



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

C. Stephen Redhead, Coordinator
Specialist in Health Policy

Jennifer Staman
Legislative Attorney

Vanessa K. Burrows
Legislative Attorney

Bernadette Fernandez
Specialist in Health Care Financing

March 23, 2012

Congressional Research Service

7-5700

www.crs.gov

R41664

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 (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. The costs for expanding access to health insurance and other provisions 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 address ACA's requirement for individuals to have health insurance (i.e., the individual mandate), and claim that it is beyond the scope of Congress's enumerated powers. Appellate courts evaluating the constitutionality of this requirement have reached varying conclusions. The expansion of the Medicaid program has also been challenged, as state plaintiffs contend that the expansion impermissibly infringes upon states' rights, coercing them into accepting onerous conditions in exchange for federal funds. Several petitions for Supreme Court review have been filed in these cases, and on November 14, 2011, the Supreme Court agreed to hear arguments relating these provisions of ACA. The arguments are now scheduled to occur the week of March 26, 2012.

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.

Contents

Overview of Health Reform Law	1
Coverage Expansions and Market Reforms: Pre-2014.....	1
Coverage Expansions and Market Reforms: Beginning in 2014.....	2
Health Care Quality and Payment Incentives.....	3
Estimated Costs and Impact of Health Reform	3
Implementation and Oversight.....	5
Rules and Guidance Documents.....	5
Congressional Oversight	6
Legal Challenges	6
Individual Mandate.....	7
States' Rights Issues	7

Contacts

Author Contact Information.....	8
Acknowledgments	8

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 (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. State Medicaid programs will be required to expand coverage to all eligible non-pregnant, non-elderly legal residents with incomes up to 133% of the federal poverty level (FPL). 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 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).²

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 above 100% and no more than 400% of the FPL and they meet other requirements.

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

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 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*.

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.

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.³ 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.⁴ 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.

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-FY2021.⁵

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

³ 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*.

⁴ For more information about IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*.

⁵ 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.

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.⁶

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.⁷

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.⁸

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.⁹

⁶ *Ibid.*, see Table 1.

⁷ *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)*.

⁸ 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.

⁹ *Ibid.*, see Table 3.

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. While the HHS Secretary is responsible for implementation and oversight of many of ACA's provisions, other federal officials and entities are also given new responsibilities. For many of the law's most significant reform provisions, the Secretary is 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).

States must expand Medicaid coverage 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 appropriates (and transfers from the Medicare trust funds) billions of dollars over the coming years to support many of the law's provisions. They include providing funding for states to plan and establish exchanges (once established, exchanges must become self-sustaining), and support for CMMI to test innovative payment and service delivery models. ACA also creates three multi-billion dollar trust funds to support health centers and health workforce programs, comparative effectiveness research, and public health programs.¹⁰ Finally, the law establishes many new grant programs and provides for each an authorization of appropriations, and it reauthorizes funding for numerous existing programs whose authorization of appropriations had expired. Obtaining funding for all these discretionary programs requires action by the congressional appropriators.¹¹

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),¹² other statutes, and executive orders. Under the APA's informal rulemaking procedures, agencies generally are required to publish

¹⁰ 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)*.

¹¹ For more details on all of ACA's discretionary spending provisions, see CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (ACA)*.

¹² 5 U.S.C. §§551 *et seq.*

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.¹³ Agencies' compliance with the APA is subject to judicial review. The APA's rulemaking requirements do not apply to guidance documents.¹⁴ 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."¹⁵

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.¹⁶

Legal Challenges

Following enactment of ACA, state attorneys general and others have brought a number of lawsuits challenging provisions of the act, including the individual mandate, on constitutional grounds. So far, plaintiffs' success in these challenges has been mixed. For example, in one of the most publicized cases, *Florida v. HHS*, attorneys general and governors in 26 states as well as others brought an action against the Secretaries of Health and Human Services, the Treasury, and Labor, seeking relief from the individual mandate and other ACA requirements. On August 12, 2011, the Eleventh Circuit held that the individual mandate is unconstitutional. Conversely, the Sixth Circuit in *Thomas More Law Center v. Obama* and the District of Columbia Circuit in *Seven-Sky v. Holder* upheld the individual mandate as an appropriate exercise of Congress's enumerated powers. Other courts, such as the Fourth Circuit in *Virginia v. Sebelius* and *Liberty University v. Geithner*, dismissed these challenges, not based on the merits of the case, but for procedural reasons. Several petitions for Supreme Court review were filed, and on November 14, 2011, the Supreme Court agreed to hear appeals arising from the *Florida* case. Oral arguments will take place in March 2012.¹⁷

