-2016 protecting against pricing uncertainty by sharing gains and losses between plans and the federal government. The risk corridors program applies only to qualified health plans (QHPs) in the individual and small group markets. This program requires each plan issuer to calculate, for each QHP[‡], their allowable costs as well as a target amount. Allowable costs include claims and money spent on quality improvement, and the target costs include premiums collected minus a limited percentage of administrative costs.

$$Allowable\ Costs = Medical\ Claims + Quality\ Improvement\ Costs$$

$$Target = Premiums\ Collected - Administrative\ Costs$$

$$Risk\ Corridor\ Ratio = \frac{Allowable\ Costs}{Target}$$

If an insurer's risk corridors ratio is below 97 percent, the insurance issuer presumably made a profit on that plan, and must share a portion of that profit with HHS. If the costs are above 103 percent of the target amount, the insurance issuer presumably took a loss on the plan, and HHS will cover some of that loss. When a plan's costs are 92-97 percent, or 103-108 percent of the allowable amount 50 percent of the plan's gain or loss is shared with HHS. If the costs are below 92 percent of above 108 percent, 20 percent of that gain or loss is shared. For 2015, these parameters will be shifted by two percentage points, increasing the ceiling payments and raising the floor on profits.[11]

Because the target costs and allowable costs are calculated via a specific formula, with caps on the administrative expenses, the risk corridor calculation is not necessarily reflective of the plan's true profit or loss; a ratio of 100 percent does not mean the plan broke even.

RISK ADJUSTMENT

The risk adjustment provision in the ACA applies to ACA-compliant plans in both the individual and small group insurance markets (both on and off the exchanges), but unlike the previously described two mechanisms, will be permanent. The risk adjustment program will be operated by the federal government, or by states operating their own exchange, if they so choose. States that are operating their own risk adjustment program must use the federal methodology or develop an alternate methodology that is approved by HHS. [12]

Under the risk adjustment program, HHS or the exchanges will assess the actuarial risk of the insurance pool within each plan and compare it to the average actuarial risk of all plans in the state, including the large group plans. Plans that have an enrolled population with lower than average actuarial risk will make payments to those plans that have enrolled individuals with higher than average actuarial risk. However, it is important to note this is the only one of these three risk mitigation strategies that is determined by enrollee projections. The risk adjustment program only transfers funds between eligible plans, which will net to zero within a market, within a state.

Table 2: Overview of the Reinsurance, Risk Corridors and Risk Adjustment Provisions

Program, and Statutory Authority	Operated by	Administered	Time Span	Costs Involved	Plans Participating	Protects Against

Reinsurance, PPACA Section 1341	State or Federal Government	Third Party entity, required to be a non-profit.	2014-2016	2014: $10 billion ($12b including admin costs) 2015: $6 billion ($8b including admin costs) 2016: $4 billion ($5b including admin costs)	Issuers of major medical coverage make reinsurance payments, ACA-compliant plans in the individual market (inside and outside of the exchanges) are eligible to receive reinsurance payments	Individuals with high medical claims costs

Risk Corridors, PPACA Section 1342	Federal Government	Secretary of HHS	2014-2016	TBD	Qualified health plans in the individual and small group markets	Uncertainty in rate setting and costs associated with pricing for a new risk pool
Risk Adjustment, PPACA Section 1343	States who established exchanges, Federal exchange	States who established exchanges, Federal runs the others (methods for all developed by HHS Secretary)	2014 and beyond	Plan transfers net to zero within a market, within a state	Qualified health plans in the individual and small group markets	Adverse selection among Qualified Health Plans

BUDGETARY IMPACT

According to their latest estimate, the Congressional Budget Office (CBO) projects these provisions to be budget neutral.[13] Despite CBO projections, there is a concern that more plans may need payment from the risk mitigation provisions and, as a result, the amount paid out to plans will exceed the amount paid into the programs. Furthering this concern, the administration's decision to allow reinstatement of 2013 plans – plans that would have otherwise been cancelled – may limit the number of healthy people signing up on the exchanges and make the new exchange pools disproportionately sicker. Since health plans set

premiums based on assumptions about who will enroll, the transitional policy could have major impacts on the risk mitigation programs.

In addition, it is worth noting that the provisions keeping premiums lower will also reduce federal spending on the exchange subsidies. In the absence of the risk mechanisms, higher health insurance premiums would result in more households qualifying for subsidies and increased cost for those who are subsidized. So while it is possible that payments may need to come from general revenue to make up any funding deficits, repealing these provisions is unlikely to be budget neutral.

Risk Corridors

While the risk adjustment and reinsurance programs are funded by transfers between health plans, the risk corridors program has no similar funding mechanism. Since risk is shared between health plans and the federal government, the risk corridors program could ultimately represent a net gain or a net loss to the federal government. According to a CBO analysis of the ACA, the risk corridor collections will equal payments, and the risk adjustment and reinsurance collections and payments will be equal as well. However, reinsurance and risk adjustment payments will be made prior to all collections received, and thus the outlays are $1 billion more than receipts in the 2014-2016 budget window.[14]

HHS signaled in early 2014—after premiums for the 2014 benefit year had already been set—that they were planning to operate the risk corridors program in a budget neutral way.[15] In other words, that the risk corridors formula would be adjusted so that it required payments to health plans with risk corridors ratios above 103 percent to equal payments from plans with risk corridors below 97 percent. This likely represented a significant departure from the health plans expectations when they incorporated the impact of the risk corridors program into premiums. Ultimately, HHS acknowledged through regulation that while it believes the program will be budget neutral, it recognizes the requirement of the ACA to make payments to those issuers with risk corridors ratios above 103 percent. HHS indicated in final regulation that the ACA requires HHS to provide payments in-full to issuers, and the final rule states that the agency will provide other sources of funding if the program's funds are insufficient – according to "the availability of appropriations".[16]

More recently, however, the 2015 Cromnibus bill, which narrowly passed both houses of Congress, denied any additional appropriations or transfers to fund risk corridors, and instead limited risk corridor payments to money available through the program's revolving fund.[17]

HISTORY OF RISK-MITIGATION PROVISIONS

The ACA's exchanges are not the first federal entitlement program to use risk-spreading mechanisms to protect participating health insurance issuers. When the Medicare Part D drug benefit launched in 2006 participating insurers were pricing plans with a high degree of uncertainty. Similar to the exchange environment, plans did not know who would enroll and what their prescription drug needs would be. Part D features three risk mitigation programs that were the model for those included in the ACA: a permanent risk corridors program where CMS shares in gains or losses with Part D plans, a risk adjustment program where the subsidies paid to plans are adjusted based on patient characteristics, and a permanent form of reinsurance that protects Part D sponsors from unexpectedly high prescription drug costs.[18]

Other programs like Medicaid Managed Care and Medicare Advantage also use risk adjustment to determine payments from the entitlement program to the private insurance plans, but these calculations are based on the risk projections of the population, rather than

actual claims information.

CONCLUSION

The ACA brings a tremendous amount of uncertainty to the private insurance market. The risk spreading provisions were designed to stabilize the individual and small group market and allow companies to compete on the exchanges without excessive risk during the initial years of implementation. Certainly entering the new market is not without risk; the reinsurance and risk corridors only partially reimburse plans for their costs above specific points. In 2015, health policy researchers will better understand budgetary impacts and whether taxpayer funded general revenue was needed to make up excessive losses sustained by the insurers in the first year of exchange implementation.

* An earlier version of this Primer was written by Emily Egan, formerly AAF Senior Health Policy Analyst.

[‡] The Robert Wood Johnson Foundation's "Analysis of HHS Final Rules On Reinsurance, Risk Corridors And Risk Adjustment." Released April, 2012 specifies that risk corridors will be calculated on a plan-specific level rather than looking at the insurer's entire book of business in each state. (http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72568). The Health Affairs Blog also notes that it will be done at the plan benefit level (http://healthaffairs.org/blog/2012/03/16/implementing-health-reform-the-reinsurnace-risk-adjustment-and-risk-corridor-final-rule/). However, CMS documents use plan and insurance issuer interchangeably when referring to risk corridor calculations. (http://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf)

APPENDIX 2

5. It shall not be in order to consider any proposed committee amendment (other than a technical, clerical, or conforming amendment) which contains any significant matter not within the jurisdiction of the committee proposing such amendment.

RULE XVI

APPROPRIATIONS AND AMENDMENTS TO GENERAL APPROPRIATIONS BILLS

1. On a point of order made by any Senator, no amendments shall be received to any general appropriation bill the effect of which will be to increase an appropriation already contained in the bill, or to add a new item of appropriation, unless it be made to carry out the provisions of some existing law, or treaty stipulation, or act or resolution previously passed by the Senate during that session; or unless the same be moved by direction of the Committee on Appropriations or of a committee of the Senate having legislative jurisdiction of the subject matter, or proposed in pursuance of an estimate submitted in accordance with law.

2. The Committee on Appropriations shall not report an appropriation bill containing amendments to such bill proposing new or general legislation or any restriction on the expenditure of the funds appropriated which proposes a limitation not authorized by law if such restriction is to take effect or cease to be effective upon the happening of a contingency, and if an appropriation bill is reported to the Senate containing amendments to such bill proposing new or general legislation or any such restriction, a point of order may be made against the bill, and if the point is sustained, the bill shall be recommitted to the Committee on Appropriations.

3. All amendments to general appropriation bills moved by direction of a committee having legislative jurisdiction of the subject matter proposing to increase an appropriation already contained in the bill, or to add new items of appropriation, shall, at least one day before they are considered, be referred to the Committee on Appropriations, and when actually proposed to the bill no amendment proposing to increase the amount stated in such amendment shall be received on a point of order made by any Senator.

4. On a point of order made by any Senator, no amendment offered by any other Senator which proposes general legislation shall be received to any general appropriation bill, nor shall any amendment not germane or relevant to the subject matter contained in the bill be received; nor shall any amendment to any item or clause of such bill be received which does not directly relate thereto; nor shall any restriction on the expenditure of the funds appropriated which proposes a limitation not authorized by law be received if such restriction is to take effect or cease to be effective upon the happening of a contingency; and all questions of relevancy of amendments under this rule, when raised, shall be submitted to the Senate and be decided without debate; and any such amendment or restriction to a general appropriation bill may be laid on the table without prejudice to the bill.

5. On a point of order made by any Senator, no amendment, the object of which is to provide for a private claim, shall be received to any general appropriation bill, unless it be to carry out the pro-

APPENDIX 3

the adjustment to the House. Such an announcement shall not be subject to appeal. In the case of a death, the Speaker may lay before the House such documentation from Federal, State, or local officials as the Speaker deems pertinent.

6. (a) When a quorum fails to vote on a question, a quorum is not present, and objection is made for that cause (unless the House shall adjourn)—

(1) there shall be a call of the House;

(2) the Sergeant-at-Arms shall proceed forthwith to bring in absent Members; and

(3) the yeas and nays on the pending question shall at the same time be considered as ordered.

(b) The Clerk shall record Members by the yeas and nays on the pending question, using such procedure as the Speaker may invoke under clause 2, 3, or 4. Each Member arrested under this clause shall be brought by the Sergeant-at-Arms before the House, whereupon the Member shall be noted as present, discharged from arrest, and given an opportunity to vote; and such vote shall be recorded. If those voting on the question and those who are present and decline to vote together make a majority of the House, the Speaker shall declare that a quorum is constituted, and the pending question shall be decided as the requisite majority of those voting shall have determined. Thereupon further proceedings under the call shall be considered as dispensed with.

