



ACA: A Brief Overview of the Law, Implementation, and Legal Challenges

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Summary

In March 2010, the 111th Congress passed health reform legislation, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152) and other laws. ACA increases access to health insurance coverage, expands federal private health insurance market requirements, and requires the creation of health insurance exchanges to provide individuals and small employers with access to insurance. It also expands Medicaid coverage. The costs to the federal government of expanding health insurance and Medicaid coverage are projected to be offset by increased taxes and revenues and reduced spending on Medicare and other federal health programs. Implementation of ACA, which began upon the law's enactment and is scheduled to unfold over the next few years, involves all the major health care stakeholders, including the federal and state governments, as well as employers, insurers, and health care providers.

Following the enactment of ACA, individuals, states, and other entities challenged various provisions of ACA on constitutional grounds. Many of these suits addressed ACA's requirement for individuals to have health insurance (i.e., the individual mandate), and claimed that it is beyond the scope of Congress's enumerated powers. The expansion of the Medicaid program was also challenged, as state plaintiffs contended that the expansion impermissibly infringes upon states' rights, coercing them into accepting onerous conditions in exchange for federal funds.

On June 28, 2012, the Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the individual mandate is a constitutional exercise of Congress's authority to levy taxes. However, the Court held that it was not a valid exercise of Congress's power under the Commerce Clause or the Necessary and Proper Clause. With regard to the Medicaid expansion provision, the Court further held that the federal government cannot terminate current Medicaid program federal matching funds if a state refuses to expand its Medicaid program. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but, based on the Court's opinion, it appears that a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. All other provisions of ACA, as amended by HCERA, remain intact.

This report provides a brief summary of major ACA provisions, implementation and oversight activities, and current legal challenges. For more detailed information on ACA's provisions, CRS has produced a series of more comprehensive reports, which are available at <http://www.crs.gov>. The information provided in these reports ranges from broad overviews of ACA provisions, such as the law's Medicare provisions, to more narrowly focused topics, such as dependent coverage for children under age 26.

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The 111th Congress passed major health reform legislation, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), which was substantially amended by the health provisions in the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152). Several other laws that were subsequently enacted made more targeted changes to specific ACA provisions. All references to ACA in this report refer to the law as amended. The report provides a brief summary of major ACA provisions, implementation and oversight activities, and current legal challenges. For more detailed information on ACA's provisions, CRS has produced a series of more comprehensive reports, which are available at <http://www.crs.gov>. The information provided in these reports ranges from broad overviews of ACA provisions, such as the law's Medicare provisions, to more narrowly focused topics, such as dependent coverage for children under age 26.

Overview of Health Reform Law

The primary goal of ACA is to increase access to affordable health insurance for the millions of Americans without coverage and make health insurance more affordable for those already covered. In addition, ACA makes numerous changes in the way health care is financed, organized, and delivered. Among its many provisions, ACA restructures the private health insurance market, sets minimum standards for health coverage, creates a mandate for most U.S. residents to obtain health insurance coverage, and provides for the establishment by 2014 of state-based insurance exchanges for the purchase of private health insurance. Certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing coverage through the exchanges. The new law also expands eligibility for Medicaid; amends the Medicare program in ways that are intended to reduce the growth in Medicare spending; imposes an excise tax on insurance plans found to have high premiums; and makes numerous other changes to the tax code, Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and many other federal programs.

ACA is projected to have a significant impact on federal spending and revenues. The law includes spending to subsidize the purchase of health insurance coverage through the exchanges, as well as increased outlays for the expansion of the Medicaid program. ACA also includes numerous mandatory appropriations to fund temporary programs to increase access and funding for targeted groups, provide funding to states to plan and establish exchanges, and support many other research and demonstration programs and activities. The costs of expanding public and private health insurance coverage and other spending are offset by revenues from new taxes and fees, and by savings from payment and health care delivery system reforms designed to reduce spending on Medicare and other federal health care programs.

While most of the major provisions of the law do not take effect until 2014, some provisions are already in place, with others to be phased in over the next few years.

