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Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)

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Summary

On December 3, 2015, the Senate passed an amendment to H.R. 3762. For information about the Senate amendment to H.R. 3762 and how it compares to the House-passed version of H.R. 3762, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*, coordinated by Annie L. Mach. This report will not be updated to reflect the Senate's actions or subsequent actions taken by the House.

The FY2016 budget resolution (S.Con.Res. 11) established the congressional budget for the federal government for FY2016 and set forth budgetary levels for FY2017-FY2025. It also included reconciliation instructions for House and Senate committees to submit changes in laws to reduce the federal deficit to their respective budget committees.

On October 23, 2015, the House passed H.R. 3762, a reconciliation bill containing provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and the Workforce—pursuant to the reconciliation instructions included in the FY2016 budget resolution. The House reconciliation bill—H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015—would repeal several provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). These provisions are as follows:

- the individual mandate;
- the employer mandate;
- the excise tax on high-cost employer-sponsored coverage (the Cadillac tax);
- the medical device tax;
- the auto-enrollment requirement for large employers; and
- the Prevention and Public Health Fund (PPHF).

Additionally, H.R. 3762 could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics for a period of one year. The bill also would appropriate an additional $235 million for each of FY2016 and FY2017 to the federal health centers program.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the House reconciliation bill would reduce federal deficits by $78.1 billion over the 2016-2025 period.

This report provides background on the reconciliation process and summarizes the provisions in H.R. 3762, including their projected budgetary impact. It then briefly examines some of the bill's policy implications. The report will be updated as necessary to reflect key legislative developments.

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Introduction

On December 3, 2015, the Senate passed an amendment to H.R. 3762. For information about the Senate amendment to H.R. 3762 and how it compares to the House-passed version of H.R. 3762, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*, coordinated by Annie L. Mach. This report will not be updated to reflect the Senate's actions or subsequent actions taken by the House.

On October 23, 2015, the House passed a reconciliation bill containing provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and the Workforce—pursuant to reconciliation instructions included in the FY2016 budget resolution (S.Con.Res. 11). The bill, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762), would repeal several provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). It would also restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics for a period of one year.

This report provides background on the reconciliation process and summarizes the provisions in H.R. 3762, including their projected budgetary impact. It then briefly examines the bill's policy implications. The report will be updated as necessary to reflect key legislative developments.

Background on the Reconciliation Process

Budget reconciliation is an optional, expedited legislative process that consists of several stages, beginning with the adoption of the budget resolution. As provided in Section 310 of the Congressional Budget Act of 1974 (P.L. 93-344, as amended; referred to below as the Budget Act), the purpose of the reconciliation process is to allow Congress to use an expedited procedure when considering legislation that would bring existing spending, revenue, and debt-limit laws into compliance with current fiscal priorities established in the annual budget resolution.

In adopting a budget resolution, Congress is agreeing upon budgetary goals for the upcoming fiscal year (as well as for a period of at least four additional out-years). In some cases, to achieve these goals, Congress must enact legislation that alters current revenue, direct spending, or debt-limit laws. In these situations, Congress seeks to reconcile existing law with current priorities. Since the first use of the reconciliation process in 1980, this expedited procedure has been used to pass 23 reconciliation bills.[1]

Reconciliation Instructions and Committee Action

If Congress intends to use the reconciliation process, reconciliation directives (also referred to as reconciliation instructions) must be included in the annual budget resolution. These directives trigger the second stage of the process by instructing individual committees to develop and report legislation that would change laws within their respective jurisdictions related to direct spending, revenue, or the debt limit.

When a committee is instructed to submit legislation reducing the deficit by a specific amount, that amount is considered a minimum, meaning a committee may report greater net savings. Although there is no procedural mechanism to ensure that legislation submitted by a committee in response to reconciliation instructions will be in compliance with the instructed levels, if a

[1] For a list of all reconciliation bills, see CRS Report R40480, *Budget Reconciliation Measures Enacted Into Law: 1980-2010*, by Megan S. Lynch.

committee does not report legislation—or if such legislation is not in compliance with the reconciliation instructions—procedures are available that would allow either chamber to move forward with reconciliation legislation. In either situation, legislative language that falls within the noncompliant committee's jurisdiction can be added to a reconciliation bill during floor consideration that would bring the bill into compliance with its reconciliation instructions. These methods vary by chamber.