(c) At any time after Members have had the requisite opportunity to respond by the yeas and nays ordered under this clause, but before a result has been announced, a motion that the House adjourn shall be in order if seconded by a majority of those present, to be ascertained by actual count by the Speaker. If the House adjourns on such a motion, all proceedings under this clause shall be considered as vacated.

7. (a) The Speaker may not entertain a point of order that a quorum is not present unless a question has been put to a vote.

(b) Subject to paragraph (c) the Speaker may recognize a Member, Delegate, or Resident Commissioner to move a call of the House at any time. When a quorum is established pursuant to a call of the House, further proceedings under the call shall be considered as dispensed with unless the Speaker recognizes for a motion to compel attendance of Members under clause 5(b).

(c) A call of the House shall not be in order after the previous question is ordered unless the Speaker determines by actual count that a quorum is not present.

Postponement of proceedings

8. (a)(1) When a recorded vote is ordered, or the yeas and nays are ordered, or a vote is objected to under clause 6—

(A) on any of the questions specified in subparagraph (2), the Speaker may postpone further proceedings to a designated place in the legislative schedule within two additional legislative days; and

(B) on the question of agreeing to the Speaker's approval of the Journal, the Speaker may postpone further proceedings to a designated place in the legislative schedule on that legislative day.

(2) The questions described in subparagraph (1) are as follows:

(A) The question of passing a bill or joint resolution.

(B) The question of adopting a resolution or concurrent resolution.

(C) The question of agreeing to a motion to instruct managers on the part of the House (except that proceedings may not resume on such a motion under clause 7(c) of rule XXII if the managers have filed a report in the House).

(D) The question of agreeing to a conference report.

(E) The question of ordering the previous question on a question described in subdivision (A), (B), (C), or (D).

(F) The question of agreeing to a motion to suspend the rules.

(G) The question of agreeing to a motion to reconsider or the question of agreeing to a motion to lay on the table a motion to reconsider.

(H) The question of agreeing to an amendment reported from the Committee of the Whole.

(b) At the time designated by the Speaker for further proceedings on questions postponed under paragraph (a), the Speaker shall resume proceedings on each postponed question.

(c) The Speaker may reduce to five minutes the minimum time for electronic voting on a question postponed under this clause, or on a question incidental thereto, that—

(1) follows another electronic vote without intervening business, so long as the minimum time for electronic voting on the first in any series of questions is 15 minutes; or

(2) follows a report from the Committee of the Whole without intervening debate or motion if in the discretion of the Speaker Members would be afforded an adequate opportunity to vote.

(d) If the House adjourns on a legislative day designated for further proceedings on questions postponed under this clause without disposing of such questions, then on the next legislative day the unfinished business is the disposition of such questions.

Five-minute votes

9. The Speaker may reduce to five minutes the minimum time for electronic voting—

(a) on any question arising without intervening business after an electronic vote on another question if notice of possible five-minute voting for a given series of votes was issued before the preceding electronic vote;

(b) on any question arising after a report from the Committee of the Whole without debate or intervening motion; or

(c) on the question of adoption of a motion to recommit (or ordering the previous question thereon) arising without intervening motion or debate other than debate on the motion.

Automatic yeas and nays

10. The yeas and nays shall be considered as ordered when the Speaker puts the question on passage of a bill or joint resolution, or on adoption of a conference report, making general appropriations, or increasing Federal income tax rates (within the meaning of clause 5 of rule XXI), or on final adoption of a concurrent resolution on the budget or conference report thereon.

Ballot votes

11. In a case of ballot for election, a majority of the votes shall be necessary to an election. When there is not such a majority on the first ballot, the process shall be repeated until a majority is obtained. In all balloting blanks shall be rejected, may not be counted in the enumeration of votes, and may not be reported by the tellers.

RULE XXI

RESTRICTIONS ON CERTAIN BILLS

Reservation of certain points of order

1. At the time a general appropriation bill is reported, all points of order against provisions therein shall be considered as reserved.

General appropriation bills and amendments

2. (a)(1) An appropriation may not be reported in a general appropriation bill, and may not be in order as an amendment thereto, for an expenditure not previously authorized by law, except to continue appropriations for public works and objects that are already in progress.

(2) A reappropriation of unexpended balances of appropriations may not be reported in a general appropriation bill, and may not be in order as an amendment thereto, except to continue appropriations for public works and objects that are already in progress. This subparagraph does not apply to transfers of unexpended balances within the department or agency for which they were originally appropriated that are reported by the Committee on Appropriations.

(b) A provision changing existing law may not be reported in a general appropriation bill, including a provision making the availability of funds contingent on the receipt or possession of information not required by existing law for the period of the appropriation, except germane provisions that retrench expenditures by the reduction of amounts of money covered by the bill (which may include those recommended to the Committee on Appro-

priations by direction of a legislative committee having jurisdiction over the subject matter) and except rescissions of appropriations contained in appropriation Acts.

(c) An amendment to a general appropriation bill shall not be in order if changing existing law, including an amendment making the availability of funds contingent on the receipt or possession of information not required by existing law for the period of the appropriation. Except as provided in paragraph (d), an amendment proposing a limitation not specifically contained or authorized in existing law for the period of the limitation shall not be in order during consideration of a general appropriation bill.

(d) After a general appropriation bill has been read for amendment, a motion that the Committee of the Whole House on the state of the Union rise and report the bill to the House with such amendments as may have been adopted shall, if offered by the Majority Leader or a designee, have precedence over motions to amend the bill. If such a motion to rise and report is rejected or not offered, amendments proposing limitations not specifically contained or authorized in existing law for the period of the limitation or proposing germane amendments that retrench expenditures by reductions of amounts of money covered by the bill may be considered.

(e) A provision other than an appropriation designated an emergency under section 251(b)(2) or section 252(e) of the Balanced Budget and Emergency Deficit Control Act, a rescission of budget authority, or a reduction in direct spending or an amount for a designated emergency may not be reported in an appropriation bill or joint resolution containing an emergency designation under section 251(b)(2) or section 252(e) of such Act and may not be in order as an amendment thereto.

(f) During the reading of an appropriation bill for amendment in the Committee of the Whole House on the state of the Union, it shall be in order to consider en bloc amendments proposing only to transfer appropriations among objects in the bill without increasing the levels of budget authority or outlays in the bill. When considered en bloc under this paragraph, such amendments may amend portions of the bill not yet read for amendment (following disposition of any points of order against such portions) and are not subject to a demand for division of the question in the House or in the Committee of the Whole.

3. It shall not be in order to consider a general appropriation bill or joint resolution, or conference report thereon, that—

(a) provides spending authority derived from receipts deposited in the Highway Trust Fund (excluding any transfers from the General Fund of the Treasury); or

(b) reduces or otherwise limits the accruing balances of the Highway Trust Fund,

for any purpose other than for those activities authorized for the highway or mass transit categories.

Appropriations on legislative bills

4. A bill or joint resolution carrying an appropriation may not be reported by a committee not having jurisdiction to report appropriations, and an amendment proposing an appropriation shall not be in order during the consideration of a bill or joint resolution reported by a committee not having that jurisdiction. A point of order against an appropriation in such a bill, joint resolution, or amendment thereto may be raised at any time during pendency of that measure for amendment.

Tax and tariff measures and amendments

5. (a)(1) A bill or joint resolution carrying a tax or tariff measure may not be reported by a committee not having jurisdiction to report tax or tariff measures, and an amendment in the House or proposed by the Senate carrying a tax or tariff measure shall not be in order during the consideration of a bill or joint resolution reported by a committee not having that jurisdiction. A point of order against a tax or tariff measure in such a bill, joint resolution, or amendment thereto may be raised at any time during pendency of that measure for amendment.

(2) For purposes of paragraph (1), a tax or tariff measure includes an amendment proposing a limitation on funds in a general appropriation bill for the administration of a tax or tariff.

Passage of tax rate increases

(b) A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present. In this paragraph the term "Federal income tax rate increase" means any amendment to subsection (a), (b), (c), (d), or (e) of section 1, or to section 11(b) or 55(b), of the Internal Revenue Code of 1986, that imposes a new percentage as a rate of tax and thereby increases the amount of tax imposed by any such section.

Consideration of retroactive tax rate increases

(c) It shall not be in order to consider a bill, joint resolution, amendment, or conference report carrying a retroactive Federal income tax rate increase. In this paragraph—

(1) the term "Federal income tax rate increase" means any amendment to subsection (a), (b), (c), (d), or (e) of section 1, or to section 11(b) or 55(b), of the Internal Revenue Code of 1986, that imposes a new percentage as a rate of tax and thereby increases the amount of tax imposed by any such section; and

(2) a Federal income tax rate increase is retroactive if it applies to a period beginning before the enactment of the provision.

Designation of public works

6. It shall not be in order to consider a bill, joint resolution, amendment, or conference report that provides for the designation or redesignation of a public work in honor of an individual then serving as a Member, Delegate, Resident Commissioner, or Senator.

7. It shall not be in order to consider a concurrent resolution on the budget, or an amendment thereto, or a conference report thereon that contains reconciliation directives under section 310 of the Congressional Budget Act of 1974 that specify changes in law such that the reconciliation legislation reported pursuant to such directives would cause an increase in net direct spending (as such term is defined in clause 10) for the period covered by such concurrent resolution.

8. With respect to measures considered pursuant to a special order of business, points of order under title III of the Congressional Budget Act of 1974 shall operate without regard to whether the measure concerned has been reported from committee. Such points of order shall operate with respect to (as the case may be)—

(a) the form of a measure recommended by the reporting committee where the statute uses the term "as reported" (in the case of a measure that has been so reported);

(b) the form of the measure made in order as an original bill or joint resolution for the purpose of amendment; or

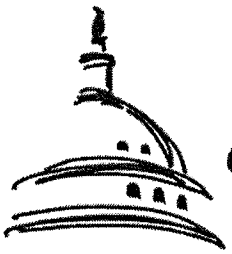
(c) the form of the measure on which the previous question is ordered directly to passage.

9. (a) It shall not be in order to consider—

(1) a bill or joint resolution reported by a committee unless the report includes a list of congressional earmarks, limited tax benefits, and limited tariff benefits in the bill or in the report (and the name of any Member, Delegate, or Resident Commissioner who submitted a request to the committee for each respective item included in such list) or a statement that the proposition contains no congressional earmarks, limited tax benefits, or limited tariff benefits;

(2) a bill or joint resolution not reported by a committee unless the chair of each committee of initial referral has caused a list of congressional earmarks, limited tax benefits, and limited tariff benefits in the bill (and the name of any Member, Delegate, or Resident Commissioner who submitted a request to the committee for each respective item included in such list) or a statement that the proposition contains no congressional earmarks, limited tax benefits, or limited tariff benefits to be

APPENDIX 4



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

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CRS REPORT
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Committees of Congress

Summary

Congress remains deeply divided over implementation of the Patient Protection and Affordable Care Act (ACA), the health reform law enacted in March 2010. 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.

