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Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act

C. Stephen Redhead
Specialist in Health Policy

Janet Kinzer
Senior Research Librarian

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Summary

Congress is deeply divided over implementation of the Affordable Care Act (ACA), the health reform law enacted in March 2010 during the 111th Congress. Since the ACA's enactment, lawmakers opposed to specific provisions in the ACA or the entire law have repeatedly debated its implementation and considered bills to repeal, defund, delay, or otherwise amend the law.

During the 112th, 113th, and 114th Congresses, the Republican-led House passed numerous ACA-related bills, including legislation that would repeal the entire law. There was much less debate in the Senate, which remained under Democratic control during the 112th and 113th Congresses. Most of the House-passed ACA legislation was not considered in the Senate during that period. With Republicans in control of both chambers in the 114th Congress, opponents of the ACA sought new opportunities to pass legislation that would change the law.

The House-passed legislation included stand-alone bills as well as provisions in broader, often unrelated measures that would have (1) repealed the ACA in its entirety and, in some cases, replaced it with new law; (2) repealed, or by amendment restricted or otherwise limited, specific provisions in the ACA; (3) eliminated appropriations provided by the ACA and rescinded all unobligated funds; (4) replaced the ACA's mandatory appropriations with authorizations of (discretionary) appropriations, and rescinded all unobligated funds; or (5) blocked or otherwise delayed implementation of specific ACA provisions.

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 On October 23, 2015, the House passed a reconciliation bill that would have repealed several provisions of the ACA.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

A few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support were approved by both the House and the Senate and signed into law. During the 111th Congress, a number of clarifications and technical adjustments to the ACA were enacted. During the 112th, 113th, and 114th Congresses, several more substantive ACA amendments became law. For example, Congress repealed Title VIII of the ACA—the Community Living Assistance Services and Supports (CLASS) Act—which would have established a voluntary, long-term care insurance program to pay for community-based services and supports for individuals with functional limitations. Lawmakers also repealed a tax-filing provision (IRS Form 1099) that had been included in the ACA, and, in two separate legislative actions, reduced the annual appropriations to the ACA's Prevention and Public Health Fund over the period FY2013-FY2024 by a total of $9.75 billion.

In addition to considering ACA repeal or amendment in authorizing legislation, lawmakers used the annual appropriations process in an effort to eliminate funding for the ACA's implementation and address other concerns they have with the law. A companion report, CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)*, summarizes the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law.

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Introduction

Congress is deeply divided over implementation of the Affordable Care Act (ACA), the health reform law enacted in March 2010 during the 111th Congress.[1] Since the ACA's enactment, lawmakers opposed to specific provisions in the ACA or the entire law have repeatedly debated its implementation and considered bills to repeal, defund, delay, or otherwise amend the law.

This report summarizes legislative actions taken during the 112th, 113th, and 114th Congresses to repeal, defund, delay, or otherwise amend the ACA. Much of this legislative activity took place in the House, which reverted to Republican control at the beginning of the 112th Congress (2011-2012). The Republican-led House passed numerous ACA-related bills, including legislation that would have repealed the entire law.

There was less debate in the Senate, which remained under Democratic control during the 112th and 113th Congresses. Most of the House-passed ACA legislation was not considered in the Senate during that period. A few bills to amend specific elements of the ACA that attracted sufficiently broad and bipartisan support were approved by both the House and the Senate and signed into law.

With Republicans in control of both chambers in the 114th Congress, opponents of the ACA sought new opportunities to pass and send to the President legislation that would change the law.

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

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

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

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

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

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

The information in this report is presented in three tables. **Table 1** summarizes the ACA changes that were signed into law during the 112th, 113th, and 114th Congresses. **Table 2** lists all the other ACA bills passed by the House during that period. **Table 3** summarizes the ACA provisions in the reconciliation bill that President Obama vetoed. While a detailed examination of the ACA itself is beyond the scope of this report, a brief overview of the ACA's core provisions and its impact on federal spending is provided as context for the material presented in the tables.[4]

In addition to considering ACA repeal or amendment in authorizing legislation, lawmakers have used the annual appropriations process in an effort to eliminate funding for ACA implementation and address other concerns they have with the law. A companion report, CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)*, summarizes the ACA-related language added to annual appropriations legislation by congressional appropriators since the ACA was signed into law.

A Brief Overview of the ACA

The ACA made significant changes to the way U.S. health care is financed, organized, and delivered. Its primary goal is to increase access to affordable health care for the medically uninsured and underinsured. To that end, the law included a complex set of interconnected provisions that address the private health insurance market.

First, the ACA requires health insurers to comply with a set of federal standards ("market reforms") to ensure that individuals may purchase, keep, and renew coverage that provides a minimum level of benefits and consumer protections, with some limits on costs. Second, the law establishes competitive private health insurance exchanges (also known as marketplaces) through which individuals and small employers are able to compare and enroll in qualified health plans.

Exchanges operate in every state and the District of Columbia. They are administered by states or by the federal government, or through a partnership between the state and federal governments. Qualified individuals who enroll in exchange plans may receive financial assistance if they meet income and certain other requirements. Refundable tax credits are available to individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) to help pay the insurance premium. The premium tax credits are available upon enrollment so that eligible individuals and families can choose to receive the subsidy immediately rather than wait until they file taxes the following year. In addition, certain individuals and families receiving the tax credit may be eligible for cost-sharing subsidies to reduce their out-of-pocket costs (e.g., deductibles, co-payments) when receiving health services. Small employers with no more than 25 full-time equivalent employees (FTEs) may also use the exchanges to purchase insurance coverage for their employees and may qualify for a tax credit to help cover the cost of providing that coverage.