In developing legislation in response to reconciliation instructions, the policy choices made remain the prerogative of the committee. In some instances, reconciliation directives have been couched in terms of particular options or assumptions regarding how an instructed committee might be expected to achieve its reconciliation target, but such language has not been considered binding on committees and would not be enforceable through points of order.

Once a specified committee develops legislation, the reconciliation directive may further direct the committee to report the legislation for consideration in the respective chamber or to submit the legislation to the Budget Committee to be included in an omnibus reconciliation measure. Under Section 310(b)(2) of the Budget Act, the Budget Committee is required to mark up and report such omnibus legislation "without any substantive revision." Reported reconciliation legislation is eligible to be considered under expedited procedures in both the House and the Senate. As with all legislation, any differences in the reconciliation legislation passed by the two chambers must be resolved before the bill can be sent to the President for approval or veto.

Although reconciliation instructions may include target dates,[2] there is no requirement that the Budget Committee—in either chamber—wait for all committees to submit legislative language. Nor is there a requirement for the Budget Committee to report an omnibus reconciliation bill on a specific date. The late response of one or more committees would not cause the bill to lose its privileged status as a reconciliation bill. In the case of omnibus reconciliation measures, the House and Senate Budget Committees have at times delayed reporting a bill. As a consequence, the target date included in reconciliation instructions is not necessarily indicative of a timetable for consideration of reconciliation legislation.[3]

FY2016 Budget Resolution

S.Con.Res. 11 established the congressional budget for the federal government for FY2016 and set forth budgetary levels for FY2017-FY2025. It also included reconciliation instructions for House and Senate committees to submit changes in laws to reduce the federal deficit to their respective budget committees.

Section 2001(a) of S.Con.Res. 11 instructed two committees of the Senate—the Committee on Finance and the Committee on Health, Education, Labor, and Pensions—to submit changes in laws within each committee's jurisdiction to reduce the deficit by not less than $1 billion for the period FY2016-FY2025.

Section 2002(a) instructed three committees of the House—the Committees on Education and the Workforce, Energy and Commerce, and Ways and Means—to submit changes in laws within each committee's jurisdiction to reduce the deficit by not less than $1 billion for the period FY2016-FY2025.

[2] For example, the FY2016 budget resolution (S.Con.Res. 11) included a target date of July 24, 2015, for the instructed committees to submit legislative language to the Budget Committee in their respective chambers.

[3] For more on reconciliation instructions, see CRS Report R41186, *Reconciliation Directives: Components and Enforcement*, by Megan S. Lynch.

Section 2002(b)(2) further provided that these committees shall "note the policies discussed in title VI [of S.Con.Res. 11] that repeal the Affordable Care Act and the health care related provisions of the Health Care and Education Reconciliation Act of 2010" and "determine the most effective methods" by which they "shall be repealed in their entirety."

On October 9, 2015, the House Budget Committee held a markup and voted to report a reconciliation bill, the Restoring Americans' Healthcare Freedom Reconciliation Act, combining the submissions of the three committees (H.R. 3762, H.Rept. 114-293). The House Rules Committee subsequently reported a resolution on October 21, setting the terms for consideration of H.R. 3762 (H.Res. 483, H.Rept. 114-303). In addition to allowing two hours of general debate on the bill, the resolution provided that the vote to approve the terms for consideration of the bill would also amend the language in the bill concerning grants to Planned Parenthood, and striking the language concerning the Independent Payment Advisory Board (IPAB).[4] H.Res. 483 was approved by the House, 240-187, on October 22, and H.R. 3762, as amended, was considered and passed the following day, 240-189. As of the date of this report, the Senate has not taken any public action related to the reconciliation instructions in S.Con.Res. 11.

House Reconciliation Bill

Table 1 summarizes the ACA provisions that would be repealed by H.R. 3762, the House reconciliation bill. The table also shows the impact that repealing these ACA provisions would have on the federal deficit, excluding any macroeconomic effects, as estimated by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT). According to CBO and JCT, the House reconciliation bill would reduce federal deficits by $78.1 billion over the 2016-2025 period, excluding any macroeconomic effects.[5]

Some of the policy implications of repealing these provisions are discussed in the final section of this report. (See "Policy Implications of Repeal.")