Much of this legislative activity has taken place in the House, which reverted to Republican control in 2011. The Republican-led House has passed numerous ACA-related bills, including legislation that would repeal the entire law. There has been less debate in the Senate, which remained under Democratic control through 2014. Most of the House-passed ACA legislation has not been considered in the Senate. 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.

The House-passed legislation includes stand-alone bills as well as provisions in broader, often unrelated measures that would (1) repeal the ACA in its entirety and, in some cases, replace it with new law; (2) repeal, or by amendment restrict or otherwise limit, specific provisions in the ACA; (3) eliminate appropriations provided by the ACA and rescind all unobligated funds; (4) replace the ACA's mandatory appropriations with authorizations of (discretionary) appropriations, and rescind all unobligated funds; or (5) block or otherwise delay implementation of specific ACA provisions.

Republican leaders also have used a special legislative process known as budget reconciliation in an effort to repeal parts of the ACA. On October 23, 2015, the House passed a reconciliation bill that would repeal several provisions of the ACA. The House-passed bill (H.R. 3762) was taken up by the Senate, which substituted its own more extensive set of ACA repeal provisions. The Senate approved H.R. 3762, as amended, on December 3, 2015. The House subsequently approved the Senate-passed bill. President Obama vetoed H.R. 3762 on January 8, 2016. The House failed to override the veto.

A few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support have been approved by both the House and the Senate and signed into law. During the 111th Congress, a number of clarifications and technical adjustments to the ACA were enacted. Since then, several more substantive ACA amendments have become 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 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 annual appropriation to the Prevention and Public Health Fund over the period FY2013-FY2021 by a total of $6.25 billion.

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. A companion report, CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2016)*, summarizes the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law.

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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.

Much of this legislative activity has taken place in the House, which reverted to Republican control in 2011. The Republican-led House has passed numerous ACA-related bills, including legislation that would repeal the entire law. There has been less debate in the Senate, which remained under Democratic control through 2014. Most of the House-passed ACA legislation has not been considered in the Senate. However, a few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support have been 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 Obama legislation that would change the law.

Republican leaders also have used a special legislative process known as budget reconciliation in an effort to repeal parts of the ACA. Pursuant to the Congressional Budget Act (Budget Act), budget reconciliation allows Congress to use expedited procedures when considering legislation that would bring existing spending, revenue, and debt limit laws into compliance with the fiscal priorities set out in the annual budget resolution. Using the reconciliation process to try and dismantle the ACA appeals to opponents of the law because reconciliation bills are not subject to filibuster and can be passed with a simple majority vote in the Senate.

On October 23, 2015, the House passed a reconciliation bill (H.R. 3762) containing provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and Workforce—pursuant to reconciliation instructions included in the FY2016 budget resolution. This bill would have repealed several provisions of the ACA, among other things.[2]

The House-passed bill was taken up by the Senate, which substituted its own more extensive set of ACA repeal provisions. These provisions were submitted by the Finance Committee and the Health, Education, Labor, and Pensions (HELP) Committee in accordance with the instructions in the budget resolution. The Senate approved H.R. 3762, as amended, on December 3, 2015.[3] The House approved the Senate-passed bill on January 6, 2016, and the measure was sent to President Obama. On January 8, 2016, the President vetoed H.R. 3762. The House failed to override the veto in a vote taken on February 2, 2016.

This report summarizes legislative actions taken to repeal, defund, delay, or otherwise amend the ACA since it was enacted. The information is presented in three tables. **Table 1** summarizes the ACA changes that have been signed into law. **Table 2** lists all the House-passed ACA bills. **Table 3** summarizes the ACA provisions in the vetoed reconciliation bill. While a detailed examination

[1] The ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029). HCERA included several new health reform provisions and amended numerous provisions in the ACA. Several subsequently enacted bills made additional changes to selected ACA provisions. All references to the ACA in this report refer collectively to the law and to the changes made by HCERA and subsequent legislation.

[2] For more information, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

[3] For more information, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*, coordinated by Annie L. Mach.

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 as context for the material presented in the tables.[4] This report is updated periodically to reflect legislative and other developments.

In addition to considering ACA repeal or amendment in authorizing legislation, lawmakers have used the annual appropriations process in an effort to eliminate funding for ACA implementation and address other concerns they have with the law. A companion report, CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2016)*, summarizes the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law.

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.

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 exchanges (also known as marketplaces) 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 no more 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.

In June 2015, the U.S. Supreme Court in *King v. Burwell* ruled that the premium tax credits are available to all qualified individuals who enroll in exchange plans and meet the necessary income and other requirements, regardless of whether the exchange is administered by the state or the federal government.[5]

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's

[4] 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.

[5] *King v. Burwell*, No. 14-114 slip op. (June 25, 2015), http://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf.

"employer mandate" requires 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.[6] 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 the federal spending on exchange subsidies and Medicaid expansion.

ACA's 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.[7] 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.[8] *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.[9]

Federal spending on ACA implementation can be grouped into three categories: (1) mandatory spending on expanding insurance coverage, (2) mandatory spending on other programs, and (3) discretionary spending. Each of these categories is briefly discussed below.

[6] *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.

[7] 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.

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

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

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) and the Joint Committee on Taxation (JCT) projected that this and other ACA mandatory spending (discussed in the second category, below) would be more than 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.[10]

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.[11] 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 (CMMI), within the Centers for Medicare & Medicaid Services (CMS), to test and implement innovative health care payment and service delivery models.

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) for the federal health centers program and the National Health Service Corps.[12] 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 supporting 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 pay for 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.

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[10] U.S. Congressional Budget Office, letter to the Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, providing an estimate of the direct spending and revenue effects of ACA, as amended by HCERA (March 20, 2010), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

[11] 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.

[12] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10, 129 Stat. 87) extended CHCF funding for the health centers program and the NHSC for two years by appropriating a total of $3.910 billion to the fund for each of FY2016 and FY2017. Of that amount, $3.6 billion is for the health centers program and the remaining $310 million is for the NHSC.

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.[13] Second, the two agencies primarily responsible for implementing the ACA's provisions to expand insurance coverage—CMS's Center for Consumer Information and Insurance Oversight (CCIIO) and the Internal Revenue Service (IRS)—are incurring significant costs in connection with administering and enforcing the law. Both agencies requested increases in funding in each of their past four budget submissions (i.e., FY2013-FY2016) to help pay for ACA implementation. But congressional appropriators have not provided either agency with any additional discretionary funds. CMS instead has relied on discretionary fund transfers from other accounts, amounts from the Nonrecurring Expenses Fund (NEF),[14] and 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

Enacted Laws

Table 1 summarizes the authorizing legislation to amend the ACA that has been enacted since the ACA became law in March 2010. 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 (HCERA).[15]

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 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.

[13] 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-FY2015 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.

[14] The Nonrecurring Expenses Fund is an account within the Department of the Treasury. The HHS Secretary is authorized to transfer to the NEF unobligated balances of expired discretionary funds. NEF funds are available until expended for use by the HHS Secretary for capital acquisitions including facility and information technology infrastructure.

[15] See footnote 1.

In compiling **Table 1**, CRS made decisions about which laws—or specific provisions in a particular law—to include, and which ones to leave out. CRS elected to include only those provisions that made changes (including funding extensions or rescissions) to *new* programs and activities first authorized and funded by the ACA. CRS excluded provisions addressing *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 provisions in more recently enacted laws. The ACA also extended funding for a number of existing grant programs whose funding has been further extended by provisions in newer laws. None of these types of provisions are included in **Table 1**.

House-Passed Bills

Table 2 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 Democratic-led Senate, though neither measure became law.

Table 2 also summarizes the ACA legislation that has passed the House to date in the 114th Congress. As noted in the table, some of these House-passed ACA bills have been used by the Senate as vehicles for considering other, unrelated legislation.

The House-passed legislation includes stand-alone bills as well as provisions in broader, often unrelated measures that would (1) repeal the ACA in its entirety and, in some cases, replace it with new law; (2) repeal, or by amendment restrict or otherwise limit, specific provisions in the ACA; (3) eliminate appropriations provided by the ACA and rescind all unobligated funds;[16] (4) replace the mandatory appropriations for one or more ACA programs with authorizations of (discretionary) appropriations, and rescind all unobligated funds; and (5) block or otherwise delay implementation of specific ACA provisions.

Generally, **Table 2** lists only legislation that, if enacted, would have a direct impact on the ACA and its implementation; measures that would not have such an effect are not included. Thus, budget resolutions, which are only binding on certain matters before Congress, are not included.[17]

[16] 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.

[17] 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 budget resolutions for FY2012 and FY2013 (H.Con.Res. 34 and H.Con.Res. 112, respectively) during the 112th Congress (2011-2012) and passed budget resolutions for FY2014 and FY2015 (H.Con.Res. 25 and H.Con.Res. 96, respectively) during the 113th Congress (2013-2014). All four House budget resolutions included language addressing full repeal of the ACA. In 2015, the House and the Senate each passed a budget resolution for FY2016 (H.Con.Res. 27 and S.Con.Res. 11, respectively). Both measures—as well as the subsequent conference agreement (S.Con.Res. 11) approved by the two chambers—included language calling for full repeal of the ACA.

On July 30, 2014, the House approved a simple resolution (H.Res. 676) that authorized 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.[18]

Reconciliation Bill

Table 3 summarizes the ACA provisions in H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, which President Obama vetoed on January 8, 2016.

H.R. 3762 was reported by the House Budget Committee on October 16, 2015, and passed by the full House on October 23, 2015. The measure contained provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and Workforce—pursuant to reconciliation instructions included in the FY2016 budget resolution (S.Con.Res. 11).[19]

As passed by the House, H.R. 3762 would repeal the individual and employer mandates, eliminate the medical device tax and the tax on high-value employer-sponsored health plans (i.e., "Cadillac tax"), and defund the PPHF, among other things. CBO and JCT estimated that the bill would reduce the budget deficit over the period FY2016-FY2025 by a total of $129 billion. That amount includes the bill's impact on the U.S. economy, the so-called macroeconomic feedback effect.[20]

The Senate took up consideration of H.R. 3762 and substituted its own significantly broader set of ACA provisions. Those provisions were submitted by the Finance and HELP Committees, in accordance with the reconciliation instructions in S.Con.Res. 11. As amended, H.R. 3762 passed the Senate on December 3, 2015.[21] CBO and JCT estimated that the Senate-passed bill would reduce the budget deficit over the period FY2016-FY2025 by a total of $282 billion. That estimate does not include a macroeconomic analysis.[22]

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[18] *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.

[19] For more information, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

[20] U.S. Congressional Budget Office, "Estimate of Direct Spending and Revenue Effects of H.R. 3762, The Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the House and Following Enactment of the Bipartisan Budget Act of 2015," November 4, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassed.pdf. Excluding macroeconomic feedback effects, CBO and JCT estimated that H.R. 3762 would reduce the deficit by $78 billion over the FY2016–FY2025 period. They estimated that macroeconomic feedback effects would reduce deficits by an additional $51 billion over that period. The largest effect would be an increase in revenues arising from the increased supply of labor, which in turn would boost employment and taxable income.

[21] For more information, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*, coordinated by Annie L. Mach.

[22] U.S. Congressional Budget Office, "Estimate of Direct Spending and Revenue Effects of H.R. 3762, The Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015," December 8, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/H.R.3762aspassedbythesenate.pdf.