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

Third, the ACA's "individual mandate" requires most U.S. citizens and legal residents to obtain coverage. Those who remain uninsured may have to pay a penalty unless they qualify for an

[4] Numerous CRS products that provide more in-depth information on the many new programs and activities authorized and funded by the ACA are available at http://www.crs.gov/iap/health-care.

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

exemption. The individual mandate is intended to encourage healthy individuals to participate in the insurance market and not wait until they get sick to buy coverage. Finally, the law's "employer mandate" requires employers with 50 or more FTEs to offer health coverage that meets affordability and adequacy standards for their full-time employees and those workers' dependents. Employers who do not comply with these requirements may be subject to a tax if one or more of their employees purchase coverage through an exchange and receive a subsidy. The purpose of the ACA's employer requirements is to encourage larger firms to maintain affordable and adequate coverage for their employees.

The ACA coupled its private insurance provisions with the requirement that states expand their Medicaid programs to cover all nonelderly individuals with incomes up to 138% FPL. Those with higher incomes, up to 400% FPL, may be eligible to get subsidized coverage through an exchange. In June 2012, the U.S. Supreme Court in *NFIB v. Sebelius* found the Medicaid expansion to be unconstitutionally coercive and prohibited the federal government from enforcing it.[6] The Court's decision made Medicaid expansion optional for states.

In addition to expanding access to insurance coverage, the ACA contains hundreds of other provisions that address health care access, costs, and quality. They include new programs to test alternative ways of delivering and paying for health care. The law also includes new taxes and fees as well as adjustments to Medicare payments to hospitals and other health care providers. These provisions are designed to offset the federal spending on exchange subsidies and Medicaid expansion.

ACA's Impact on Federal Spending

Implementation of the ACA is affecting both mandatory and discretionary spending. *Mandatory spending*—also referred to as direct spending—is controlled through authorizing laws.[7] It includes spending on entitlement programs such as Medicare and Social Security. Authorizing laws may provide permanent or temporary appropriations or other forms of budget authority for such spending. When the authorizing law contains no appropriations, mandatory programs may be funded through the annual appropriations process. This is sometimes referred to as "appropriated mandatory" or "appropriated entitlement" spending.[8] *Discretionary spending* is both controlled and funded through the annual appropriations process. It typically covers the routine costs of running federal agencies and offices, including wages and salaries.[9]

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

[6] *NFIB v. Sebelius*, No. 11-393, slip op. (June 28, 2012), http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. For more information, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

[7] Authorizing legislation generally refers to substantive legislation, reported by a committee (or committees) of jurisdiction other than the House or Senate Appropriations Committees, that establishes or continues the operation of a federal program or agency either indefinitely or for a specific period.

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

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

Mandatory Spending on Expanding Insurance Coverage

This category accounts for most of the federal spending under the ACA. It includes the exchange subsidies (i.e., premium tax credits and cost-sharing subsidies), the federal government's share of the costs of Medicaid expansion, and tax credits for small employers. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) projected that this and other ACA mandatory spending (discussed in the second category, below) would be more than offset by (1) revenues from the ACA's new taxes and fees, and (2) savings from the law's adjustments to Medicare provider payments that are projected to slow the rate of growth of Medicare spending.[10]

Mandatory Spending on Other Programs

The ACA authorized new Medicare and Medicaid spending. For example, it phased out the Medicare prescription drug benefit "donut hole" through a combination of subsidies and manufacturer discounts, and it increased Medicare payments for primary care services and medical education. The ACA also included numerous appropriations that are providing billions of dollars of mandatory funding to support grant programs and other activities authorized by the law.[11] For example, the law funded temporary insurance programs for targeted groups prior to the exchanges becoming operational, and it provided funding for grants to states to plan and establish health insurance exchanges. The ACA included a permanent appropriation, available for 10-year periods, for the Center for Medicare & Medicaid Innovation (CMMI), within the Centers for Medicare & Medicaid Services (CMS), to test and implement innovative health care payment and service delivery models.

In addition, the ACA created four special funds and appropriated amounts to each one. First, the Community Health Center Fund (CHCF) has provided almost $11 billion over five years (FY2011-FY2015) for the federal health centers program and the National Health Service Corps.[12] Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) is supporting patient-centered comparative clinical effectiveness research through FY2019 with a mix of appropriations, fees on health plans, and transfers from the Medicare trust funds. Third, the Prevention and Public Health Fund (PPHF), for which the ACA provided a permanent annual appropriation, is supporting prevention, wellness, and other public health-related programs and activities. Finally, the Health Insurance Reform Implementation Fund (HIRIF), for which the ACA appropriated $1 billion, helped pay for the initial administrative costs of implementing the law.

Discretionary Spending

The ACA is affecting discretionary spending in two ways. First, the law created numerous new discretionary grant programs and provided each of them with an authorization of appropriations.

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

[11] For a summary of all the ACA's mandatory appropriations, and the status of obligation of those funds, see CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, by C. Stephen Redhead.