¹³ 5 U.S.C. §§553(c), (d).

¹⁴ 5 U.S.C. §553(b)(3)(A).

¹⁵ 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*.

¹⁶ 5 U.S.C. §§801 *et seq.*

¹⁷ For further analysis of the constitutionality of the individual mandate and a discussion of these lawsuits, see CRS Report R40725, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*.

Individual Mandate

At issue in many of the lawsuits is whether Congress has the authority to pass the individual mandate under either its power to regulate interstate commerce or its taxing power. Under the Commerce Clause, one issue that has arisen is whether the requirement to purchase health insurance is a valid regulation of economic activity or not. Supporters argue that the requirement to purchase health insurance is economic in nature because it regulates how an individual participates in the health care market, through insurance or otherwise. Opponents contend that while regulation of the health insurance industry or the health care system is economic activity, requiring the purchase of health insurance is not economic regulation. While supporters emphasize that requiring Americans to have health insurance is important for the proper functioning of the U.S. health care system, opponents stress that requiring a private individual to purchase health insurance would be an unprecedented expansion of Congress's commerce powers.

Supporters of the individual mandate also argue that Congress can use its taxing powers to encourage taxpayers to purchase health insurance. Opponents assert that since the tax associated with the individual mandate may be avoided by purchasing insurance, it is a penalty and thus the taxing power does not, by itself, provide Congress the constitutional authority to support this provision.

States' Rights Issues

The states and the federal government have a very complicated, shared power relationship when it comes to health care. Recently, this relationship has engendered intense and contentious debate, with considerable resistance by a number of states in the form of lawsuits, statutes, and constitutional amendments intended to limit, opt-out of, or nullify certain ACA provisions, most often the individual mandate.¹⁸ The expansion of the Medicaid program has also been subject to challenge, as states have argued that the expansion turns Medicaid from a voluntary program into something that is forced upon them, in violation of state sovereignty and the federal spending power. Conversely, the federal government has argued that ACA's broader eligibility requirements for the Medicaid program are appropriate conditions attached to receiving federal funds. Along with issues related to the individual mandate, the Supreme Court also agreed to hear arguments with respect to the constitutionality of the Medicaid expansion.

Legislation attempting to nullify selected provisions of ACA has been enacted in several states. In addition, voters in some states recently approved state constitutional amendments intended to prevent implementation of the individual mandate and keep the purchase of health insurance optional for individuals. If the underlying constitutional issues are resolved by the courts in favor of Congress's power to enact the individual insurance mandate, then these state nullification provisions would likely be ineffective under the Supremacy Clause of the U.S. Constitution, under which federal laws are the "supreme Law of the Land."¹⁹

¹⁸ For a discussion of states' rights issues in the context of health care, see CRS Report R40846, *Health Care: Constitutional Rights and Legislative Powers*.

¹⁹ U.S. Const. Art. VI, cl. 2.

Author Contact Information

C. Stephen Redhead, Coordinator
Specialist in Health Policy
credhead@crs.loc.gov, 7-2261

Jennifer Staman
Legislative Attorney
jstaman@crs.loc.gov, 7-2610

Vanessa K. Burrows
Legislative Attorney
vburrows@crs.loc.gov, 7-0831

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

Acknowledgments

The authors would like to thank Hinda Chaikind, Section Research Manager, and Curtis Copeland, former Specialist in American National Government, for co-authoring the original report. Patricia Davis, Kathleen Swendiman, Edward Liu, and Amanda Sarata provided assistance in writing and researching this report.