The House approved the Senate-passed bill on January 6, 2016. The enrolled bill was sent to the President, who vetoed it on January 8, 2016. The House voted to override the veto on February 2, 2016, but failed to muster the two-thirds vote required.

Reconciliation bills are considered by the full House and Senate under expedited procedures. In the Senate, a reconciliation bill can pass with only a simple majority, rather than the 60 votes that are often needed for controversial legislation (because reconciliation bills are not subject to filibuster). The Budget Act limits Senate debate on a reconciliation bill to 20 hours and requires any amendments offered to be germane to the bill.

However, the Budget Act includes language—known as the Byrd rule, after the late Senator Robert Byrd—that allows senators to block provisions of (or amendments to) a reconciliation bill that are determined to be "extraneous" to the bill's basic purpose of implementing budget changes.[23] The Byrd rule includes six criteria for determining whether a provision is extraneous. For example, provisions that do not produce a change in spending or revenues or that produce a change in spending or revenues which is "merely incidental" to the provision's non-budgetary effects are generally considered extraneous.[24]

Senators may raise a parliamentary objection (i.e., a point of order) against any provision that they believe to be extraneous. If the point of order is sustained by the parliamentarian, the extraneous material is deleted. Importantly, the Budget Act requires 60 votes to waive the Byrd rule or override a ruling on a point of order under the Byrd rule.[25]

After the House first approved H.R. 3762 and sent the measure to the Senate, the Senate parliamentarian ruled that the bill's provisions to repeal the individual and employer mandates were extraneous. The ruling meant that Senate Republicans would need 60 votes to protect the language if Democrats raised Byrd Rule points of order. Lacking a supermajority in the Senate, the Republicans chose instead to modify the provisions so that they would not violate the Byrd Rule.

The Senate version kept the mandates but eliminated the penalties for noncompliance. As summarized in **Table 3**, the bill also would repeal the optional Medicaid expansion and eliminate most of the new taxes and fees in the ACA.

[23] 2 U.S.C. §644.

[24] 2 U.S.C. §644(b)(1).

[25] For more information, see CRS Report RL30862, *The Budget Reconciliation Process: The Senate's "Byrd Rule,"* by Bill Heniff Jr.

Table 1. Enacted Legislation That Modified, or Extended or Rescinded Funding for, Programs Established by the ACA

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		114th Congress
P.L. 114-113 Dec. 18, 2015	H.R. 2029 (Dent)	**Consolidated Appropriations Act, 2016.** P.L. 114-113 incorporated a number of ACA tax provisions, including a two-year delay of the Cadillac tax, a one-year moratorium on the ACA's annual fee on certain health insurance providers, and a two-year moratorium on the ACA's medical device excise tax. [For more information on all the ACA-related provisions in P.L. 114-113, see CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2016)*, by C. Stephen Redhead and Ada S. Cornell.]
P.L. 114-97 Dec. 11, 2015	S. 599 (Cardin)	**Improving Access to Emergency Psychiatric Care Act.** Extended the Medicaid Emergency Psychiatric Demonstration program, authorized by ACA Sec. 2707, through September 30, 2016, provided it meets budget neutrality requirements. Gives the HHS Secretary the authority to further extend and expand the demonstration program through December 31, 2019, subject to the budget neutrality requirements. Requires the Secretary, by April 1, 2019, to submit recommendations to Congress on whether to make the program permanent.
P.L. 114-74 Nov. 2, 2015	H.R. 1314 (Meehan)	**Bipartisan Budget Act of 2015.** Among its provisions, P.L. 114-74: • Repealed the ACA requirement that employers with more than 200 employees automatically enroll new full-time employees in health insurance and continue coverage for current employees.
P.L. 114-60 Oct. 7, 2015	H.R. 1624 (Guthrie)	**Protecting Affordable Coverage for Employees (PACE) Act.** Amended the ACA's definition of small employer to mean employers with up to 50 employees, while giving states the option to expand the definition to include employers with up to 100 employees. [Under the ACA as originally enacted, all employers with 100 or fewer employees would have been regarded as small employers as of January 1, 2016. The PACE Act limits small employers to those with up to 50 employees, which typically is how small employers are defined under state law. Employers with 51 to 100 employees are now defined under the ACA as large employers. This change is significant because certain ACA reforms apply only to individual and small group (i.e., small employer) plans. For example, these plans must cover ten essential health benefits and meet the actuarial value levels (platinum, gold, silver, bronze) defined by the ACA. Moreover, insurers may only consider age, geographic location, family composition, and tobacco use in setting premium rates for small groups. Large group plans are not bound by these requirements.]
P.L. 114-41 July 31, 2015	H.R. 3236 (Shuster)	**Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.** Among its provisions, P.L. 114-41: • Incorporated the Hire More Heroes Act, which excludes employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count for the purpose of meeting the ACA's employer responsibilities.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
P.L. 114-10 Apr. 16, 2015	H.R. 2 (Burgess)	**Medicare Access and CHIP Reauthorization Act of 2015.** Among its provisions, P.L. 114-10: • Amended Section 1848(p) of the Social Security Act (SSA), as added by ACA Section 3007, to terminate application of the physician value-based payment modifier (VBM) at the end of 2018. [Beginning in 2019, the VBM will be used as one of the components of the composite score under the new Merit-Based Incentive Payment System (MIPS).] • Appropriated a total of $3.910 billion to the CHCF for each of FY2016 and FY2017; $3.600 billion for the health centers program, and $310 million for the NHSC. • Appropriated $60 million for each of FY2016 and FY2017 for graduate medical education (GME) payments to teaching health centers, authorized by ACA Section 5508(c). • Appropriated $400 million for each of FY2015 through FY2017 for the Maternal, Infant, and Early Childhood Home Visiting program, established by ACA Section 2951. • Appropriated $75 million for each of FY2016 and FY2017 for the Personal Responsibility Education Program (PREP), established by ACA Section 2953. • Appropriated $85 million for each of FY2016 and FY2017 for the Health Profession Opportunity Grant (HPOG) program, established by ACA Section 5507(a). • Appropriated $20 million for the two-year period FY2016 through FY2017 to develop Medicaid adult quality measures, pursuant to ACA Section 2701.
		113th Congress
P.L. 113-93 Apr. 1, 2014	H.R. 4302 (Pitts)	**Protecting Access to Medicare Act of 2014.** Among its 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 level (AV) level for bronze plans. CMS had already agreed to waive the deductible cap if a plan could not "reasonably reach" the AV level without exceeding the cap.] • Appropriated $400 million for the first half of FY2015 for the Maternal, Infant, and Early Childhood Home Visiting program, established by ACA Section 2951. [Superseded by the appropriation in P.L. 114-10.] • Appropriated $85 million for FY2015 for HPOG program, established by ACA Section 5507(a). • Appropriated $75 million for FY2015 for the PREP, established by ACA Section 2953.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		112th Congress
P.L. 112-240 Jan. 2, 2013	H.R. 8 (Camp)	**American Taxpayer Relief Act of 2012.** Among its provisions, P.L. 112-240: • 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 these funds.[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 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 effective date.
P.L. 112-96 Feb. 22, 2012	H.R. 3630 (Camp)	**Middle Class Tax Relief and Job Creation Act of 2012.** Among its provisions, P.L. 112-96: • Amended ACA Section 4002 to reduce the 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 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 Section 36B of the Internal Revenue Code (IRC), 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.]

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
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 tax credits is based on income as reported on tax returns. These amounts are reconciled the following year, which could result in an overpayment of tax credits if income increases. The ACA placed limits on the amount of any premium tax credit overpayment that had to be repaid to the government.]
P.L. 111-226 Aug. 10, 2010	H.R. 1586 (Rangel)	**FAA Air Transportation Modernization and Safety Improvement Act.** Among its 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. The FY2011 and FY2012 Labor-HHS-ED appropriations acts (P.L. 112-10 and P.L. 112-74, respectively) rescinded a total of $2.6 billion of the ACA's original $6 billion appropriation for the CO-OP program. 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.

Table 2. 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. 3762 (Price, T.)	**Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.** Passed the House by vote of 240-189 on October 23, 2015. As originally passed by the House, the bill would repeal the following ACA provisions: individual mandate; employer mandate; Cadillac tax; medical device tax; automatic enrollment requirement for large employers; and Prevention and Public Health Fund (PPHF). It also would appropriate an additional $235 million to the Community Health Center Fund (CHCF) in each of FY2016 and FY2017 for health center operations. The Senate took up H.R. 3762 and substituted its own more extensive set of ACA repeal provisions. The amended bill passed the Senate by a vote of 52-47 on December 3, 2015, and passed the House by a vote of 240-181 on January 6, 2016. H.R. 3762 was sent to the President, who vetoed it on January 8, 2016. The House failed to override the veto in a vote taken on February 2, 2016. See **Table 3** for a summary of the provisions in H.R. 3762, as passed by both chambers.
H.R. 2061 (Davis, R.)	**Equitable Access to Care and Health (EACH) Act.** Passed the House by voice vote on September 28, 2015. H.R. 2061 would expand the religious exemption in the ACA by exempting from the law's insurance mandate any individual who is a member of a religious sect or division, who relies solely on a religious method of healing, and for whom accepting medical health services (not including certain preventive and other specified services) would be inconsistent with his or her 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 all insurance benefits, including Medicare and Social Security (e.g., Amish).] The House passed a related bill in March 2014 (see H.R. 1814 in the 113th Congress).
H.J.Res. 61 (Davis, R.)	**Hire More Heroes Act of 2015.** Passed the House by voice vote on July 27, 2015. H.J.Res. 61 would exclude employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count. The House passed the same legislation in January 2015 (see H.R. 22 below) and in March 2014 (see H.R. 3474 in the 113th Congress). [Note: The Hire More Heroes Act was incorporated into P.L. 114-41; see **Table 1**.] *H.J.Res. 61 was used unsuccessfully by the Senate as the legislative vehicle to provide continuing appropriations for FY2016.*
H.R. 1190 (Roe)	**Protecting Seniors' Access to Medicare Act of 2015.** Passed the House by a vote of 244-154 on June 23, 2015. H.R. 1190 would repeal the authority and appropriations for the Independent Payment Advisory Board (IPAB). It also would reduce the PPHF annual appropriations over the period FY2017-FY2025 by a total of $8.846 billion to offset the cost of repealing IPAB. [Note: This is the second time the House has passed a stand-alone bill to repeal IPAB.]
H.R. 160 (Paulsen)	**Protect Medical Innovation Act of 2015.** Passed the House by a vote of 280-140 on June 18, 2015. H.R. 160 would repeal the ACA's 2.3% excise tax on medical devices. [Note: This is the second time the House has passed a stand-alone bill to repeal the medical device tax.]
H.R. 1191 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act.** Passed the House by a vote of 415-0 on March 17, 2015. H.R. 1191 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. Last year the IRS ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 1191 would codify that ruling.] The House passed the same legislation in January 2015 (see H.R. 33 below) and in March 2014 (see H.R. 3979 in the 113th Congress). *The Senate took up H.R. 1191 and used it as the legislative vehicle for the Iran Nuclear Agreement Review Act of 2015, which passed both chambers and was signed into law (P.L. 114-17).*