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

To date, however, few of these programs have received discretionary funding through annual appropriations acts, though several of them have been supported with mandatory funds from the PPHF.[13] Second, the two agencies primarily responsible for implementing the ACA's provisions to expand insurance coverage—CMS's Center for Consumer Information and Insurance Oversight (CCIIO) and the Internal Revenue Service (IRS)—are incurring significant costs in connection with administering and enforcing the law. Both agencies requested increases in funding in each of their past four budget submissions (i.e., FY2013-FY2016) to help pay for ACA implementation. But congressional appropriators have not provided either agency with any additional discretionary funds. CMS instead has relied on discretionary fund transfers from other accounts, amounts from the Nonrecurring Expenses Fund (NEF),[14] and ACA mandatory funds (i.e., HIRIF, PPHF) to support its ACA implementation activities. CMS also has transferred HIRIF funds to the IRS.

ACA Provisions in Authorization Legislation

Enacted Laws

Table 1 summarizes the authorizing legislation to amend the ACA that has been enacted since the ACA became law in March 2010. Each table entry includes the public law number and date of enactment, the original bill number and sponsor, and a brief description and explanation of the change(s) made to the ACA. The laws are listed in reverse chronological order, beginning with the most recently enacted legislation and extending back to the first measure signed into law following enactment of the ACA and the accompanying package of amendments in the Health Care and Education Reconciliation Act (HCERA).[15]

During the 111th Congress, when the House was still under Democratic control, a number of clarifications and technical adjustments to the law were enacted. In the 112th, 113th, and 114th Congresses, several more substantive ACA amendments that garnered bipartisan support were signed into law. For example, Congress repealed Title VIII of the ACA—the Community Living Assistance Services and Supports (CLASS) Act—which would have established a voluntary, long-term care insurance program to pay for community-based services and supports for individuals with functional limitations. Lawmakers also repealed a tax-filing provision (IRS Form 1099) that had been included in the ACA, and, in two separate legislative actions, they reduced the PPHF annual appropriations over the period FY2013-FY2024 by a total of $9.75 billion.

[13] The ACA also reauthorized funding for many *existing* discretionary grant programs authorized under the Public Health Service Act; notably, the federal health workforce programs administered by the Health Resources and Services Administration (HRSA). The authorizations of appropriations for many of these programs expired prior to the ACA's enactment, though most of them were still receiving annual appropriations. The ACA also permanently reauthorized appropriations for the federal health centers program and for programs and services provided by the Indian Health Service (IHS). Congressional appropriators have in general continued to provide discretionary funding for these long-standing programs, though typically at funding levels below the amounts authorized by the ACA. For more details on all the authorizations (and reauthorizations) of discretionary funding in ACA, including the FY2011-FY2015 funding levels for programs that received an appropriation, see CRS Report R41390, *Discretionary Spending Under the Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

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

[15] See footnote 1.

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

House-Passed Bills

Table 2 summarizes the ACA provisions in authorizing legislation that passed the House in the 112th, 113th, and 114th Congresses (2011-2016) but saw little if any further legislative action. As noted in the table, some of these House-passed ACA bills were used by the Senate as vehicles for considering other, unrelated legislation.

The House-passed legislation included stand-alone bills as well as provisions in broader, often unrelated measures that would have (1) repealed the ACA in its entirety and, in some cases, replaced it with new law; (2) repealed, or by amendment restricted or otherwise limited, specific provisions in the ACA; (3) eliminated appropriations provided by the ACA and rescinded all unobligated funds;[16] (4) replaced the mandatory appropriations for one or more ACA programs with authorizations of (discretionary) appropriations, and rescinded all unobligated funds; and (5) blocked or otherwise delayed implementation of specific ACA provisions.

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

[16] Appropriations bills provide agencies with budget authority, which is the legal authority to incur financial obligations (e.g., hire employees, purchase services, award grants, or sign contracts) that result in immediate or future government expenditures (or outlays). Budget authority is generally made available for obligation during a specified time period, typically the upcoming fiscal year. Once budget authority reaches the end of that time period, it "expires," meaning that it is no longer available for obligation. A rescission is a provision of law that cancels budget authority prior to when it would otherwise expire, making it unavailable for future obligation. For further explanations of these terms, see GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, pp. 85-86, available at http://www.gao.gov.

[17] The House has taken multiple votes on amendments to, and passage of, budget resolutions that expressed support for a full repeal of the ACA, or the repeal or amendment of specific provisions in the law. However, budget resolutions are concurrent resolutions that apply only to Congress. They are not presented to the President for his signature and do not have the force of law. The House approved budget resolutions for FY2012 and FY2013 (H.Con.Res. 34 and H.Con.Res. 112, respectively) during the 112th Congress (2011-2012) and passed budget resolutions for FY2014 and FY2015 (H.Con.Res. 25 and H.Con.Res. 96, respectively) during the 113th Congress (2013-2014). All four House budget resolutions included language addressing full repeal of the ACA. In 2015, the House and the Senate each passed a budget resolution for FY2016 (H.Con.Res. 27 and S.Con.Res. 11, respectively). Both measures—as well as the subsequent conference agreement (S.Con.Res. 11) approved by the two chambers—included language calling for full repeal of the ACA. Neither the House nor the Senate passed a FY2017 budget resolution in 2016.

ACA Reconciliation Legislation

In addition to their efforts to repeal or otherwise amend the ACA through regular legislative procedures, Republican leaders used the reconciliation process to pass legislation that would eliminate several core provisions of the ACA. **Table 3** summarizes the ACA provisions in H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, which President Obama vetoed on January 8, 2016.