Table 1. ACA Provisions That Would Be Repealed by the House Reconciliation Bill, H.R. 3762

(includes CBO/JCT's estimates of the 10-year impact on the deficit in billions of dollars)

Provision	Brief Description	Impact on Deficit[a] (2016-2025)
Individual Mandate	Most individuals are required to maintain health insurance coverage or pay a penalty for noncompliance. The mandate went into effect in 2014.	[b]

[4] For information about the IPAB, see CRS Report R44075, *The Independent Payment Advisory Board (IPAB): Frequently Asked Questions*, by Jim Hahn, Christopher M. Davis, and Edward C. Liu.

[5] Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *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, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassed.pdf. (Hereinafter, CBO and JCT, *Direct Spending and Revenue Effects of* H.R. 3762.) For estimates that include macroeconomic feedback, see CBO and JCT, *Cost Estimate:* H.R. 3762 *Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762.pdf. (Hereinafter, CBO and JCT, *Cost Estimate of* H.R. 3762.) It should be noted that the estimates with macroeconomic feedback include repeal of the auto-enrollment requirement (which has since been repealed by the Balanced Budget Act of 2015, P.L. 114-74) and repeal of the Independent Payment Advisory Board, which was dropped from H.R. 3762 before it passed the House.

Provision	Brief Description	Impact on Deficit[a] (2016-2025)
Employer Mandate	Large employers must either provide health insurance coverage or face potential employer tax penalties. The requirement went into effect in 2015 for employers with at least 100 full-time-equivalent (FTE) employees and is to be expanded to employers with at least 50 FTE employees in 2016.	-$168.5[b]
Excise Tax on High-Cost Employer-Sponsored Coverage	A 40% excise tax is to be assessed on the amount of employer-sponsored health coverage that exceeds a specified dollar limit. The tax is to go into effect in 2018.	$91.1
Medical Device Tax	A 2.3% tax is imposed on the manufacturer or importer of medical devices intended for consumption in the United States. The tax went into effect in 2013.	$23.9
Auto-enrollment	Employers with more than 200 full-time employees are required to automatically enroll new employees in health insurance and to continue coverage for current employees. Employers are to comply with the requirement once regulations are issued.	$0.0[c]
Prevention and Public Health Fund (PPHF)	The PPHF was authorized and permanently appropriated under the ACA. The PPHF is to be administered by the HHS Secretary, and the Secretary is instructed to transfer amounts from the PPHF to HHS accounts for prevention, wellness, and public health activities. The PPHF annual appropriation is currently $1 billion through FY2017, and thereafter it will increase in increments, becoming $2 billion for FY2022 and each subsequent fiscal year.	-$12.7[d]
Total Impact on Deficit		**-$78.1[e]**

Source: Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *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, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassed.pdf.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

a. Excluding any macroeconomic effects.

b. CBO and JCT provide one estimate for repealing both the individual and employer mandates.

c. The Bipartisan Budget Act of 2015 (P.L. 114-74) was enacted November 2, 2015, and repeals the auto-enrollment requirement. As such, CBO and JCT estimate that repeal of the requirement in H.R. 3762 will have no effect relative to current law.

d. This estimate includes the projected reduction in Medicaid spending ($235 million) and additional spending on community health centers ($470 million); see discussion in the "Federal Funding for Planned Parenthood and Health Centers" section of this report.

e. The total also includes interactive effects (i.e., the additional budgetary effects of the provisions in combination with one another).

In addition to repealing certain ACA provisions, H.R. 3762 would prohibit federal funds from being made available to a state, whether directly or through a contracted managed-care organization, for a period of one year following enactment to any entity (including its affiliates, subsidiaries, and clinics) that meets the following criteria:

- First, the entity is a nonprofit community provider primarily engaged in providing family planning and reproductive health services and related medical care.

- Second, the entity provides abortions other than in circumstances where the pregnancy was the result of rape or incest or where the pregnancy places the woman's life in danger.
- Third, the entity's Medicaid expenditures for FY2014 exceeded $350 million.

Based on these criteria, CBO inferred that only PPFA and its affiliates and clinics would be affected (although CBO did not rule out the possibility that other health care clinics might also be impacted). CBO estimated that $235 million could be saved—mainly from the Medicaid program—as a result of this one-year funding restriction.