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
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 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. Last year the IRS has ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 33 would codify that ruling.] The House passed the same measure in March 2014 (see H.R. 3979 in the 113th Congress). *The Senate took up H.R. 33 and substituted language to provide continuing FY2015 appropriations for the Department of Homeland Security. As amended by the Senate, H.R. 33 passed both chambers and was signed into law (P.L. 114-3).*
H.R. 30 (Young, T.)	**Save American Workers Act of 2015.** 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 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 2015.** 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. The House first passed the Hire More Heroes Act in 2014; see H.R. 3474 below. [Note: The Hire More Heroes Act was incorporated into P.L. 114-41; see **Table 1**.] *H.R. 22 was used as the legislative vehicle for the Fixing America's Surface Transportation (FAST) Act, which passed both chambers and was signed into law (P.L. 114-94).*
	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).]
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 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 would have codified that ruling.] *The Senate passed H.R. 3979 by a vote of 59-38 on April 7, 2014, after adding a five-month extension of unemployment benefits to the bill, among other provisions, and renaming it the Emergency Unemployment Compensation Act of 2014. No further action was taken on that measure. H.R. 3979 subsequently was used as the legislative vehicle for the FY2015 National Defense Authorization Act (P.L. 113-291).*
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 all insurance benefits, including Medicare and Social Security (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.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
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.]
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. 3550 (Upton)	**Keep Your Health Plan Act of 2013.** Passed the House by a vote of 261-157 on November 15, 2013. H.R. 3550 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.]
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.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
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.
	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 permanent annual appropriation 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 the 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 permanent annual appropriation 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. 4268 (Biggert)	**Interest Rate Reduction Act.** Passed the House by a vote of 215-195 on April 27, 2012. H.R. 4268 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 1**). 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 IPAB.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
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 1**.]
H.R. 358 (Pitts)	**Protect Life Act.** Passed the House by a vote of 251-172 on October 13, 2011. H.R. 358 would have prohibited using any funds authorized or appropriated by the ACA to pay for an abortion or to pay for any part of the costs of a health plan that covers abortions, except if the pregnancy is the result of rape or incest, or the life of the pregnant female is at risk unless an abortion is performed. It would have required insurers that offer plans through the exchanges that cover abortion services to offer identical plans that do not cover abortion services. It also would have prohibited federal, state, or local government programs that receive ACA funding from discriminating against health care entities that refuse to provide abortion services or abortion training.
H.R. 1216 (Guthrie)	**A bill to convert funding for graduate medical education (GME) in qualified teaching health centers (THCs) to an authorization of appropriations.** Passed the House by a vote of 234-185 on May 25, 2011. H.R. 1216 would have replaced the appropriation for GME payments to THCs with an authorization of appropriations for each of FY2012 through FY2015, and rescinded all unobligated funds. It would have prohibited the GME funds from being used to provide abortions, except in cases of rape or incest or when the woman's life is in danger.
H.R. 1214 (Burgess)	**A bill to repeal ACA funding for school-based health center (SBHC) construction.** Passed the House by a vote of 235-191 on May 4, 2011. H.R. 1214 would have repealed the authority and appropriations for SBHC construction grants and rescinded all unobligated funds.
H.R. 1213 (Upton)	**A bill to repeal ACA funding for health insurance exchanges.** Passed the House by a vote of 238-183 on May 3, 2011. H.R. 1213 would have repealed the authority and appropriations for state exchange planning and establishment grants and rescinded all unobligated funds.
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 permanent annual appropriation 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.

Table 3. ACA Provisions in the Restoring Americans' Healthcare Freedom Reconciliation Act (H.R. 3762)

Vetoed by President Obama on January 8, 2016

Topic	Summary of Provision (As Passed by the House and Senate)
Prevention and Public Health Fund (PPHF)	Repeals the authority and permanent annual appropriation for the PPHF. [The PPHF annual appropriation is currently $1 billion through FY2017. Thereafter, it will increase in increments to $2 billion for FY2022 and each subsequent fiscal year.]
Community Health Center Fund (CHCF)	Appropriates an additional $235 million to the CHCF for community health center operations for each of FY2016 and FY2017.
Funding for U.S. Territories	Prohibits the HHS Secretary from allocating ACA funds to Puerto Rico and the other U.S. territories, effective January 1, 2018. [The ACA appropriated $1 billion for U.S. territories that elect to establish an exchange. The funds are available through 2019.]
Risk Reinsurance	Prohibits the HHS Secretary from collecting risk reinsurance fees or making payments, effective January 1, 2016. [Under the ACA's transitional risk reinsurance program, most health insurance plans are assessed fees that are used to make payments to ACA-compliant plans in the individual market that enroll high-risk individuals. The program runs through 2016.]
Premium Tax Credits and Cost-Sharing Reductions	Repeals temporarily the limits on the amount of any premium tax credit overpayment that has to be repaid to the government. The repeal applies to taxable years ending after December 31, 2015, and before January 1, 2018. Repeals the premium tax credits; cost-sharing reductions; and the HHS Secretary's authority to determine individuals' eligibility to participate in an exchange and receive the tax credits and cost-sharing reductions. Repeals the IRS's authority to disclose taxpayer return information to HHS for eligibility determinations. All these provisions take effect after December 31, 2017.
Small Business Tax Credits	Repeals the tax credit for small employers with no more than 25 FTEs. The repeal applies to taxable years ending after December 31, 2017.
Individual Mandate	Eliminates the penalties for failing to comply with the individual mandate, effective January 1, 2015. [Under the ACA, most U.S. citizens and legal residents have to obtain health insurance coverage. Those who remain uninsured have to pay a penalty unless they qualify for an exemption.]
Employer Mandate	Eliminates the penalties associated with the employer mandate, effective January 1, 2015. [The ACA's employer shared responsibility provisions ("employer mandate") require larger employers to offer health coverage that meets affordability and adequacy standards. Employers who do not comply with the employer mandate may be subject to a tax penalty if one or more of their employees purchase subsidized coverage through an exchange. The mandate went into effect in 2015 for employers with at least 100 FTEs and is to be expanded to employers with at least 50 FTEs in 2016.]
Medicaid Expansion	Repeals the optional Medicaid expansion on December 31, 2017. This section also repeals several other ACA Medicaid provisions.
Medicaid DSH Payments	Repeals the ACA's reductions in Medicaid disproportionate share hospital (DSH) payments. [The ACA, as amended, directs the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2018 through FY2025.]
Cadillac Tax	Repeals the ACA's excise tax on high-premium employer-sponsored health coverage. [The "Cadillac Tax," which takes effect in 2018, is equal to 40% of the amount by which the total value of the coverage exceeds a specified dollar limit.]

Topic	Summary of Provision (As Passed by the House and Senate)
OTC Medications	Modifies the definition of qualified medical expenses for tax-advantaged health accounts so that it includes over-the-counter (OTC) medications. [Under the ACA, a medicine or drug must be a prescribed drug or insulin to be considered a qualified medical expense for the following tax-advantaged health accounts: health flexible spending accounts (health FSAs), health reimbursement accounts (HRAs), Archer medical savings accounts (Archer MSAs), and health savings accounts (HSAs).]
Health Savings Account Tax	Reduces the tax on withdrawals from HSAs and Archer MSAs that are not used to pay for qualified medical expenses from 20% to 10% and 15%, respectively.
Flexible Spending Accounts	Repeals the $2,500 contribution limit on health FSAs, effective for taxable years beginning after December 31, 2015.
Annual Fee on Prescription Drugs	Repeals the ACA's annual fee on manufacturers and importers of branded prescription drugs, effective January 1, 2016.
Medical Device Tax	Repeals the ACA's 2.3% tax on the sale of medical devices, beginning January 1, 2016. Medical devices that are regularly available at retail for individual use and not primarily intended for use by a medical professional are exempt from the tax.
Annual Fee on Health Insurance Providers	Repeals the ACA's annual fee on certain health insurance providers, effective January 1, 2016.
Deduction for Retiree Prescription Drug Costs	Reverses the ACA's amendment to the tax code so that employers do not have to reduce their business-expense deductions for retiree prescription drug costs by the amount of any federal subsidies. This change is effective for taxable years beginning after December 31, 2015. [Employers that provide Medicare-eligible retirees with prescription drug coverage are eligible for a tax-exempt federal subsidy to encourage them to maintain that coverage. Prior to the ACA, employers deducted retiree prescription drug costs from their income taxes without regard to the subsidies they received. The ACA amended the tax code requiring employers to reduce the allowable deduction for retiree prescription drug costs by the amount of any subsidy received.]
Tax Deduction for Medical Expenses	Reduces the income threshold for deducting medical expenses from 10% to 7.5%, effective for taxable years beginning after December 31, 2015. [Taxpayers who itemize their deductions may deduct qualifying medical expenses that exceed 10% of their adjusted gross income. The ACA had increased the threshold from 7.5% to 10%.]
Medicare Surtax on Higher-Income Individuals	Repeals the ACA's 0.9% Medicare surtax on higher-income individuals, effective for taxable years beginning after December 31, 2015.
Excise Tax on Tanning Services	Repeals the ACA's 10% excise tax on indoor tanning services, effective December 31, 2015.
Investment Tax on High-Income Individuals	Repeals the ACA's 3.8% tax on the net investment income of higher-income individuals, effective for taxable years beginning after December 31, 2015.
Remuneration Paid by Health Insurance Providers	Terminates the provision in the tax code, added by the ACA, which prohibits health insurance providers from deducting as business expenses any remuneration paid to an officer, director, or employee in excess of $500,000.

Source: Prepared by the Congressional Research Service based on the text of H.R 3762, as amended and passed by the House and Senate.

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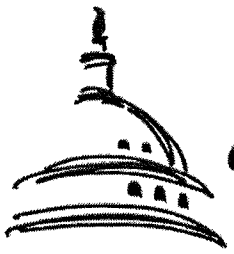
APPENDIX 5



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Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)

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Summary

Congress remains deeply divided over implementation of the Patient Protection and Affordable Care Act (ACA), the health reform law enacted in March 2010. 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.

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 aspects of 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 Republican-led House and Democratic-controlled 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.

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, and Education, and Related Agencies ("Labor-HHS-ED") Appropriations Act, which funds the Centers for Medicare & Medicaid Services (CMS). A few provisions were incorporated in the Financial Services and General Government ("Financial Services") Appropriations Act, which funds the Internal Revenue Service (IRS). By comparison, the Labor-HHS-ED and Financial Services appropriations bills drafted by the Senate Appropriations Committee were largely free of any ACA-related provisions while the committee remained under Democratic control through 2014.

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. Second, House appropriators repeatedly have added limitations (often referred to as riders) to the Labor-HHS-ED and Financial Services appropriations bills to prohibit CMS and the IRS from using discretionary funds provided in the bills for ACA implementation activities. To date, the ACA limitation provisions added by House appropriators have been removed during negotiations with the Senate. None of them have been included in any of the enacted appropriations acts.

Third, House appropriators have incorporated ACA-related legislative language in the Labor-HHS-ED appropriations bills. For example, appropriators have included language to rescind (i.e., cancel) certain mandatory funding provided by the ACA.

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 funding from the Prevention and Public Health Fund and to provide an accounting of administrative spending on ACA implementation.