H.R. 3762 was reported by the House Budget Committee on October 16, 2015, and passed by the full House on October 23, 2015. The measure contained provisions submitted by three committees—Ways and Means, Energy and Commerce, and Education and Workforce—pursuant to reconciliation instructions included in the FY2016 budget resolution (S.Con.Res. 11).[18]

As passed by the House, H.R. 3762 would have repealed the individual and employer mandates, eliminated the medical device tax and the tax on high-value employer-sponsored health plans (i.e., "Cadillac tax"), and defunded the PPHF, among other things. CBO and JCT estimated that the bill would reduce the budget deficit over the period FY2016-FY2025 by about $129 billion. That amount reflects not just the bill's direct impact on federal spending and revenues but also its broader impact on the U.S. economy, the so-called macroeconomic feedback effects.[19]

The Senate took up consideration of H.R. 3762 and substituted its own significantly broader set of ACA provisions. Those provisions were submitted by the Finance and HELP Committees, in accordance with the reconciliation instructions in S.Con.Res. 11. As amended, H.R. 3762 passed the Senate on December 3, 2015.[20]

The House approved the Senate-passed bill on January 6, 2016. The enrolled bill was sent to the President, who vetoed it on January 8, 2016. The House voted to override the veto on February 2, 2016, but did not muster the two-thirds vote required.

As summarized in **Table 3**, the vetoed bill would have repealed the premium tax credits and cost-sharing subsidies, eliminated the penalties associated with the individual and employer mandates, terminated the requirements and enhanced federal funding for the Medicaid expansion, and repealed most of the ACA's taxes and fees, among other things.

CBO and JCT estimated that the loss of tax and other revenue under the bill would be more than offset by eliminating spending on subsidies and Medicaid expansion. They projected that the bill would reduce the budget deficit over the period FY2016-FY2025 by about $474 billion, including macroeconomic feedback effects.[21]

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

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

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

[21] U.S. Congressional Budget Office, "Re: Budgetary Effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015," December 11, 2015, (continued...)

The Senate's Byrd Rule

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

However, the Budget Act includes language known as the Byrd rule, after the late Senator Robert Byrd, that allows Senators to block provisions of (or amendments to) a reconciliation bill that are determined to be "extraneous" to the bill's basic purpose of implementing budget changes.[22] The Byrd rule includes several criteria for determining whether a provision is extraneous. For example, a provision is extraneous if

- it does not produce a change in outlays or revenues, unless the provision establishes the terms and conditions of another provision that has a budgetary impact;
- it produces a change in outlays or revenues that is "merely incidental" to the provision's non-budgetary effects; or
- it increases the deficits in any year after the time period covered by the reconciliation instructions, unless other provisions recommended by the same committee fully offset those "out-year" costs.[23]

Senators may raise a parliamentary objection (i.e., a point of order) against any provision that they believe to be extraneous. If the point of order is sustained by the parliamentarian, the extraneous material is deleted. Importantly, the Budget Act requires 60 votes to waive the Byrd rule or override the parliamentarian's ruling on a point of order under the Byrd rule.[24]

After the House first approved H.R. 3762 and referred the measure to the Senate, the Senate parliamentarian ruled that the bill's provisions to repeal the individual and employer mandates were extraneous. Specifically, the parliamentarian determined that the budgetary impact of repealing the mandates, though significant, was "merely incidental" to the broader non-budgetary (i.e., policy) impact of making those changes in law.

The ruling meant that Senate Republicans would need 60 votes to protect the language if Democrats raised Byrd Rule points of order. Lacking such a supermajority in the Senate, the Republicans chose instead to modify the provisions so that they would not violate the Byrd Rule. The Senate version kept the mandates but eliminated the penalties for noncompliance.

(...continued)

https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf. Excluding macroeconomic feedback effects, CBO and JCT estimated that H.R. 3762, as amended and passed by the Senate, would reduce the deficit by about $282 billion over the FY2016–FY2025 period. They estimated that macroeconomic feedback effects would reduce deficits by an additional $193 billion over that period. The largest effect would be an increase in revenues arising from the increased supply of labor, which in turn would boost employment and taxable income.

[22] 2 U.S.C. §644.

[23] 2 U.S.C. §644(b)(1).

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

H.R. 3762 also would have repealed most of the ACA's taxes and fees. Each provision that permanently repeals an ACA tax or fee is potentially vulnerable to a challenge under the Byrd rule because it reduces revenues (and, thus, increases the deficit) in the out years. However, as noted above, such provisions are not considered extraneous if the loss of revenue is offset by other provisions.

While CBO and JCT projected that the loss of revenue under H.R. 3762 would be more than offset by the spending reductions during the first 10 years (i.e., FY2016-FY2025), they concluded that the bill could start adding to the deficit over the longer term because the revenue losses would grow more rapidly beyond 2025 than the spending reductions, primarily as a result of repealing the Cadillac tax.[25] According to CBO and JCT, the loss of revenue from repealing this tax on high-premium health insurance plans would grow at a significantly higher rate than other components of their estimate, as more and more plans became subject to the tax over time.

U.S. House of Representatives v. Burwell

On July 30, 2014, the House approved a simple resolution (H.Res. 676) on a party-line vote that authorized Speaker John Boehner to sue the President or other executive branch officials for actions taken to implement the ACA that are inconsistent with their duties under the Constitution and laws of the United States.

