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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 is deeply divided over implementation of the 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 (LHHS) 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 LHHS 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 LHHS 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, congressional appropriators have incorporated ACA-related legislative language in the LHHS appropriations bills. For example, appropriators have included language to rescind (i.e., cancel) certain mandatory funding provided by the ACA and delay (or place a temporary moratorium on) certain taxes and fees established by the ACA.

Finally, the appropriators have added to recent LHHS 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 is 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.

Most of this legislative activity has taken place in the House, which reverted to Republican control in 2011. Over the past six 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.

Repealing core provisions of the ACA and replacing them with new law is a legislative priority for the Republican-controlled 115th Congress.

In addition to their attempts to repeal or amend the ACA through authorizing legislation, 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 in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act*, summarizes the authorizing legislation to amend the ACA that was enacted during the last three Congresses. It also reviews all the ACA legislation taken up and passed by the House during that 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/search/#/0?termsToSearch=Health%20Care%20Reform&orderBy=Date&navIds=4294938515.

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 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 alternative ways of delivering and paying for health care. The law also includes new taxes and

[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.

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 law.[9] For example, the law funded temporary insurance programs for targeted groups prior to 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*.

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

[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.

[9] For a summary of all the ACA's mandatory appropriations, and the status of obligation of those funds, see CRS

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) 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.

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

Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*.

[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)*.

(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 at the beginning of the 112th Congress. Most of these provisions were included in the Departments of Labor, Health and Human Services, and Education, and Related Agencies (LHHS) Appropriations Act, which funds CMS. A few were incorporated in the Financial Services and General Government (Financial Services) Appropriations Act, which funds the IRS. Appropriations bills drafted by the Senate Appropriations Committee remained largely free of ACA-related provisions during the 112th and 113th Congresses, while the Senate remained under Democratic control, with one key exception. Each year, the Senate LHHS appropriations bill included instructions on the allocation of PPHF funding.

Disagreement between the Republican-controlled House and the Democrat-led Senate during the 113th Congress on whether to include ACA provisions in the FY2014 continuing resolution (CR) shut down programs and activities across the federal government in October 2013; see text box.

Government Shutdown in the 113th Congress

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.[14] The measure funded the federal government through January 15, 2014, and did not include any provisions to defund or delay ACA implementation. Instead, it required the HHS Secretary to certify to Congress that the ACA health insurance exchanges were verifying the eligibility of individuals applying for subsidies to help cover the cost of purchasing insurance coverage. In January 2014, Congress completed action on the FY2014 appropriations process by approving the Consolidated Appropriations Act, 2014, which included all 12 annual appropriations acts for FY2014.[15] See **Table 1** for more details.

With Republicans in control of both chambers in the 114th Congress, House and Senate appropriators were able to coordinate their efforts to include ACA-related provisions in appropriations bills. The House and Senate FY2016 and FY2017 LHHS appropriations bills included several overlapping ACA provisions and reporting requirements.

[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 transferred more than half of the HIRIF funds to the IRS.

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

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

The appropriations committees 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. These options are briefly summarized below.

Administrative Spending Levels

The appropriators 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 LHHS appropriations acts for FY2013-FY2017. 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.[16]

Limitation Provisions

House appropriators repeatedly have added limitations (often referred to as riders) to the LHHS 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.[17] During the FY2011-FY2015 appropriations cycles the ACA limitation provisions added by House appropriators were removed during negotiations with the Senate.

The House FY2016 and FY2017 LHHS appropriations bills included limitations that 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, and prohibited from collecting user fees from health insurers to help cover the costs of operating the federal exchange.

None of these limitation provisions were included in the final enacted versions of the FY2016 and FY2017 LHHS appropriations acts.

Legislative Provisions

House appropriators have incorporated ACA-related legislative language in the LHHS appropriations bills. Unlike limitations, legislative provisions have the effect of making new law or changing existing law.[18] As an example, appropriators have included language to rescind (i.e., cancel) certain mandatory funding provided by the ACA. The enacted FY2016 LHHS

[16] 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)*.

[17] 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*.

[18] Ibid.

appropriations act included 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).

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.

Reporting and Other Administrative Requirements

Appropriators have added to recent LHHS 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 LHHS and Financial Services appropriations acts for each of FY2011-FY2017. 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 LHHS and Financial Services appropriations acts.