Finally, H.R. 3762 would appropriate an additional $235 million for each of FY2016 and FY2017 to the federal health centers program.[6]

Policy Implications of Repeal

This section provides a brief overview of the potential policy implications associated with each of the ACA repeal provisions in H.R. 3762. While the bill would repeal a number of ACA provisions, it would not repeal the entirety of the ACA. If the bill were to be enacted as is, many ACA provisions would remain intact, such as the health insurance exchanges and the availability of financial assistance through the exchanges.

This section is not intended to provide a comprehensive analysis of the impact of repealing the ACA provisions included in the bill, but it does provide an overview of potential policy implications, including those that may occur because some ACA provisions would remain in place. For additional information, Congressional clients may contact one of the Congressional Research Service (CRS) analysts upon request.

Estimated Effects on Health Insurance Coverage

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that repealing the individual mandate, the employer mandate, the Cadillac tax, and the auto-enrollment requirement would have a net effect of reducing the number of individuals with health insurance coverage.[7] They estimate that repealing the provisions would result in 16 million more uninsured individuals in most years after 2016.

CBO and JCT estimate that the decrease in coverage would be the result of 7 million fewer individuals with non-group coverage, 5 million fewer with employer-sponsored insurance, and about 4 million fewer covered under Medicaid or the State Children's Health Insurance Program (CHIP).

The reduction in coverage would be largely the result of repealing the individual mandate and its associated penalties, but repealing the employer mandate, the Cadillac tax, and the auto-enrollment requirement also would contribute to the estimated shifts in coverage. Repealing the individual mandate would mean fewer individuals would obtain coverage. Repealing the employer mandate, the Cadillac tax, and the auto-enrollment requirement would affect whether employers offer and whether employees take up coverage.

Source: Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *Cost Estimate: H.R. 3762 Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015.

[6] See CRS Report R43937, *Federal Health Centers: An Overview*, by Elayne J. Heisler.

[7] These estimates were developed prior to repeal of the auto-enrollment requirement in the Balanced Budget Act of 2015.

Individual Mandate

H.R. 3762 would repeal the ACA's individual mandate and its associated penalty,[8] effective January 1, 2015.

As shown in **Table 1**, CBO and JCT estimate a net savings from repealing both the individual and employer mandates.[9]

Individuals and employers that do not comply with the mandates are required to pay penalties, and if the mandates are repealed, the federal government is expected to lose revenue in the form of forgone tax receipts. However, the loss of revenue would not be great as the savings that would be incurred by repealing the mandates, particularly the individual mandate. Eliminating the individual mandate would reduce the number of individuals with coverage (see the text box for more details). This would mean fewer individuals who receive federally subsidized coverage, whether under Medicaid, the State Children's Health Insurance Program, or by receiving federal financial assistance through a health insurance exchange, resulting in budgetary savings for the federal government.

The individual mandate is often described as working in conjunction with certain ACA market reforms, including guaranteed issue and renewability, nondiscrimination based on health status, coverage of preexisting health conditions, and rating restrictions.[10] These reforms require insurers to accept all applicants and restrict insurers' ability to vary premiums based on an applicant's health status and other characteristics. The individual mandate works in tandem with these reforms by encouraging healthy individuals to participate in the market so that insurers' risk pools are not entirely composed of individuals who are at high risk of using health care services.

The House reconciliation bill would repeal the individual mandate and the penalty, but it would not modify or repeal any of the ACA market reforms. The concern of many is that this scenario could lead to adverse selection, in which individuals who need health care services purchase coverage and stay in the risk pool while those who do not have the same desire for coverage leave the pool and stop paying premiums. Because health insurance premiums are based on estimated costs for covering a risk pool, this situation could cause the cost of coverage to rise for the remaining participants, thus making coverage even less attractive to those who do not perceive a need for coverage. This pattern could lead to an increasingly expensive risk pool.

This concern is particularly salient with respect to the non-group (i.e., individual) market. The ACA market reforms, along with the financial assistance available through the health insurance exchanges,[11] have increased access to non-group coverage. Premiums for non-group coverage would likely increase if the individual mandate were repealed, but accessibility to the non-group market remained the same. CBO and JCT estimate that if the mandate were repealed, premiums for policies sold in the non-group market would increase by about 20% in years after 2016.[12]

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[8] For an overview of the individual mandate, see CRS Report R41331, *Individual Mandate Under the ACA*, by Annie L. Mach.