On November 21, 2014, the House filed a lawsuit in the U.S. District Court for the District of Columbia, which contained two counts against the Administration.[26] First, the lawsuit claimed that the President had exceeded his constitutional duty to faithfully execute federal laws by delaying implementation of the ACA's employer mandate. Second, the lawsuit asserted that the cost-sharing subsidies were in violation of the Constitution because Congress had not appropriated any funds for them.[27]

The Administration challenged the lawsuit claiming that the House had no legal standing to sue, and asked for the lawsuit to be dismissed. On September 9, 2015, the judge agreed that the House did not have standing to pursue its claim regarding delay of the employer mandate. But the judge ruled that the House did have standing to pursue the second claim that the Administration was violating the Constitution by paying cost-sharing subsidies without an appropriation to cover those outlays.[28] On May 12, 2016, the judge issued a merits decision, holding that Congress had not appropriated funds for the payment of cost-sharing subsidies.[29]

That ruling has been stayed while the case is on appeal to the U.S. Court of Appeals for the D.C. Circuit.

[25] See footnote 21.

[26] *United States House of Representatives v. Burwell*, 1:14-cv-01967 (D.D.C. 2014), http://www.speaker.gov/sites/speaker.house.gov/files/HouseLitigation.pdf.

[27] Article I of the U.S. Constitution states that "No money shall be drawn from the Treasury, but in consequence of appropriations made by law."

[28] The cost-sharing subsidies are paid directly to insurers to compensate them for providing certain beneficiaries with reduced deductibles, co-payments, and other out-of-pocket costs. Through the end of FY2016, a total of $13.145 billion in cost-sharing subsidies was paid to insurers according to the IRS budget office.

[29] *United States House of Representatives v. Burwell*, 2016 U.S. Dist. LEXIS 62646 (May 12, 2016).