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

Public Law and Date of Enactment	Summary of Provisions
	FY2017
P.L. 115-31 May 5, 2017	**Consolidated Appropriations Act, 2017.** Division H of P.L. 115-31—the FY2017 LHHS Appropriations Act—includes the following ACA-related provisions: • Rescinds $15 million of IPAB's FY2017 appropriation. [Note: An IPAB funding rescission was included in the LHHS appropriations acts for each of the past five fiscal years (FY2012-FY2016); see below.] • Requires the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program or by state. [Note: The same provision was included in the LHHS appropriations acts for each of the past three fiscal years (FY2014-FY2016); see below.] • Prohibits the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: The same provision was included in the LHHS appropriations acts for each of the past three fiscal years (FY2014-FY2016); see below.] • Authorizes the HHS Secretary to transfer up to $305 million from the Medicare trust funds to the CMS Program Management account for Medicare operations, but prohibits the use of such transferred funds for ACA implementation. [Note: The same provision was included in the LHHS appropriations acts for each of the past three fiscal years (FY2014-FY2016); see below.] • Requires the HHS Secretary to include in the FY2018 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 FY2017 and each fiscal year since the ACA was enacted. [Note: The same provision was included in the LHHS appropriations acts for each of the past three fiscal years (FY2014-FY2016); see below.] • Requires the HHS Secretary to include in the FY2018 budget justification a detailed breakdown of all funds used to date by CMS for the exchanges, including the proposed use of such funds in FY2018. 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. 115-31 *(Congressional Record*, May 3, 2017, p. H3954). [Note: The same provision was included in the FY2015 and FY2016 LHHS appropriations acts; see below.] • Prohibits risk corridor payments (authorized by ACA Section 1342) from the CMS Program Management appropriations account. [Note: The same provision was included in the FY2015 and FY2016 appropriations acts; see below.] • Requires 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 [Note: The same provision was included in the FY2016 appropriations act; see below.] • Requires 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. [Note: A similar provision was included in the FY2014 and FY2016 appropriations acts; see below.] • Requires that through January 1, 2019, 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. [Note: The same provision was included in the FY2016 appropriations act; see below.]

	The explanatory statement to accompany P.L. 115-31, submitted by the House Appropriations Committee chairman, was published in the May 3, 2017, *Congressional Record*. Section 4 of P.L. 115-31 states that the explanatory statement is to be treated as if it were a joint explanatory statement of the conference committee. Division E of P.L. 115-31—the Financial Services Appropriations Act, 2017—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. [Note: The same provision was included in the FY2016 appropriations act; see below.]
P.L. 114-254 Dec. 10, 2016	**Further Continuing and Security Assistance Appropriations Act, 2017.** Division A of P.L. 114-254—the Further Continuing Appropriations Act, 2017—amended P.L. 114-223 (see below) to provide continuing appropriations for the federal government through April 28, 2017, generally at the levels of—and under the terms and conditions of—the FY2016 appropriations acts, minus an across-the-board reduction of 0.1901%. It included the following ACA-related provision (in addition to the rescission in P.L. 114-223): • Required the HHS Secretary to transfer the FY2017 Prevention and Public Health Fund (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 the FY2016 appropriations act (P.L. 114-113; see below), but with an overall reduction of $1 million in the amounts transferred to the Centers for Disease Control and Prevention. 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 LHHS 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 below.]
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 included the FY2017 Military Construction and Veterans Affairs Appropriations Act and provided 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 included the following ACA-related provision: • Rescinded $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 LHHS appropriations bill (S. 3040, S.Rept. 114-274) on June 9, 2016. The bill recommended the same level of discretionary funding for the Centers for Medicare & Medicaid Services (CMS) Program Management account as in FY2016. It also included all the ACA provisions in the enacted FY2016 LHHS appropriations act (see below).

The House Appropriations Committee reported its FY2017 LHHS appropriations bill (H.R. 5926, H.Rept. 114-699) on July 22, 2016. H.R. 5926 would have reduced funding for CMS's Program Management account by about 16% compared to the FY2016 level. It included all but one of the ACA provisions in the enacted FY2016 LHHS appropriations act (see below)—the provision authorizing the transfer of Medicare trust funds to the CMS Program Management Account was not included. The House bill included most of the ACA-related provisions that were in the FY2016 bill (H.R. 3020; see below). It would have prohibited using any of the funds provided for CMS's Program Management account to support CMS's Center for Consumer Information and Insurance Oversight (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 the FY2017 appropriation for the Independent Payment Advisory Board (IPAB), which was authorized and funded by ACA Section 3403, the bill would have rescinded (1) $7 billion of $10 billion appropriation for the Center for Medicare and Medicaid Innovation (CMMI); and (2) $150 million of FY2017 funding for the Patient-Centered Outcomes Research Trust Fund (PCORTF). The bill would have terminated the Nonrecurring Expenses Fund (NEF) and rescinded all its unobligated funds. In addition, it would have required 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 incorporated the Health Care Conscience Rights Act (H.R. 940). Among other things, H.R. 940 would have amended 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 have reduced the IRS's discretionary funding by about 2% compared to the FY2016 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 FY2017 Financial Services appropriations bill (S. 3067, S.Rept. 114-280) on June 16, 2016. The bill recommended the same level of discretionary funding for the IRS as in FY2016.