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Introduction

Congress remains deeply divided over implementation of the Affordable Care Act (ACA), which President Obama signed into law 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 five years, the Republican-led House has passed numerous ACA-related bills, including legislation that would repeal the entire law. There has been less debate in the Senate, which remained under Democratic control through 2014. Most of the ACA legislation passed by the House during that period was not taken up by 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 these attempts to repeal or amend the ACA through 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 the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law. The information is presented in **Table 1**. 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 as context for the material in the table.[2] This report is updated as necessary to reflect key developments in the annual appropriations process.

A companion report, CRS Report R43289, *Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act*, summarizes the authorizing legislation to amend the ACA that has been enacted since 2010. It also reviews all the ACA legislation taken up and passed by the House during this period.

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

[1] The ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029). HCERA included several new health reform provisions and amended numerous provisions in the ACA. Several subsequently enacted bills made additional changes to certain ACA provisions. All references to the ACA in this report refer collectively to the law and to the changes made by HCERA and subsequent legislation.

[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.

uninsured and underinsured. To that end, the law included a complex set of interconnected provisions that address the private health insurance market.

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 exchanges (also known as marketplaces) 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.

In June 2015, the U.S. Supreme Court in *King v. Burwell* ruled that the premium tax credits are available to all qualified individuals who enroll in exchange plans and meet the necessary income and other requirements, regardless of whether the exchange is administered by the state or the federal government.[3]

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.[4] 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

[3] *King v. Burwell*, No. 14-114 slip op. (June 25, 2015), http://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf.

[4] *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.

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 the federal spending on exchange subsidies and Medicaid expansion.

ACA's 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.[5] 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.[6] *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.[7]

Federal spending on ACA implementation can be grouped into three categories: (1) mandatory spending on expanding insurance coverage, (2) mandatory spending on other programs, and (3) discretionary spending. Each of these categories is briefly discussed below.

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) and the Joint Committee on Taxation (JCT) projected that this and other ACA mandatory spending (discussed in the second category, below) would be more than 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.[8]

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

[5] 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.

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

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

[8] U.S. Congressional Budget Office, letter to the Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, providing an estimate of the direct spending and revenue effects of ACA, as amended by HCERA (March 20, 2010), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

law.[9] 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 (CMMI), within the Centers for Medicare & Medicaid Services (CMS), to test and implement innovative health care payment and service delivery models.

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) for the federal health centers program and the National Health Service Corps.[10] 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 supporting 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 pay for 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.[11]

Second, the two agencies primarily responsible for implementing the ACA's provisions to expand insurance coverage—CMS's Center for Consumer Information and Insurance Oversight (CCIIO) and the Internal Revenue Service (IRS)—are incurring significant costs in connection with administering and enforcing the law. Both agencies requested increases in funding in each of their past five budget submissions (i.e., FY2013-FY2017) to help pay for ACA implementation. But congressional appropriators have not provided either agency with any additional discretionary funds.

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[9] 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.

[10] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10, 129 Stat. 87) extended CHCF funding for the health centers program and the NHSC for two years by appropriating a total of $3.910 billion to the fund for each of FY2016 and FY2017. Of that amount, $3.6 billion is for the health centers program and the remaining $310 million is for the NHSC.

[11] 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 generally have 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-FY2015 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.

CMS instead has relied on funding from other sources to support the federal health insurance exchange (Healthcare.gov) and other ACA implementation activities. Those sources include discretionary fund transfers from other accounts, amounts from the Nonrecurring Expenses Fund (NEF),[12] ACA mandatory funds (i.e., HIRIF, PPHF),[13] and, more recently, user fees assessed on health insurers that participate in the federal exchange.

ACA Provisions in Enacted Appropriations Acts

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, and 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 were largely free of ACA-related provisions while the committee remained under Democratic control, 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 new funding to cover the administrative costs of ACA implementation. CMS has requested substantial increases in funding for its Program Management account in each of the past five budgets (i.e., FY2013-FY2017). Those new funds were to help support operation of the federally facilitated exchange and other ACA-related activities. Congress, however, did not provide any additional discretionary funds for CMS in the enacted Labor-HHS-ED appropriations acts for FY2013-FY2016. Similarly, the IRS requested additional discretionary funds in each of the last five budgets to support administration and enforcement of the ACA's tax provisions, including the premium tax credits and the individual mandate penalties. Again, Congress has not given the IRS the extra funds it requested.[14]

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 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, House appropriators on multiple occasions have added language prohibiting an agency from using any of the funds for ACA implementation activities. Limitation provisions also may be used to restrict the availability of funds for transfer.[15] During the FY2011-FY2016 appropriations cycles the ACA limitation

[12] The Nonrecurring Expenses Fund is an account within the Department of the Treasury. The HHS Secretary is authorized to transfer to the NEF unobligated balances of expired discretionary funds. NEF funds are available until expended for use by the HHS Secretary for capital acquisitions including facility and information technology infrastructure.

[13] CMS has transferred more than half of the HIRIF funds to the IRS.

[14] 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.

[15] 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...)

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

Third, House appropriators have incorporated ACA-related legislative language in the Labor-HHS-ED appropriations bills. Unlike limitations, legislative provisions have the effect of making new law or changing existing law.[16] 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 to provide an accounting of administrative spending on ACA implementation.

Table 1 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-FY2016. 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 in the 113th Congress

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, 2013) 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.[17]

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[16] CRS Report R41634, *Limitations in Appropriations Measures: An Overview of Procedural Issues* (see footnote 2) discusses the differences between limitations and legislative provisions in appropriations measures, and how to distinguish between the two.

[17] P.L. 113-46, 127 Stat. 558. For more analysis of the various legal and procedural considerations arising from the use of the appropriations process to delay or defund the ACA, see CRS Report R43246, *Affordable Care Act (ACA) and the Appropriations Process: FAQs Regarding Potential Legislative Changes and Effects of a Government Shutdown*, (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.[18]

Actions Taken in the 114th Congress

With Republicans in control of both chambers in the 114th Congress, House and Senate appropriators are able to coordinate their efforts to include ACA-related provisions in appropriations bills. Last year, the House and Senate FY2016 Labor-HHS-ED appropriations bills included several overlapping ACA provisions and reporting requirements. In addition, the bills incorporated most of the ACA language that was in the enacted FY2015 Labor-HHS-ED appropriations act.

The House FY2016 Labor-HHS-ED appropriations bill also included other ACA funding rescissions and limitation provisions. The limitations would have prohibited HHS (and the Labor Department) from using any discretionary funding to enforce the ACA's market reforms, operate the federal exchange, or administer other ACA programs. Also, they would have banned the use of other funding made available by the appropriations act to implement the ACA. For example, CMS would have been prohibited from funding the Medicaid expansion. In addition, the House bill would have prohibited CMS from collecting user fees from health insurers to help cover the costs of operating the federal exchange. Finally, it would have rescinded $6.8 billion of the ACA's $10 billion appropriation for CMMI for the period FY2011-FY2019.

None of these limitation provisions, or the CMMI rescission, were included in the final version of the FY2016 Labor-HHS-ED appropriations act, which was part of the FY2016 omnibus spending bill.[19] However, that law did include a temporary moratorium on the ACA's medical device tax and the annual fee on health insurance providers, as well as a two-year delay of the Cadillac tax (i.e., the ACA's excise tax on high-cost employer-sponsored health plans); see **Table 1**.

This year to date, the Senate Appropriations Committee has reported its FY2017 Labor-HHS-ED appropriations bill. The measure includes all the ACA provisions that were in the enacted FY2016 Labor-HHS-ED appropriations act. The House Appropriations Committee also has reported an FY2017 Labor-HHS-ED bill, which revives most of the ACA limitation provisions and rescissions that were in its FY2016 bill; see **Table 1**.

On September 29, 2016, the President signed a bill that includes the FY2017 Military Construction and Veterans Affairs Appropriations Act and provides continuing appropriations for the rest of the federal government through December 9, 2016.[20] The measure includes one ACA-related rescission; see **Table 1**.

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coordinated by C. Stephen Redhead.

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

[19] P.L. 114-113, 129 Stat. 2242.

[20] P.L. 114-223, 130 Stat. 857.

Table 1. ACA-Related Provisions in Appropriations Acts, FY2011-FY2017

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: • Rescinded $2.2 billion of the $6 billion appropriation for the Consumer Operated and Oriented Plan (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. Note: 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 Prevention and Public Health Fund (PPHF) funds for FY2011 to the accounts specified, in the amounts specified, and for the activities specified in a table included in the accompanying committee report (S.Rept. 111-243). The House Appropriations Subcommittee on Labor-HHS-ED approved a draft (unnumbered) FY2011 bill, but no further legislative action was taken. On February 19, 2011, the House by a vote of 235-189 passed H.R. 1, a bill that included the FY2011 Department of Defense Appropriations Act as well as full-year continuing appropriations for FY2011 for Labor-HHS-ED and all the other nondefense appropriations acts. H.R. 1, as passed, included nine separate but overlapping limitation provisions that would have prohibited using any of the 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.	

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 CO-OP program; see P.L. 112-10, above. • Rescinded $10 million of the FY2012 appropriation for the Independent Payment Advisory Board (IPAB), which was authorized and funded by ACA Section 3403. • 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 bill (H.R. 3070) on September 29, 2011, but no further legislative action was taken. H.R. 3070, as introduced, would have (1) rescinded the entire FY2012 appropriations for the 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 (CMMI) for the period FY2011-FY2019; and (4) prohibited using any of the funds provided in the bill to implement and administer the ACA until 90 days after all ACA legal challenges were complete.

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 accounts specified, in the amounts specified, and for the activities 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 House Appropriations Committee reported the FY2012 Financial Services appropriations bill (H.R. 2434, H.Rept. 112-136) on July 7, 2011. It would have prohibited the IRS from using any of the funds provided in the bill to (1) implement the ACA individual mandate, or (2) transfer any ACA funds to the IRS.

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
	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: A similar rescission was included in the FY2012 appropriations act; see above.] • 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 above.] • 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 above.]
Legislative activity prior to enactment of P.L. 113-6. The House Appropriations Subcommittee on Labor-HHS-ED approved an unnumbered draft bill for FY2013 on July 18, 2012, but no further legislative 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 funding provided in the bill to support CMS's Center for Consumer Information and Insurance Oversight (CCIIO). The draft bill also would have (1) rescinded the FY2013 appropriations for the 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 CMMI for the period FY2011-FY2019; (4) rescinded $300 million of the $1.5 billion appropriation to the CHCF in FY2013 for community health centers; (5) prohibited using any of the 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 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 accounts specified, in the amounts specified, and for the activities 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 House Appropriations Committee reported the 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 funds provided in the bill to carry out the transfer of ACA funds to the agency. The Senate Appropriations Committee reported its 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
	FY2014
P.L. 113-76 Jan. 17, 2014	**Consolidated Appropriations Act, 2014.** Division H of P.L. 113-76—the FY2014 Labor-HHS-ED Appropriations Act—included the following ACA-related provisions: • Rescinded $10 million of IPAB's FY2014 appropriation. [Note: A similar rescission was included in both the FY2012 and FY2013 Labor-HHS-ED appropriations acts; see above.] • 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 by the committee was included in each of the FY2011, FY2012, and FY2013 Labor-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 above.] • 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 above.] • 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 above.] • 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 Nonrecurring 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 Office of Inspector General (OIG) 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 prohibit any premium contribution by the government. Once again, the Senate tabled the House amendments. With the House and Senate unable to agree on the FY2014 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 the FY2014 Labor-HHS-ED appropriations bill (S. 1284) on July 11, 2013. For the fourth year in a row, the Senate's Labor-HHS-ED appropriations bill would have instructed the HHS Secretary to allocate the PPHF funds to the accounts specified, in the amounts specified, and for the activities 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 House Appropriations Subcommittee on Labor-HHS-ED did not introduce a FY2014 appropriations bill.