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

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		114th Congress
P.L. 114-301 Dec. 16, 2016	H.R. 5687	**GAO Mandates Revision Act of 2016.** Among its provisions, P.L. 114-301: • Amended Section 399V–4 of the Public Health Service Act ("State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation"), as added by ACA Section 10607, regarding the composition and duties of the expert panel established to review demonstration grant applications.
P.L. 114-255 Dec. 13, 2016	H.R. 34	**21st Century Cures Act.** Among its provisions, P.L. 114-255: • Amended provisions in Title XIX of the Social Security Act (SSA) to improve the ability of states to identify health care providers who have been terminated from participating in Medicare or in another state's Medicaid or CHIP program, by (1) requiring providers participating in Medicaid and CHIP managed care to enroll with the state, and (2) increasing state oversight and reporting requirements. [The ACA required CMS to establish a system for notifying each state Medicaid/CHIP program of health care providers who have been terminated from participating in Medicare or in another state's Medicaid/CHIP program.] • Amended ACA Section 4002 to reduce the PPHF annual appropriations over the period FY2017-FY2024 by a total of $3.5 billion. [This is the second time that the PPHF annual appropriations have been reduced; see entry for P.L. 112-96, below.] • Instructed the Secretary to collect certain specified information from each state that has participated in the Medicaid Emergency Psychiatric Demonstration program, established by ACA Section 2707, and, within two years, submit to Congress a report that summarizes and analyses that information. • Amended provisions in the Internal Revenue Code (IRC) to allow certain small employers to use health reimbursement arrangements (HRAs) without incurring penalties under the ACA, provided the reimbursement payments do not exceed specified amounts. [An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses incurred by the employee (or his/her spouse and dependents) up to a maximum dollar amount. The IRS had concluded that HRAs are group health plans that fail to comply with the ACA market reforms and are therefore subject to tax penalties under the law. However, the IRS provided transition relief from the penalty.]
P.L. 114-113 Dec. 18, 2015	H.R. 2029 (Dent)	**Consolidated Appropriations Act, 2016.** P.L. 114-113 incorporated a number of ACA tax provisions, including a two-year delay of the Cadillac tax, a one-year moratorium on the ACA's annual fee on certain health insurance providers, and a two-year moratorium on the ACA's medical device excise tax. [For more information on all the ACA-related provisions in P.L. 114-113, see CRS Report R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2017)*, by C. Stephen Redhead and Ada S. Cornell.]
P.L. 114-97 Dec. 11, 2015	S. 599 (Cardin)	**Improving Access to Emergency Psychiatric Care Act.** Extended the Medicaid Emergency Psychiatric Demonstration program, established by ACA Section 2707, through September 30, 2016, provided it meets budget neutrality requirements. Gives the HHS Secretary the authority to further extend and expand the demonstration program through December 31, 2019, subject to the budget neutrality requirements. Requires the Secretary, by April 1, 2019, to submit recommendations to Congress on whether to make the program permanent.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
P.L. 114-74 Nov. 2, 2015	H.R. 1314 (Meehan)	**Bipartisan Budget Act of 2015.** Among its provisions, P.L. 114-74: • Repealed the ACA requirement that employers with more than 200 employees automatically enroll new full-time employees in health insurance and continue coverage for current employees.
P.L. 114-60 Oct. 7, 2015	H.R. 1624 (Guthrie)	**Protecting Affordable Coverage for Employees (PACE) Act.** Amended the ACA's definition of small employer to mean employers with up to 50 employees, while giving states the option to expand the definition to include employers with up to 100 employees. [Under the ACA as originally enacted, all employers with 100 or fewer employees would have been regarded as small employers as of January 1, 2016. The PACE Act limits small employers to those with up to 50 employees, which typically is how small employers are defined under state law. Employers with 51 to 100 employees are now defined under the ACA as large employers. This change is significant because certain ACA reforms apply only to individual and small group (i.e., small employer) plans. For example, these plans must cover ten essential health benefits and meet the actuarial value levels (platinum, gold, silver, bronze) defined by the ACA. Moreover, insurers may only consider age, geographic location, family composition, and tobacco use in setting premium rates for small groups. Large group plans are not bound by these requirements.]
P.L. 114-41 July 31, 2015	H.R. 3236 (Shuster)	**Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.** Among its provisions, P.L. 114-41: • Incorporated the Hire More Heroes Act, which excludes employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count for the purpose of meeting the ACA's employer responsibilities.
P.L. 114-10 Apr. 16, 2015	H.R. 2 (Burgess)	**Medicare Access and CHIP Reauthorization Act of 2015.** Among its provisions, P.L. 114-10: • Amended Section 1848(p) of the SSA, as added by ACA Section 3007, to terminate application of the physician value-based payment modifier (VBM) at the end of 2018. [Beginning in 2019, the VBM will be used as one of the components of the composite score under the new Merit-Based Incentive Payment System (MIPS).] • Appropriated a total of $3.910 billion to the CHCF for each of FY2016 and FY2017; $3.600 billion for the health centers program, and $310 million for the NHSC. • Appropriated $60 million for each of FY2016 and FY2017 for graduate medical education (GME) payments to teaching health centers, authorized by ACA Section 5508(c). • Appropriated $400 million for each of FY2015 through FY2017 for the Maternal, Infant, and Early Childhood Home Visiting program, established by ACA Section 2951. • Appropriated $75 million for each of FY2016 and FY2017 for the Personal Responsibility Education Program (PREP), established by ACA Section 2953. • Appropriated $85 million for each of FY2016 and FY2017 for the Health Profession Opportunity Grant (HPOG) program, established by ACA Section 5507(a). • Appropriated $20 million for the two-year period FY2016 through FY2017 to develop Medicaid adult quality measures, pursuant to ACA Section 2701.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
		113th Congress
P.L. 113-93 Apr. 1, 2014	H.R. 4302 (Pitts)	**Protecting Access to Medicare Act of 2014.** Among its provisions, P.L. 113-93: • Eliminated paragraph (2) of ACA Section 1302(c), which capped deductibles for small group health plans at $2,000 for singles and $4,000 for families (indexed after 2014 to average per capita premium costs). [Insurers were finding it difficult staying within the deductible cap while covering all essential health benefits and meeting the 60% actuarial level (AV) level for bronze plans. CMS had already agreed to waive the deductible cap if a plan could not "reasonably reach" the AV level without exceeding the cap.] • Appropriated $400 million for the first half of FY2015 for the Maternal, Infant, and Early Childhood Home Visiting program, established by ACA Section 2951. [Superseded by the appropriation in P.L. 114-10.] • Appropriated $85 million for FY2015 for HPOG program, established by ACA Section 5507(a). • Appropriated $75 million for FY2015 for the PREP, established by ACA Section 2953.
		112th Congress
P.L. 112-240 Jan. 2, 2013	H.R. 8 (Camp)	**American Taxpayer Relief Act of 2012.** Among its provisions, P.L. 112-240: • Transferred 10% of the remaining unobligated Consumer Operated and Oriented Plan (CO-OP) program funds to a new CO-OP contingency fund (to provide assistance and oversight to CO-OP loan recipients) and rescinded the other 90% of these funds.[a] • Repealed ACA Title VIII, the Community Living Assistance Services and Supports (CLASS) Act. • Repealed the ACA's appropriations for the National Clearinghouse for Long-Term Care Information and rescinded all unobligated funds.
P.L. 112-141 July 6, 2012	H.R. 4348 (Mica)	**Moving Ahead for Progress in the 21st Century Act, or "MAP-21."** Among its provisions, P.L. 112-141 further modified the Medicaid disaster-recovery Federal Medical Assistance Percentage (FMAP) adjustment (see entry for P.L. 112-96, below) by changing the adjustment factor and effective date.
P.L. 112-96 Feb. 22, 2012	H.R. 3630 (Camp)	**Middle Class Tax Relief and Job Creation Act of 2012.** Among its provisions, P.L. 112-96: • Amended ACA Section 4002 to reduce the PPHF annual appropriations over the period FY2013-FY2021 by a total of $6.25 billion to help offset the cost of extending the payroll tax cut and other programs in P.L. 112-96. • Amended SSA Section 1923(f) to extend by one year the disproportionate share hospital (DSH) allotment reduction imposed by ACA Section 3203. • Amended SSA Section 1905(aa), as added by ACA Section 2006, to make a technical correction to the formula to phase down the Medicaid disaster-recovery FMAP adjustment as originally intended. [The purpose of the adjustment was to help Louisiana avoid a significant reduction in its federal Medicaid match (i.e., FMAP) in the aftermath of Hurricane Katrina. As written in ACA Section 2006, the formula for the disaster-recovery FMAP adjustment unintentionally caused the FMAP adjustment to increase, rather than phase down, each year the state qualifies for the adjustment.]
P.L. 112-56 Nov. 21, 2011	H.R. 674 (Herger)	**3% Withholding Repeal and Job Creation Act.** Among its provisions, P.L. 112-56 amended IRC Section 36B, as added by ACA Section 1401(a) (as amended), by modifying the calculation of Modified Adjusted Gross Income (MAGI) to include Social Security benefits. MAGI will be used to determine eligibility for exchange subsidies and Medicaid, beginning in 2014.