Coverage Expansions and Market Reforms: Pre-2014

The law creates several temporary programs to increase access and funding for targeted groups. They include (1) temporary high-risk pools for uninsured individuals with preexisting conditions; (2) a reinsurance program to reimburse employers for a portion of the health insurance claims' costs for their 55- to 64-year-old retirees; and (3) small business tax credits for firms with fewer than 25 full-time equivalents (FTEs) and average wages below \$50,000 that choose to offer

health insurance. Additionally, prior to 2014, states may choose voluntarily to expand their Medicaid programs.

Some private health insurance market reforms have already taken effect, such as extending dependent coverage to children under age 26, and not allowing children under age 19 to be denied insurance and benefits based on a preexisting health conditions. Major medical plans can no longer impose any lifetime dollar limits on essential health benefits, and plans may only restrict annual dollar limits on essential benefits to defined amounts (such annual limits will be prohibited altogether beginning in 2014). Plans must cover preventive care with no cost-sharing, and they cannot rescind coverage, except in cases of fraud. They must also establish an appeals process for coverage and claims. Insurers must also limit the ratio of premiums spent on administrative costs compared to medical costs, referred to as medical loss ratios, or MLRs.¹

Coverage Expansions and Market Reforms: Beginning in 2014

The major expansion and reform provisions in ACA take effect beginning in 2014. States are expected to establish health insurance exchanges that provide access to private health insurance plans with standardized benefit and cost-sharing packages for eligible individuals and small employers. In 2017, states may allow larger employers to purchase health insurance through the exchanges, but are not required to do so. The Secretary of Health and Human Services (HHS) will establish exchanges in states that do not create their own approved exchange. Premium credits and cost-sharing subsidies will be available to individuals who enroll in exchange plans, provided their income is generally at or above 100% and does not exceed 400% of the FPL and they meet certain other requirements.²

Also beginning in 2014, most individuals will be required to have insurance or pay a penalty (an individual mandate). Certain employers with more than 50 employees who do not offer health insurance may be subject to penalties. While most of these employers who offer health insurance will meet the law's requirements, some also may be required to pay a penalty if any of their full-time workers enroll in exchange plans and receive premium tax credits.

ACA's market reforms are further expanded in 2014, with no annual dollar limits allowed on essential health benefits, and no coverage exclusions for preexisting conditions allowed regardless of age. Plans offered within the exchanges and certain other plans must meet essential benefit standards and cover emergency services, hospital care, physician services, preventive services, prescription drugs, and mental health and substance use treatment, among other services. Premiums for individual and small group coverage may vary by limited amounts, but only based on age, family size, geographic area, and tobacco use. Additionally, plans must sell and renew policies to all individuals and may not discriminate based on health status.

In addition to the expanding private health insurance coverage, ACA, as enacted, requires state Medicaid programs to expand coverage to all eligible non-pregnant, non-elderly legal residents with incomes up to 133% of the federal poverty level (FPL), or risk losing their federal Medicaid

¹ For more information on the private insurance market reforms in ACA, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

² The 100% FPL eligibility threshold for the premium credits and cost-sharing subsidies may have important implications for low-income individuals residing in states that choose not to expand their Medicaid programs following the U.S. Supreme Court decision.

matching funds. The federal government will initially cover all the costs for this group, with the federal matching percentage phased down to 90% of the costs by 2020. The law also requires states to maintain the current CHIP structure through FY2019, and provides federal CHIP appropriations through FY2015 (thus providing a two-year extension on CHIP funding).³

In *National Federation of Independent Business v. Sebelius*, the Supreme Court found that the Medicaid expansion violated the Constitution by threatening states with the loss of their existing federal Medicaid matching funds if they fail to comply with the expansion (see discussion below under “U.S. Supreme Court Decision”).

Health Care Quality and Payment Incentives

ACA incorporates numerous Medicare payment provisions intended to reduce the rate of growth in spending. They include reductions in Medicare Advantage (MA) plan payments and a lowering of the annual payment update for hospitals and certain other providers.⁴ ACA established an Independent Payment Advisory Board (IPAB) to make recommendations for achieving specific Medicare spending reductions if costs exceed a target growth rate. IPAB’s recommendations will take effect unless Congress overrides them, in which case Congress would be responsible for achieving the same level of savings.⁵ Also, ACA provides tools to help reduce fraud, waste, and abuse in both Medicare and Medicaid.