The House Appropriations Committee reported 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 funds provided in the bill to (1) implement the individual mandate, or (2) transfer funding from HHS to the IRS to implement the ACA.

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.

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 Labor-HHS-ED Appropriations Act—included the following ACA-related provisions: • Rescinded $10 million of IPAB's FY2015 appropriation. [Note: A similar rescission was included in the Labor-HHS-ED appropriations acts for each of the past three fiscal years (FY2012-FY2014); see above.] • Required 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). Prohibited the Secretary from making further transfers. [Note: The requirement to transfer PPHF funds in accordance with the allocations specified by the committee has been included in each Labor-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.] • 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: The same provision was included in the FY2014 appropriations act; see above.] • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: The same provision was included in the FY2014 appropriations act; see above.] • 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. [Note: The same provision was included in the FY2014 appropriations act; see above.] • Required 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 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 above.] • Required 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 above.] • Prohibited 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, instructed HHS to include in the FY2016 budget justification the amount of expired unobligated balances available for transfer to the NEF, and the amount of any such balances transferred to the NEF. In addition, the explanatory statement instructed the HHS OIG 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 stated 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—did not include any ACA-related provisions. However, the explanatory statement to accompany P.L. 113-235 (discussed above) instructed the IRS to submit quarterly reports to Congress during FY2015 on actions planned and taken to reconcile advance premium tax credit payments received in 2014 when 2014 tax returns are filed in 2015. It also required the Treasury Secretary to provide Congress with 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—exempts 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.
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 funds provided in the bill to implement the individual mandate or to transfer funding from HHS to the IRS for ACA implementation; and (2) 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 Senate Appropriations Subcommittee on Financial Services approved a draft bill for FY2015 on June 24, 2014, but no further legislative action was taken. The House Appropriations Subcommittee on Labor-HHS-ED did not introduce a FY2015 appropriations bill. The Senate Appropriations Subcommittee on Labor-HHS-ED approved a draft bill for FY2015 on June 10, 2014, and released an accompanying draft committee report, but no further legislative action was taken.	

Public Law and Date of Enactment	Summary of Provisions
	FY2016
P.L. 114-113 Dec. 18, 2015	**Consolidated Appropriations Act, 2016.** Division H of P.L. 114-113—the FY2016 Labor-HHS-ED Appropriations Act—included the following ACA-related provisions: • Rescinded $15 million of IPAB's FY2016 appropriation. [Note: An IPAB funding rescission was included in the Labor-HHS-ED appropriations acts for each of the past four fiscal years (FY2012-FY2015); see above.] • Required the HHS Secretary to transfer the FY2016 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. 114-113 (Congressional Record, December 17, 2015, p. H10290). Prohibited the Secretary from making further transfers. [Note: The requirement to transfer PPHF funds in accordance with the allocations specified by the committee has been included in each Labor-HHS-ED appropriations bill reported by the Senate Appropriations Committee since the ACA was enacted. However, the provision did not get included in the final enacted appropriations legislation until FY2014; see above.] • 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: The same provision was included in the FY2014 and FY2015 appropriations acts; see above.] • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: The same provision was included in the FY2014 and FY2015 appropriations acts; see above.] • 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. [Note: The same provision was included in the FY2014 and FY2015 appropriations acts; see above.] • Required the HHS Secretary to include in the FY2017 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 FTEs, for FY2016 and each fiscal year since the ACA was enacted. [Note: The same provision was included in the FY2014 and FY2015 appropriations acts; see above.] • Required the HHS Secretary to include in the FY2017 budget justification a detailed breakdown of all funds used to date by CMS for the exchanges, including the proposed use of such funds in FY2017. Funding details must be provided for all the activities specified under the heading "Health Insurance Exchange Transparency" in the explanatory statement to accompany P.L. 114-113 (Congressional Record, December 17, 2015, p. H10288). [Note: The same provision was included in the FY2015 appropriations act; see above.] • Prohibited risk corridor payments (authorized by ACA Section 1342) from the CMS Program Management appropriations account. [Note: The same provision was included in the FY2015 appropriations act; see above.] • Required the HHS Secretary to provide the Appropriations Committees with detailed monthly enrollment figures for the exchanges at least two days before making the information publicly available. • Required the HHS Secretary to include in the FY2017 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. [Note: A similar provision was included in the FY2014 appropriations act; see above.]

Public Law and Date of Enactment	Summary of Provisions

- Required that through January 1, 2018, any provision of the ACA (or other law) that references the recommendations of the U.S. Preventive Services Task Force (USPSTF) regarding breast cancer screening must use the recommendations prior to 2009 that gave routine screening mammography for women ages 40-49 a "B" grade, rather than the more recent USPSTF recommendations (both current and draft) that give routine screening mammography for that age group a "C" grade. Under the ACA, most private insurance plans must cover preventive services that receive a USPSTF "A" or "B" grade, generally without out-of-pocket costs. Coverage of preventive services that receive a USPSTF grade of "C" or lower is not required.

The explanatory statement to accompany P.L. 114-113, submitted by the House Appropriations Committee Chairman and published in the December 17, 2015, Congressional Record, instructed HHS to include in the FY2017 budget justification the amount of expired unobligated balances available for transfer to the NEF, the amount of any such balances transferred to the NEF, and details of the specific projects supported with NEF funds. In addition, the explanatory statement instructed CMS to ensure that state-based exchanges (SBEs) are not using ACA Section 1311 funds (i.e., exchange planning and establishment grants) for operational expenses, contrary to law. CMS was directed, within 120 days, to report on its efforts to implement the recommendations in the HHS OIG's April 2015 alert on this issue. It also must immediately notify House and Senate appropriators of any unauthorized use of Section 1311 funds and explain how it plans to recoup those funds from the states. Finally, the explanatory statement instructed CMS, within 90 days, to submit a report to House and Senate appropriators explaining its policy that allows exchange plans to refuse to accept premium payments from certain nonprofit organizations on behalf of needy individuals. [Note: Section 4 of P.L. 114-113 stated that the explanatory statement is to be treated as if it were a joint explanatory statement of the conference committee.]

Division E of P.L. 114-113—the FY2016 Financial Services Appropriations Act—included the following ACA-related provision:

- Provided an additional $290 million to the IRS Commissioner to be used, pursuant to a plan submitted to the Appropriations Committees, for improving customer service, preventing refund fraud and identity theft, and enhancing cybersecurity. These funds may not be used for ACA implementation.

Division P of P.L. 114-113 ("Tax-Related Provisions") included the following ACA-related provisions:

- Delayed the ACA's Cadillac tax (i.e., excise tax on high-premium employer-sponsored health coverage) by two years; the Cadillac tax now takes effect in 2020.
- Allowed the Cadillac tax to be deducted as a business expense.
- Required GAO to study and report within 18 months on the suitability of using the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan as a benchmark for the age and gender adjustment of the applicable dollar limit for the Cadillac tax.
- Established a one-year moratorium on the ACA's annual fee on certain health insurance providers for 2017.

Division Q of P.L. 114-113—the Protecting Americans from Tax Hikes Act of 2015—included the following ACA-related provision:

- Established a two-year moratorium on the ACA's medical device excise tax for 2016 and 2017.

Public Law and Date of Enactment	Summary of Provisions
	Legislative activity prior to enactment of P.L. 114-113. The House Appropriations Committee approved the FY2016 Financial Services appropriations bill (H.R. 2995, H.Rept. 114-194) on June 17, 2015. The measure would have reduced the IRS's discretionary funding by about 8% compared to the FY2015 level. It also would have prohibited the IRS from using any of the funds provided in the bill to (1) implement the individual mandate, or (2) transfer funding from HHS to the IRS for ACA implementation. The Senate Appropriations Committee reported its FY2016 Financial Service appropriations bill (S. 1910, S.Rept. 114-97) on July 30, 2015. The measure would have reduced the IRS's discretionary funding by about 4% compared to the FY2015 level. The House Appropriations Committee reported the FY2016 Labor-HHS-ED appropriations bill (H.R. 3020, H.Rept. 114-195) on July 10, 2015. The bill would have reduced funding for the CMS Program Management account by about 9% compared to the FY2015 level. It would have continued all but one of the ACA provisions in the enacted FY2015 Labor-HHS-ED appropriations act (see above)—the provision authorizing the transfer of Medicare trust funds to the CMS Program Management Account was not included. The House committee bill included numerous other ACA-related provisions. It would have prohibited the use of any of the funds provided for CMS's Program Management account to support CCIIO. It would have prohibited using any of the funds provided in the bill for (1) patient-centered outcomes research; (2) exchange navigators; or (3) implementation of any provision of the ACA. It also would have prohibited CMS from collecting and using exchange user fees. Besides rescinding $15 million of IPAB's FY2016 appropriation (up from the $10 million in FY2015), the bill would have rescinded (1) $6.8 billion of CMMI's $10 billion appropriation; (2) $100 million of PCORTF's FY2016 funding; (3) $18 million of the remaining CO-OP funds; and (4) all unobligated HIRIF funds. Moreover, the bill would have terminated the NEF and rescinded all its unobligated funds. In addition, it would have required the HHS Secretary to include in the FY2017 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. Finally, the House committee bill incorporated the Health Care Conscience Rights Act (H.R. 940). Among other things, H.R. 940 would amend the ACA so that individuals/employers would not have to purchase/sponsor coverage of abortion or other items or services to which they have a moral or religious objection. The Senate Appropriations Committee reported its FY2016 Labor-HHS-ED appropriations bill (S. 1695, S.Rept. 114-74) on June 25, 2015. The bill would have reduced funding for the CMS Program Management account by about 17% compared to the FY2015 level. Like the bill approved by the House Appropriations Committee, the Senate version would have continued all of the ACA provisions in the enacted FY2015 Labor-HHS-ED appropriations act with the exception of the provision authorizing the transfer of Medicare trust funds to the CMS Program Management Account. In addition, the Senate committee bill would have (1) rescinded $18 million of the remaining CO-OP funds; (2) prohibited the use of any of CMS's Program Management funds to support exchange operations; and (3) required the Secretary to provide the Appropriations Committees with detailed monthly enrollment figures for the exchanges at least two days before making the information publicly available.