[9] In their cost estimate for H.R. 3762, CBO and JCT did not provide separate estimates for repealing the individual and employer mandates.

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

[11] The financial assistance, premium tax credits, and cost-sharing subsidies are not affected by the House reconciliation bill.

[12] CBO and JCT, *Cost Estimate of* H.R. 3762.

Employer Mandate

The bill would repeal the ACA's employer shared responsibility provisions (i.e., employer mandate). The mandate went into effect on January 1, 2015, for employers with at least 100 full-time equivalent (FTE) employees, and it is to be expanded to apply to employers with at least 50 FTE employees beginning in 2016.[13] H.R. 3762 would repeal the employer mandate effective January 1, 2015. Thus, employers no longer would be exposed to a potential tax penalty for not offering affordable and adequate health coverage.

According to CBO and JCT, elimination of the employer mandate would result in a loss of revenue to the federal government—$166.9 billion over the 2016-2025 period.[14] This revenue loss is partially obscured in the CBO and JCT estimate of the budgetary effect of repealing both the employer mandate and the individual mandate where a net budgetary savings is reported (see **Table 1**). The net budgetary savings is largely the result of repealing the individual mandate, as discussed in the "Individual Mandate" section of this report.

Additionally, CBO and JCT estimate that some employers that are projected to offer health insurance to their employees under current law would no longer do so if the employer mandate were repealed. However, in their projections they estimate that the reduction in offers of employment-based coverage would be mitigated by many employers continuing to offer coverage in order to attract the best available workers at the lowest cost. (See the text box for more details about how H.R. 3762 could affect health insurance coverage.)

Excise Tax on High-Cost Employer-Sponsored Coverage

The bill would repeal the ACA's excise tax on high-cost employer-sponsored coverage (the so-called *Cadillac tax*), which is scheduled to take effect in 2018. The Cadillac tax is a 40% excise tax that is to be assessed on the aggregate cost of employer-sponsored health coverage that exceeds a dollar limit.[15]

The Cadillac tax was included in the ACA in part to raise revenue to offset the cost of other ACA provisions, primarily the financial subsidies available through the health insurance exchanges. As shown in **Table 1**, eliminating the tax would result in a loss of revenue to the federal government. CBO and JCT indicate that the loss of revenue is the result of foregone tax receipts as well as less shifting to lower-cost coverage to avoid the tax.

The idea that the Cadillac tax would incentivize employers to shift employees into or encourage employees to have lower-cost health coverage is part of the expectation that the tax would help curtail the growth in health care costs. According to a CRS analysis, the tax could, under certain assumptions, lead to an overall decline in national health expenditures of 0.6%-0.9% in 2018 and 2.5%-3.6% in 2024.[16] In other words, the tax could result in a gross reduction in national health expenditures of $7.6-$11.0 billion in 2018 and $41.0-$60.3 billion by 2024. The Cadillac tax is

[13] For detailed information about the employer mandate, see CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential ACA Employer Penalty*, by Julie M. Whittaker.

[14] CBO and JCT, *Cost Estimate of* H.R. 3762.

[15] For an overview of the tax, see CRS Report R44147, *Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief*, by Annie L. Mach. For an economic analysis of the tax, see CRS Report R44160, *The Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis*, by Sean Lowry.

[16] For more explanation and calculations, see CRS Report R44159, *The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects*, by Jane G. Gravelle.

thought to be a source of downward pressure on the cost of employer-sponsored coverage and the growth in health care costs. Repealing it would eliminate that possibility.

Medical Device Tax

H.R. 3762 would repeal the medical device tax, which went into effect on January 1, 2013. The effective date of repeal would be calendar quarters beginning after the bill is enacted.