Public Law and Date of Enactment	Bill (Sponsor)	Summary of ACA Provisions
P.L. 112-9 Apr. 14, 2011	H.R. 4 (Lungren)	**Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011.** Amended IRC Section 6041, as amended by ACA Section 9006, to repeal the requirement that businesses file an information report (IRS Form 1099) whenever they pay a vendor more than $600 for goods in a single year. To pay for the 1099 repeal, P.L. 112-9 amended Section 36B of the IRC, as added by ACA Section 1401(a), by further modifying the sliding scale that determines the amount of excess advance premium tax credits that individuals have to repay based on household income (see entry for P.L. 111-309, below).
		111th Congress
P.L. 111-383 Jan. 7, 2011	H.R. 6523 (Skelton)	**Ike Skelton National Defense Authorization Act for Fiscal Year 2011.** Extended TRICARE coverage to dependent adult children up to age 26, to conform to the private health insurance requirements under the ACA.
P.L. 111-312 Dec. 17, 2010	H.R. 4853 (Oberstar)	**Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010.** Amended ACA Section 10909 to extend the nonrefundable adoption tax credit through tax year 2012. The adoption tax credit helps offset the cost of qualified adoption expenses. [Subsequently, P.L. 112-240 made the nonrefundable adoption tax credit permanent.]
P.L. 111-309 Dec. 15, 2010	H.R. 4994 (Lewis)	**Medicare and Medicaid Extenders Act of 2010.** To help offset the costs of the Medicare and Medicaid program extensions and the postponement of cuts in Medicare physician payments, P.L. 111-309 amended IRC Section 36B, as added by ACA Section 1401(a), to increase the amount of excess advance premium tax credits that individuals would have to repay. [Under the ACA, the amount received in advance premium tax credits is based on estimated income for the upcoming year. Estimated income is later checked against actual income during tax filing season. This can result in an overpayment of tax credits if actual income ends up exceeding estimated income. The ACA placed limits on the amount of any advance premium tax credit overpayment that had to be repaid to the government by creating a sliding scale for such repayments based on household income. P.L. 111-309 modified the sliding scale.]
P.L. 111-226 Aug. 10, 2010	H.R. 1586 (Rangel)	**FAA Air Transportation Modernization and Safety Improvement Act.** Among its provisions, P.L. 111-226 amended SSA Section 1927(k)(1)(B)(i)(IV) (as added by ACA Section 2503(a)(2)(B), as amended by HCERA Section 1101(c)) by modifying the definition of average manufacturer price (AMP) to include inhalation, infusion, implanted, or injectable drugs that are not generally dispensed through a retail community pharmacy.
P.L. 111-173 May 27, 2010	H.R. 5014 (Filner)	**[No title.]** Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided by the Department of Veterans Affairs constitutes minimal essential health care coverage as required by the ACA. [Beginning in 2014, the ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]
P.L. 111-159 Apr. 26, 2010	H.R. 4887 (Skelton)	**TRICARE Affirmation Act.** Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided under TRICARE, TRICARE for Life, and the Nonappropriated Fund Health Benefits program constitutes minimal essential health care coverage as required by the ACA. [Beginning in 2014, the ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]

Source: Prepared by the Congressional Research Service based on the text of the public laws listed in the table.

a. The FY2011 and FY2012 Labor-HHS-ED appropriations acts (P.L. 112-10 and P.L. 112-74, respectively) rescinded a total of $2.6 billion of the ACA's original $6 billion appropriation for the CO-OP program. At the time P.L. 112-240 was enacted, according to HHS budget documents, the CO-OP program had an unobligated balance of $2.532 billion. P.L. 112-240 rescinded 90% of that amount (i.e., $2.279 billion), and transferred the remaining funds (i.e., $253 million) to the contingency fund. In all, Congress has rescinded $4.879 billion of the $6 billion CO-OP program appropriation.

Table 2. ACA Provisions in Bills Approved by the House in the 112th, 113th, and 114th Congresses