Public Law and Date of Enactment	Summary of Provisions
	FY2017
P.L. 114-223 Sept. 29, 2016	**Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act.** P.L. 114-223 includes the FY2017 Military Construction and Veterans Affairs Appropriations Act and provides continuing appropriations for the rest of the federal government through December 9, 2016, generally at the levels of—and under the terms and conditions of—the FY2016 appropriations acts, minus an across-the-board reduction of 0.496%. It includes the following ACA-related provision: • Rescinds $168 million of the unobligated amounts from the ACA's $1 billion appropriation for the U.S. territories, which has been used by the territories to supplement their federal Medicaid funds.
	Legislative activity prior to enactment of P.L. 114-223. The Senate Appropriations Committee reported the FY2017 Labor-HHS-ED appropriations bill (S. 3040, S.Rept. 114-274) on June 9, 2016. The bill recommends the same level of discretionary funding for CMS's Program Management account as in FY2016. It also includes all the ACA provisions in the enacted FY2016 Labor-HHS-ED appropriations act (see above). The House Appropriations Committee reported its FY2017 Labor-HHS-ED appropriations bill (H.R. 5926, H.Rept. 114-699) on July 22, 2016. H.R. 5926 would reduce funding for CMS's Program Management account by about 16% compared to the FY2016 level. It includes all but one of the ACA provisions in the enacted FY2016 Labor-HHS-ED appropriations act (see above)—the provision authorizing the transfer of Medicare trust funds to the CMS Program Management Account was not included. The House bill includes most of the ACA-related provisions that were in the FY2016 bill (H.R. 3020; see above). It would prohibit using any of the funds provided for CMS's Program Management account to support CCIIO. It would prohibit using any of the funds provided in the bill for (1) patient-centered outcomes research; (2) exchange navigators; or (3) implementation of any provision of the ACA. It also would prohibit CMS from collecting and using exchange user fees. Besides rescinding $15 million of IPAB's FY2017 appropriation, the bill would rescind (1) $7 billion of CMMI's $10 billion appropriation; and (2) $150 million of PCORTF's FY2017 funding. The bill would terminate the NEF and rescind all its unobligated funds. In addition, it would require the HHS Secretary to include in the FY2018 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. Finally, the bill incorporates the Health Care Conscience Rights Act (H.R. 940). Among other things, H.R. 940 would amend the ACA so that individuals/employers would not have to purchase/sponsor coverage of abortion or other items or services to which they have a moral or religious objection. The House approved the FY2017 Financial Services appropriations bill (H.R. 5485, H.Rept. 114-624) on July 7, 2016. The bill would reduce the IRS's discretionary funding by about 2% compared to the FY2016 level. It also would prohibit the IRS from using any of the funds provided in the bill to (1) implement the individual mandate, or (2) transfer funding from HHS to the IRS for ACA implementation. The Senate Appropriations Committee reported its FY2017 Financial Services appropriations bill (S. 3067, S.Rept. 114-280) on June 16, 2016. The bill recommends the same level of discretionary funding for the IRS as in FY2016.

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APPENDIX 6

114th CONGRESS, 1st Session

United States Library of Congress

S 359

Introduced in Senate

February 4, 2015

S. 359

To amend title I of the Patient Protection and Affordable Care Act to impose restrictions on the risk corridor program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

February 4, 2015

Mr. Cassidy (for himself and Mr. Rubio) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend title I of the Patient Protection and Affordable Care Act to impose restrictions on the risk corridor program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Taxpayer Bailout Protection Act'.

SEC. 2. RESTRICTIONS ON PPACA RISK CORRIDOR PROGRAM.

Section 1342(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18062(b)) is amended-

(1) in paragraph (1), by striking 'The Secretary' and inserting 'Subject to paragraph (3), the Secretary'; and

(2) by adding at the end the following new paragraph:

'(3) Safeguard to protect taxpayers.-

'(A) In general. The Secretary shall ensure that the amount of payments to plans under paragraph (1) for a plan year beginning during calendar year 2014, 2015, or 2016 does not exceed the amount of payments to the Secretary under paragraph (2) for such plan year.

'(B) Adjustment to protect taxpayers. The Secretary shall proportionately decrease the amount of payments to plans under paragraph (1) in order to ensure that the requirement of subparagraph (A) is satisfied each year.'.

2015 CONG US S 359

End of Document

APPENDIX 7

114th CONGRESS, 1st Session

United States Library of Congress

HR 724

Introduced in House

February 4, 2015

H. R. 724

To amend title I of the Patient Protection and Affordable Care Act to impose restrictions on the risk corridor program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

February 4, 2015

Mr. Lance (for himself and Mrs. Blackburn) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title I of the Patient Protection and Affordable Care Act to impose restrictions on the risk corridor program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Taxpayer Bailout Protection Act'.

SEC. 2. RESTRICTIONS ON PPACA RISK CORRIDOR PROGRAM.

Section 1342(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18062(b)) is amended-

(1) in paragraph (1), by striking 'The Secretary' and inserting 'Subject to paragraph (3), the Secretary'; and

(2) by adding at the end the following new paragraph:

'(3) Safeguard to protect taxpayers.-

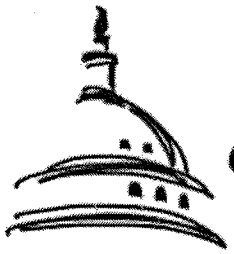
'(A) In general. The Secretary shall ensure that the amount of payments to plans under paragraph (1) for a plan year beginning during calendar year 2014, 2015, or 2016 does not exceed the amount of payments to the Secretary under paragraph (2) for such plan year.

'(B) Adjustment to protect taxpayers. The Secretary shall proportionately decrease the amount of payments to plans under paragraph (1) in order to ensure that the requirement of subparagraph (A) is satisfied each year.'.

2015 CONG US HR 724

End of Document

APPENDIX 8



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MEMORANDUM January 23, 2014

To: House Energy and Commerce Committee
[redacted]

From: Edward C. Liu, Legislative Attorney [redacted]

Subject: **Funding of Risk Corridor Payments Under ACA § 1342**

This memorandum responds to your request for an analysis of the following two questions concerning the funding of the risk corridor program under § 1342 of the Patient Protection and Affordable Care Act (ACA):

1. Is an appropriation required for payments to qualified health plans under ACA § 1342(b)(1)?
2. Can the amounts received from qualified health plans under ACA § 1342(b)(2) be used to make payments under § 1342(b)(1)?

This memo provides general background information, and may be used to respond to questions by other Members or Congressional staff.

Overview of Risk Corridors

Risk corridors are a method for constraining financial losses (or gains) because costs are greater (or lesser) than what an insurance company estimated. The corridors allow insurance companies and government to share higher-than-expected costs (or profits). Risk corridors have been employed when there is a change in the market which leaves health insurers unsure about the future costs they face, and how to price (or bid) their products.

Section § 1342 of the ACA requires the Secretary of Health and Human Services (HHS) to establish and administer a program of risk corridors for 2014, 2015, and 2016 for qualified health plans[1] (QHPs) offered to individuals and small businesses.[2] Under § 1342(b)(1), if a plan's allowable costs exceed the total premiums received (less administrative costs), the Secretary is required to pay the plan a percentage of the shortfall in premiums. In contrast, under § 1342(b)(2), if a participating plan's allowable costs are

[1] Qualified health plans are plans that provide a comprehensive set of health benefits and comply with all applicable ACA market reforms. Exchange plans must be QHPs, with limited exceptions. QHPs may also be offered in the private market outside of exchanges.

[2] 42 U.S.C. § 18062.

less than the total premiums received (less administrative costs), the plan is required to pay to the Secretary a comparable percentage of the excess premiums received.

Is an appropriation required for payments to qualified health plans under ACA § 1342(b)(1)?

As noted above, the risk corridor program directs payments to be made by the Secretary of HHS to certain insurers that have underestimated their premiums for a given plan year through 2016. However, statutory and constitutional provisions prohibit federal agencies from making payments in the absence of a valid appropriation.[3] Under longstanding GAO interpretations, an appropriation must consist of both a direction to pay and a specified source of funds.[4] While the language of ACA § 1342(b)(1) establishes a directive to the Secretary to make such payments, it does not specify a source from which those payments are to be made.[5] Therefore, § 1342 would not appear to constitute an appropriation of funds for the purposes of risk corridor payments under that section.[6]

It is possible that an appropriation that would cover these payments may arise elsewhere. One potential source would be an appropriation enacted as part of the annual appropriations process. Unfortunately, it is too early to be able to predict whether an annual appropriation exists that would cover these payments. This is because the payments under § 1342 would not be made until FY2015 for which we do not yet have a proposed budget from the President or any pending appropriations bills.

Can the amounts received from qualified health plans under ACA § 1342(b)(2) be used to make payments under § 1342(b)(1)?

In some cases, federal expenditures can be financed through a type of permanent, indefinite appropriation known as a revolving fund. Generally, such expenditures have revenue generating activities and the

[3] 31 U.S.C. § 1342 ("An officer or employee of the United States Government or of the District of Columbia government may not ... make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation [or] involve either government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law"); U.S. CONST. art. I, § 9, cl. 7 ("No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law").

[4] *See* GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-17 (2004).

[5] "[I]f ... a participating plan's allowable costs for any plan year are more than [specified thresholds] the Secretary shall pay to the plan an amount equal to [the statutory formula]." 42 U.S.C. § 18062(b)(1). It should also be noted that the question of whether an appropriation is available to make these payments is separate from the question of whether insurance plans meet the eligibility requirements for a payment under § 1342(b)(1). A qualified health plan may have a legal claim to the payments by operation of the statutory formula, but that alone does not constitute an appropriation from which that claim may be paid. *See* GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-17 (2004) (citing Comptroller General Decision B-114808, Aug. 7, 1979).

[6] In contrast, the risk corridor payments under the similar Medicare Part D program are funded through a permanent appropriation from the Medicare Prescription Drug Account established in the Federal Supplementary Medical Insurance Trust Fund. 42 U.S.C. § 1860d-16(b)(1)(B).

revenue generated from those activities is placed in a revolving fund which can be used to pay for future revenue generating activities.[7]

An agency may not create a revolving fund absent specific authorizing legislation.[8] In the absence of any specific directions, federal law requires such amounts to be deposited in the General Fund of the Treasury, from which they may be further appropriated by Congress.[9] The necessary elements for a statute to create a revolving fund are:

- It must specify the receipts or collections which the agency is authorized to credit to the fund (user charges, for example).
- It must define the fund's authorized uses, that is, the purpose or purposes for which the funds may be expended.
- It must authorize the agency to use receipts for those purposes without fiscal year limitation. However, as explained above, only receipts and collections that the fund has earned through its operations are available without fiscal year limitation.[10]

Notably for purposes of this memorandum, the amounts received by HHS from plans that have overestimated premiums for a given year are not explicitly designated to be deposited in a revolving account or otherwise made available for outgoing payments under § 1342(b)(1). Therefore, there does not appear to be sufficient statutory language creating a revolving fund that would make amounts received under § 1342(b)(2) available to pay amounts due to eligible plans under § 1342(b)(1).

As with a non-revolving appropriation to cover payments under § 1342(b)(1), a revolving fund can be created in standalone legislation, or in an annual appropriations act.[11] The lack of statutory language creating a revolving fund within § 1342 does not mean that such incoming payments may never be placed in a revolving fund to be used for outgoing payments. Such a revolving fund could be established by Congress at some point in the future, including before the first payments from qualified health plans are due for plan year 2014. Nevertheless, until such time as that legislation is enacted, it does not appear that a revolving fund exists for purposes of receipts and payments under § 1342.

[7] *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-85 (2008).

[8] *Id.* at 12-89 ("[A]gencies have no authority to administratively establish revolving funds.").

[9] 31 U.S.C. § 3302(b). *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-93 (2008) (noting that creation of revolving fund is exception to general rule of 31 U.S.C. § 3302(b)).

[10] *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-90 (2008).

[11] *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-89 (2008).