Other provisions establish pilot, demonstration, and grant programs to test integrated models of care, including accountable care organizations (ACOs), medical homes that provide coordinated care for high-need individuals, and bundling payments for acute-care episodes (including hospitalization and follow-up care). ACA creates the Center for Medicare and Medicaid Innovation (CMMI) to pilot payment and service delivery models, primarily for Medicare and Medicaid beneficiaries. The law also establishes new pay-for-reporting and pay-for-performance programs within Medicare that will pay providers based on the reporting of, or performance on, selected quality measures.

Additionally, ACA creates incentives for promoting primary care and prevention; for example, by increasing primary care payment rates under Medicare and Medicaid, covering some preventive services without cost-sharing, and funding community-based prevention and employer wellness programs, among other things. The law increases funding for community health centers and the National Health Service Corps to expand access to primary care services in rural and medically underserved areas and reduce health disparities. Finally, ACA requires the HHS Secretary to develop a national strategy for health care quality to improve care delivery, patient outcomes, and population health.

³ For more information about the Medicaid provisions in ACA, see CRS Report R41210, *Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

⁴ For more information about the Medicare provisions in ACA, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

⁵ For more information about IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*.

Estimated Costs and Impact of Health Reform

The February 2011 baseline budget projections, prepared by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), estimated that ACA implementation will reduce federal deficits by \$210 billion over the 10-year period FY2012-FY2021.⁶

CBO and JCT estimated that the law's insurance coverage expansion will result in gross costs of \$1,390 billion over the FY2012-FY2021 period. Gross costs include the exchange subsidies and related spending, increased spending on Medicaid and CHIP, and tax credits for certain small employers. CBO and JCT further estimated that those costs will be partially offset by an estimated \$348 billion from penalties paid by uninsured individuals and employers, an excise tax on high-premium insurance plans, and net savings from other effects that coverage expansion is expected to have on tax revenues and outlays. Thus, CBO and JCT projected in the February 2011 baseline that ACA's insurance coverage provisions will result in net costs of \$1,042 billion over the FY2012-FY2021 period.⁷

The projected net costs of coverage expansion under ACA are offset by (1) direct spending savings from payment and delivery system reform provisions (described in the previous section) that are designed to slow the rate of growth of federal health care spending, primarily for Medicare, and improve outcomes and the quality of care; and (2) new revenue sources from taxes and fees (other than those related to insurance coverage, mentioned above). Overall, CBO and JCT projected that the new revenues and direct spending savings will total \$1,252 billion over the FY2012-FY2021 period. ACA raises a large share of its revenue from taxes on high-income households, such as an additional Medicare payroll tax on those with incomes over \$200,000 (single) and \$250,000 (married), and by imposing fees on insurers and on manufacturers and importers of pharmaceuticals and medical devices. The law also limits the annual contribution to Flexible Spending Accounts (FSAs) to \$2,500, and excludes over-the-counter medications (except insulin) from reimbursement by FSAs and other health tax savings accounts.⁸

CBO and JCT's recently released March 2012 baseline projections include updated estimates of the gross and net costs of insurance coverage expansion under ACA, but do not include an update of the February 2011 estimates of the law's offsetting revenues and direct spending savings. The March 2012 baseline now projects gross costs of \$1,496 billion, an increase of \$106 billion over the February 2011 estimate. It also projects higher offsets, resulting in estimated net costs of \$1,083 billion for insurance coverage expansion over the 10-year period FY2012-FY2021, which is \$41 billion more than the February 2011 estimate.⁹

⁶ U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, 112th Cong., 1st sess., March 30, 2011. Available at <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>. See Table 1.

⁷ *Ibid.*, see Table 1.

⁸ *Ibid.*, see Table 1. For more information about the revenue provisions in ACA, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*.

⁹ U.S. Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012. Available at <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>. See Table 1. CBO's 2012 estimates differ from the 2011 projections as a result of (1) changes in the economic outlook, (2) new laws enacted in 2011 that modified ACA's insurance coverage provisions, (3) reduced growth in private health care spending, and (4) technical changes in the estimating procedures used by CBO and JCT.