The medical device industry has argued that the ACA's tax on its products has reduced employment and deterred innovation, particularly in smaller firms (which are subject to the tax whether or not they are earning a profit).[17] In contrast, other analysis has found that the tax likely will be passed on to consumers—who are relatively insensitive to price—in the form of higher prices and that the effects of the tax on the share of workers employed in the industry likely will be small.[18]

CRS analysis of Census Bureau and JCT data found that roughly half of U.S. medical device production is expected to be exempt from the tax because of the statutory exemptions (e.g., eyeglasses, hearing aids, and contact lenses), the "retail exemption" outlined in regulations, or the exemption for exported devices.[19]

Although the medical device tax does not meet typical justifications for selective excise taxes, the tax could arguably be better understood within the larger context of financing health reform. Generally, selective excise taxes are justified because a particular behavior causes negative spillover effects to society or because users of a public good or service receive some sort of private benefit. It appears that some justifications for the medical device excise tax could be provided based on traditional economic principles, but the justifications, in most cases, are weak. The device tax could be better understood to meet revenue needs, alongside other ACA taxes and fees on health insurers and pharmaceutical companies that potentially stand to benefit as more people enroll in health insurance as a result of the ACA's reforms.

Auto-enrollment Requirement

H.R. 3762 would repeal the ACA's requirement that employers with more than 200 full-time employees automatically enroll new employees in coverage and continue coverage for current employees. On November 2, 2015, the Bipartisan Budget Act of 2015 (P.L. 114-74) was enacted, which repeals the auto-enrollment requirement. Therefore, the inclusion of this provision in H.R. 3762 would have no effect relative to current law.

Prevention and Public Health Fund

H.R. 3762 would eliminate the authority and permanent annual appropriation for the Prevention and Public Health Fund (PPHF). It also would rescind any unobligated funds appropriated to the PPHF for the fiscal year in which the reconciliation bill was enacted.

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[17] For more information, see AdvaMed, "Medical Device Tax," at http://advamed.org/issues/19/medical-device-tax.

[18] For more information and analysis, see CRS Report R43342, *The Medical Device Excise Tax: Economic Analysis*, by Jane G. Gravelle and Sean Lowry; and CRS Report R42971, *The Medical Device Excise Tax: A Legal Overview*, by Andrew Nolan.

[19] Ibid.

If PPHF funds were to become unavailable, additional regular appropriations or another funding source would need to be provided to sustain programmatic activities currently funded by the PPHF. In the six years from FY2010, when the PPHF was established, through FY2015, almost three-quarters of PPHF funding—a total of $3.8 billion—has been distributed to the Centers for Disease Control and Prevention (CDC).[20] The agency's budget authority (i.e., funds available through annual discretionary appropriations acts) has decreased by about 6% over the same time frame.[21] CDC programs that received substantial funding from the PPHF for FY2015 include, among others, immunization grants to states, efforts to prevent health care-associated infections, and several programs to prevent or control chronic diseases such as diabetes and cancer. The Administration for Community Living (ACL) and the Substance Abuse and Mental Health Services Administration (SAMHSA) also received small amounts of PPHF funds for FY2015, for programs on Alzheimer's disease prevention, chronic disease management, and falls prevention among seniors, and Garrett Lee Smith suicide prevention grants, respectively.[22]

Federal Funding for Planned Parenthood and Health Centers

The bill's one-year prohibition on federal funding—made available to a state either directly or through a managed-care organization—for any entity that meets the criteria set out in the legislation, which were summarized in the "House Reconciliation Bill" section of this report, would probably impact the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics.[23] The bill further specifies that this prohibition would be implemented notwithstanding certain programmatic rules (e.g., the Medicaid freedom of choice of provider requirement).[24]

PPFA is an umbrella organization supporting 59 independent affiliates that operate approximately 700 health centers across the United States. Government funding—which includes federal, state, and local funds—constitutes the PPFA's largest source of revenue.[25] PPFA receives federal grants (either directly or through another entity, such as a state) and reimbursements for providing services to beneficiaries enrolled in federal programs (e.g., Medicaid). It does not receive a direct annual appropriation of any kind.

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[20] Appendix C in CRS Report R43304, *Public Health Service Agencies: Overview and Funding (FY2010-FY2016)*, coordinated by C. Stephen Redhead and Agata Dabrowska. See also John Reichard, "Advocates: CDC, Other Agencies Face Big Cuts Fast if Prevention Fund Ends," *CQ HealthBeat*, June 18, 2012.

[21] Table 4 in CRS Report R43304, *Public Health Service Agencies: Overview and Funding (FY2010-FY2016)*, coordinated by C. Stephen Redhead and Agata Dabrowska.