FY2016	
P.L. 114-113 Dec. 18, 2015	**Consolidated Appropriations Act, 2016.** Division H of P.L. 114-113—the FY2016 LHHS 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 LHHS appropriations acts for each of the past four fiscal years (FY2012-FY2015); see below.] • 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 LHHS 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 below.] • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program or by state. [Note: The same provision was included in the FY2014 and FY2015 appropriations acts; see below.] • 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 below.] • Authorized the HHS Secretary to transfer up to $305 million from the Medicare trust funds to the CMS Program Management account for Medicare operations, but prohibited the use of such transferred funds for ACA implementation. [Note: The same provision was included in the FY2014 and FY2015 appropriations acts; see below.] • 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 full-time equivalents (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 below.] • 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 below.] • 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 below.] • 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 below.] • 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 Office of Inspector General (OIG) 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.

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 LHHS 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 LHHS 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 funds for the Consumer Operated and Oriented Plan (CO-OP) program, which was established and funded by ACA Section 1322; and (4) all unobligated Health Insurance Reform Implementation Fund (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 LHHS 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 LHHS 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.

FY2015	
P.L. 113-235 Dec. 16, 2014	**Consolidated and Further Continuing Appropriations Act, 2015.** Division G of P.L. 113-235—the FY2015 LHHS Appropriations Act—included the following ACA-related provisions: • Rescinded $10 million of IPAB's FY2015 appropriation. [Note: A similar rescission was included in the LHHS appropriations acts for each of the past three fiscal years (FY2012-FY2014); see below.] • 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 LHHS 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; see below.] • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program or by state. [Note: The same provision was included in the FY2014 appropriations act; see below.] • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: The same provision was included in the FY2014 appropriations act; see below.] • Authorized the HHS Secretary to transfer up to $305 million from the Medicare trust funds to the CMS Program Management account for Medicare operations, but prohibited the use of such transferred funds for ACA implementation. [Note: The same provision was included in the FY2014 appropriations act; see below.] • 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 below.] • 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 below.] • 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.] 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 LHHS did not introduce a FY2015 appropriations bill.

The Senate Appropriations Subcommittee on LHHS approved a draft bill for FY2015 on June 10, 2014, and released an accompanying draft committee report, but no further legislative action was taken.

FY2014	
P.L. 113-76 Jan. 17, 2014	**Consolidated Appropriations Act, 2014.** Division H of P.L. 113-76—the FY2014 LHHS 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 LHHS appropriations acts; see below.] • Required the HHS Secretary to transfer the FY2014 PPHF funds to the accounts specified, in the amounts specified, and for the activities specified in a table included in the explanatory statement to accompany P.L. 113-76 (*Congressional Record*, January 15, 2014, p. H1041). Prohibited the Secretary from making further transfers. [Note: The requirement to transfer PPHF funds in accordance with the allocations specified by the committee was included in each of the FY2011, FY2012, and FY2013 LHHS appropriations bills reported by the Senate Appropriations Committee, but the provision was not included in the final enacted appropriations legislation for those years; see below.] • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds, organized by program or by state. [Note: A similar, but less detailed, provision was included in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6; see below.] • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes. [Note: This provision first appeared in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6; see below.] • Authorized the HHS Secretary to transfer up to $305 million from the Medicare trust funds to the CMS Program Management account for Medicare operations, but prohibited the use of such transferred funds for ACA implementation. • Required the HHS Secretary to include in the FY2015 budget justification and on the HHS website a detailed breakdown of the ACA programs and activities receiving funds appropriated to implement the law, including the number of 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 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.
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 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 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 LHHS appropriations bill (S. 1284) on July 11, 2013. For the fourth year in a row, the Senate's LHHS 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 LHHS 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.

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 LHHS for FY2013 generally at the level of—and under the terms and conditions of—the FY2012 appropriations act, but with some spending adjustments (both 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 below.] • Required the HHS Secretary to establish a website with detailed information on the allocation and use of PPHF funds. [Note: This provision first appeared in the FY2012 appropriations act and remained in effect in FY2013 under P.L. 113-6.] • 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.]
Legislative activity prior to enactment of P.L. 113-6. The House Appropriations Subcommittee on LHHS 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 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 PCORTF; (2) rescinded $3 billion of the remaining $3.4 billion for the CO-OP funds (see P.L. 112-74, below); (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 Community Health Center Fund (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 LHHS 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 LHHS 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 HIRIF to the IRS for the purpose of ACA implementation.	

FY2012	
P.L. 112-74 Dec. 23, 2011	**Consolidated Appropriations Act, 2012.** Division F of P.L. 112-74—the FY2012 LHHS 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, below. • Rescinded $10 million of the FY2012 appropriation for the IPAB. 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 LHHSucation 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 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 LHHS 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.	

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 LHHS 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 CO-OP program. • 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 CHCF. • Mandated a 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 LHHS appropriations bill (S. 3686) on August 2, 2010. The measure would have instructed the HHS Secretary to allocate 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 LHHS 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 LHHS 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.	

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