In the March 2012 baseline, CBO and JCT also estimate that ACA will increase the number of nonelderly Americans with health insurance by about 33 million in 2021. They project that the share of legal nonelderly U.S. residents with insurance coverage in 2021 will be about 93%, up from 82% this year. Expansion of the Medicaid and CHIP programs is expected to enroll 17 million additional individuals in 2021, accounting for roughly half of the increase in coverage. The other half is due to a projected increase in private health insurance coverage. An estimated 23 million people will purchase their own coverage through insurance exchanges in 2021. However, about 6 million fewer people are projected to purchase individual coverage directly from insurers or obtain coverage through their employers, resulting in an estimated net increase in the number of people with private insurance coverage of about 16 million.¹⁰

Importantly, CBO and JCT's projections do not reflect the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, which precludes the Secretary from penalizing states that choose not to participate in the Medicaid expansion (see discussion below under "U.S. Supreme Court Decision").

Implementation and Oversight

Implementation of ACA, which began upon the law's enactment in 2010 and will continue to unfold over the next few years, involves all the major health care stakeholders, including the federal and state governments, as well as employers, insurers, and health care providers. The HHS Secretary is tasked with implementation and oversight of many of ACA's key provisions. Other federal agencies, notably the Internal Revenue Service (IRS), also have substantial regulatory and administrative responsibilities under the new law. For many of ACA's most significant reform provisions, the HHS Secretary and other federal officials are required to take certain actions, such as issuing regulations or interim final rules, by a specific date. As already noted, many of the key components of market reform and coverage expansion do not take effect until 2014. Implementing some parts of the law will entail extensive rulemaking and other actions by federal agencies; other changes will be largely self-executing, pursuant to the new statutory requirements. ACA also creates a variety of new commissions and advisory bodies, some with substantial decision-making authority (e.g., IPAB).

Under ACA, states are required to expand Medicaid coverage—though some may now elect not to do so without risk of losing federal matching funds for their existing Medicaid program—and are expected to take the lead in establishing the exchanges, even as many of them struggle with budget shortfalls and weak economies. Employers, too, have a key role to play in ACA implementation. The law made changes to the employer-based system under which more than half of all Americans get health insurance coverage. Many small employers will face decisions on whether to use the new incentives to provide coverage to their employees, while larger employers must weigh the benefits and costs of continuing to offer coverage or paying the penalties for not doing so.

The federal subsidies and outlays for expanding insurance coverage represent mandatory spending under the new law. In addition, ACA included numerous mandatory appropriations (and transfers from the Medicare trust funds) that provide billions of dollars over the coming years to support new and existing grant programs and other activities authorized under the law. For

¹⁰ Ibid., see Table 3.

example, funding is provided for states to plan and establish exchanges (once established, exchanges must become self-sustaining), and for CMMI to test innovative payment and service delivery models. ACA funded three multi-billion dollar trust funds to support health centers and health workforce programs, comparative effectiveness research, and public health programs.¹¹ It also established the Health Insurance Reform Implementation Fund (HIRIF) and appropriated \$1 billion to the Fund to cover federal regulatory and other administrative costs associated with ACA's implementation. The HIRIF funds, which have largely been used by HHS and the IRS, will all have been obligated by the end of FY2012. Consequently, the President's FY2013 budget requested more than \$1 billion in new discretionary funding for HHS and the IRS to pay ACA-related administrative costs. It remains unclear, however, whether congressional appropriators will provide some or all of those funds.¹²

Finally, the law established many new grant programs and provided for each an authorization of appropriations, and reauthorized funding for numerous existing programs whose authorization of appropriations had expired. Obtaining funding for all these discretionary programs requires action by the congressional appropriators.¹³

Rules and Guidance Documents

ACA is being implemented in a variety of ways, including new agency programs, grants, demonstration projects, guidance documents, and regulations. Whereas regulations or rules have the force and effect of law, agency guidance documents do not. The federal rulemaking process is governed by the Administrative Procedure Act (APA),¹⁴ other statutes, and executive orders. Under the APA's informal rulemaking procedures, agencies generally are required to publish notice of a proposed rulemaking, provide opportunity for the submission of comments by the public, and publish a final rule and a general statement of basis and purpose in the *Federal Register* at least 30 days before the effective date of the rule.¹⁵ Agencies' compliance with the APA is subject to judicial review. The APA's rulemaking requirements do not apply to guidance documents.¹⁶ More than 40 provisions in ACA require or permit agencies to issue rules, with some allowing the agencies to "prescribe such regulations as may be necessary."¹⁷

¹¹ For more details on all of ACA's mandatory appropriations, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by C. Stephen Redhead, Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA).