[22] HHS, "Prevention and Public Health Fund," FY2015 Funding Distribution Table, at http://www.hhs.gov/open/prevention/index.html.

[23] For historical information about the amounts of federal funding made available to the Planned Parenthood Federation of America (PPFA), see U.S. Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010-2012*, GAO-15-270R, March 20, 2015, at http://www.gao.gov/products/GAO-15-270R.

[24] See "Who Provides Reproductive Health Care for Medicaid Beneficiaries?" in CRS Report R44130, *Federal Support for Reproductive Health Services: Frequently Asked Questions*, coordinated by Elayne J. Heisler.

[25] PPFA reported total revenue of $1.3 billion in its 2014 annual report, of which 41% was from government sources. See PPFA, *Our Health. Our Decisions. Our Moment., 2013-2014 Annual Report, 2014*, at http://issuu.com/actionfund/docs/annual_report_final_proof_12.16.14_/0.

CBO estimates that PPFA and its affiliated health clinics receive approximately $450 million annually in federal funds, of which an estimated $390 million is from the Medicaid program.[26] CBO notes that the effect of the one-year federal funding prohibition would be uncertain and that this uncertainty applies to both federal spending and the potential effects on Medicaid beneficiary access to care.[27] According to CBO's analysis, some Medicaid beneficiaries would still use a PPFA affiliate for services, in which case the affiliate would have to use nonfederal funds to provide services. In other cases, the Medicaid beneficiary would access an alternative provider that could be reimbursed with federal Medicaid funds. Finally, some Medicaid beneficiaries could go without services, including preventive screenings and contraceptive services, which could increase costs in the future.

The effects of the one-year federal funding prohibition on the operations of PPFA are also uncertain because federal funding is not the entity's sole funding source. Moreover, it is not clear how a funding ban would affect any particular PPFA-affiliated clinic because the relative share of federal funding available at a given health center varies.

Overall, CBO estimated that $235 million would be saved—mainly from the Medicaid program—from a one-year prohibition on funding to PPFA.[28]

H.R. 3762 coupled the one-year ban on PPFA funding with two years of additional funding—$235 million for each of FY2016 and FY2017—for the federal Health Center Program.[29] Much of the legislation to ban federal funding for PPFA and its affiliates that was introduced prior to the reconciliation bill included language that would maintain federal funding overall for reproductive health services (and other types of services that PPFA provides).[30] Similar to what was included in these bills, H.R. 3762 would redirect funds to other facilities, such as health centers, on the assumption that these facilities could maintain services for Medicaid beneficiaries who otherwise would have sought services at a PPFA affiliate. CBO estimates of these other bills cast doubt on this assumption as they find reduced access in both the short and longer term and increased federal spending over a 10-year period, mainly because pregnancies were not averted.[31]

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[26] For CBO cost estimate, see CBO, *Cost Estimate:* H.R. 3134, *Defund Planned Parenthood Act of 2015, as Introduced on July 21, 2015*, September 16, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3134.pdf.

[27] CBO and JCT, *Cost Estimate of* H.R. 3762.

[28] In its initial estimate of a one-year funding ban to PPFA, CBO noted that $235 million was its midrange estimate. See CBO, H.R. 3134, *Defund Planned Parenthood Act of 2015, as Introduced on July 21, 2015*, Washington, DC, September 15, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3134.pdf.

[29] For information about federal health centers, see CRS Report R43937, *Federal Health Centers: An Overview*, by Elayne J. Heisler.

[30] For example, see H.R. 3134, H.R. 3301, S. 1861, and S. 1881.

[31] See CBO and JCT, *Cost Estimate of* H.R. 3762; CBO, "Legislation Providing for Reconciliation, House Committee on the Budget," October 8, 2015; and CBO, *Cost Estimate:* H.R. 3134, *Defund Planned Parenthood Act of 2015, as Introduced on July 21, 2015*, September 15, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3134.pdf. Another CBO cost estimate examines a broader prohibition over federal funds to PPFA and finds that the broader prohibition would increase the deficit by $130 million over a 10-year period. See letter from Keith Hall, Director of CBO, to Representative Kevin McCarthy, "Re: Budgetary Effect of Legislation That Would Permanently Prohibit the Availability of Federal Fund to Planned Parenthood," September 22, 2015.

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