¹² For a discussion of legislative actions taken to date on the FY2013 appropriations bills to provide discretionary funding for ACA administration, see CRS Congressional Distribution Memorandum, "Patient Protection and Affordable Care Act: Implementation Funding and Obligations," by C. Stephen Redhead, June 29, 2012.

¹³ For more details on all of ACA's discretionary spending provisions, see CRS Report R41390, *Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)*.

¹⁴ 5 U.S.C. §§551 *et seq.*

¹⁵ 5 U.S.C. §§553(c), (d).

¹⁶ 5 U.S.C. §553(b)(3)(A).

¹⁷ For more information about regulations in ACA, see CRS Report R41586, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act: Fall 2010 Unified Agenda*.

Congressional Oversight

Congress has a range of options as it oversees the implementation of ACA, including oversight hearings, confirmation hearings for agency officials, letters to and meetings with agency officials and the Office of Information and Regulatory Affairs regarding particular rules, comments on proposed rules, and new legislation regarding specific rules. Congress, committees, and individual Members can also request that the Government Accountability Office or federal offices of inspectors general (OIGs) evaluate agencies' actions to implement, or agency decisions not to implement, certain provisions of ACA. Congress can also include provisions in the text of agencies' appropriations bills directing or preventing the development or enforcement of particular regulations, or use the Congressional Review Act to disapprove an agency rule implementing ACA.¹⁸

Legal Challenges

Following enactment of ACA, state attorneys general and others brought a number of lawsuits challenging provisions of the act on constitutional grounds. While some of these cases were dismissed for procedural reasons, others moved forward, eventually reaching the U.S. Supreme Court. During the last week of March 2012, the Court heard arguments in *HHS v. Florida*, a case in which attorneys general and governors in 26 states as well as others brought an action against the Administration, seeking to invalidate the individual mandate and other provisions of ACA.

U.S. Supreme Court Decision

On June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*,¹⁹ finding that the individual mandate in ACA is a constitutional exercise of Congress's authority to levy taxes. However, the Court held that it was not a valid exercise of Congress's power under the Commerce Clause or the Necessary and Proper Clause.

With regard to the Medicaid expansion provision, the Court, in an opinion written by Chief Justice Roberts, accepted an argument that the scope of the changes imposed by the Medicaid expansion transformed the ACA requirements into a "new" Medicaid benefit program. As this "new" program was to be enforced by the threat of withholding of existing federal Medicaid matching funds, the Court found that the states were being "coerced" in violation of the Tenth Amendment into administering this new program. Chief Justice Roberts' opinion, however, went on to note that the Medicaid requirement in question was subject to other statutory language providing for severance of unconstitutional provisions. Since it was only the withholding of existing federal Medicaid matching funds that was unconstitutional, the Chief Justice held that severance under the statute could be limited to termination of those funds. Thus the federal government would still be allowed, under the statute and the Tenth Amendment, to provide federal matching funds associated with the expansion. In other words, states can now decline to participate in the Medicaid expansion without financial penalty, but, if they wish to participate, must comply with the new requirements in order to receive the expansion-related funds.

¹⁸ 5 U.S.C. §§801 *et seq.*

¹⁹ *National Federation of Independent Business v. Sebelius*, No. 11-393, slip op. (June 28, 2012).

It is unclear how many states may now decide not to participate in the Medicaid expansion. In so doing, they would forgo a substantial amount of federal funding. As already noted, the federal government will provide 100% of the costs of the expansion for the first three years, phasing down to 90% in the years thereafter. Moreover, if a state were to decide not to implement the Medicaid expansion, low-income adults below the poverty line (i.e., 100% FPL) who were not covered by, or eligible for, the state's existing Medicaid program would in general be ineligible for the exchange subsidies.

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