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
	114th Congress
H.R. 954 (Smith, Adrian)	**CO-OP Consumer Protection Act of 2016.** Passed the House by a vote of 258-165 on September 27, 2016. H.R. 954 would have exempted from the individual mandate and its penalties certain individuals who had obtained coverage through the CO-OP program that was later terminated. [Note: The ACA established and funded the Consumer Operated and Oriented Plan (CO-OP) program to provide low-interest loans to nonprofit member-run health insurance issuers that offer qualified health plans to individuals and small employers.]
H.R. 1270 (Jenkins, L.)	**Restoring Access to Medication and Improving Health Savings Act of 2016.** Passed the House by a vote of 243-164 on July 6, 2016. Title I of H.R. 1270—the Restoring Access to Medication Act of 2016—would have repealed the ACA's restrictions on using tax-preferred accounts to pay for over-the-counter drugs. The House passed the same language as part of the ACA reconciliation bill (H.R. 5447, see **Table 3**) and as part of H.R. 436 in the 112th Congress (see below). Title II of H.R. 1270—the Health Care Security Act of 2016 (H.R. 5445)—would have allowed both spouses to make catch-up contributions to the same health savings account (HSA). Under current law, each spouse must have their own HSA in order to make catch-up contributions. Title III of H.R. 1270—the Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayment Act (H.R. 4723)—would again have modified the limits on the amount of excess advance premium tax credits that must be repaid based on household income. [Under the ACA, the amount received in advance premium tax credits is based on estimated income for the upcoming year. Estimated income is later checked against actual income during tax filing season. This can result in an overpayment of tax credits if actual income ends up exceeding estimated income. The ACA placed limits on the amount of any advance premium tax credit overpayment that had to be repaid to the government by creating a sliding scale for such repayments based on household income. Since the ACA's enactment the sliding scale has been modified on two separate occasions; see P.L. 111-309 and P.L. 112-9 in **Table 1**.]
H.R. 5447 (Boustany)	**Small Business Health Care Relief Act of 2016.** Passed the House by voice vote on June 21, 2016. H.R. 5447 would have allowed employers with fewer than 50 full-time employees to offer a qualified small employer health reimbursement arrangement (QSEHRA), under which the employer pays directly for or reimburses the medical expenses of employees (and their dependents) enrolled in an individual plan. [Note: In September 2013, the IRS issued a notice prohibiting HRAs and other employer payment plans under the ACA.]
H.R. 3762 (Price, T.)	**Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.** Passed the House by vote of 240-189 on October 23, 2015. As originally passed by the House, the bill would have repealed the following ACA provisions: individual mandate; employer mandate; Cadillac tax; medical device tax; automatic enrollment requirement for large employers; and PPHF. It also would have appropriated an additional $235 million to the CHCF in each of FY2016 and FY2017 for health center operations. The Senate took up H.R. 3762 and substituted its own more extensive set of ACA repeal provisions. The amended bill passed the Senate by a vote of 52-47 on December 3, 2015, and passed the House by a vote of 240-181 on January 6, 2016. H.R. 3762 was sent to the President, who vetoed it on January 8, 2016. The House failed to override the veto in a vote taken on February 2, 2016. See **Table 3** for a summary of the provisions in H.R. 3762, as passed by both chambers.
H.R. 2061 (Davis, R.)	**Equitable Access to Care and Health (EACH) Act.** Passed the House by voice vote on September 28, 2015. H.R. 2061 would have expanded the religious exemption in the ACA by exempting from the law's insurance mandate any individual who is a member of a religious sect or division, who relies solely on a religious method of healing, and for whom accepting medical health services (not including certain preventive and other specified services) would be inconsistent with his or her religious beliefs. [Note: The ACA's religious exemption applies only to religious sects that are recognized by the Social Security Administration as being conscientiously opposed to accepting all insurance benefits, including Medicare and Social Security (e.g., Amish).] The House passed a related bill in March 2014 (see H.R. 1814 in the 113th Congress).

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.J.Res 61 (Davis, R.)	**Hire More Heroes Act of 2015.** Passed the House by voice vote on July 27, 2015. H.J.Res 61 would have excluded employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count. The House passed the same legislation in January 2015 (see H.R. 22 below) and in March 2014 (see H.R. 3474 in the 113th Congress). [Note: The Hire More Heroes Act was incorporated into P.L. 114-41; see **Table 1**.] H.J.Res 61 *was used unsuccessfully by the Senate as the legislative vehicle to provide continuing appropriations for FY2016.*
H.R. 1190 (Roe)	**Protecting Seniors' Access to Medicare Act of 2015.** Passed the House by a vote of 244-154 on June 23, 2015. H.R. 1190 would have repealed the authority and appropriations for the Independent Payment Advisory Board (IPAB). It also would have reduced the PPHF annual appropriations over the period FY2017-FY2025 by a total of $8.846 billion to offset the cost of repealing IPAB. [Note: This is the second time the House has passed a stand-alone bill to repeal IPAB.]
H.R. 160 (Paulsen)	**Protect Medical Innovation Act of 2015.** Passed the House by a vote of 280-140 on June 18, 2015. H.R. 160 would have repealed the ACA's 2.3% excise tax on medical devices. [Note: This is the second time the House has passed a stand-alone bill to repeal the medical device tax.]
H.R. 1191 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act.** Passed the House by a vote of 415-0 on March 17, 2015. H.R. 1191 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted toward the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Last year the IRS ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 1191 would codify that ruling.] The House passed the same legislation in January 2015 (see H.R. 33 below) and in March 2014 (see H.R. 3979 in the 113th Congress). *The Senate took up H.R. 1191 and used it as the legislative vehicle for the Iran Nuclear Agreement Review Act of 2015, which passed both chambers and was signed into law (P.L. 114-17).*
H.R. 596 (Byrne)	**A bill to repeal the Patient Protection and Affordable Care Act.** Passed the House by a vote of 239-186 on February 3, 2015. H.R. 596 would have repealed the ACA in its entirety and restore the provisions of law amended or repealed by the ACA as if it had not been enacted. It also instructed four House Committees (Education & Workforce, Energy & Commerce, Judiciary, and Ways & Means) each to report health reform legislation that addresses various issues specified in the bill. [Note: This was the fourth time the House passed a full-repeal bill.]
H.R. 7 (Smith, C.)	**No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2015.** Passed the House by a vote of 242-179 on January 22, 2015. H.R. 7 would have prohibited exchange applicants from obtaining premium tax credits or cost-sharing subsidies to help purchase health plans that cover elective abortions, and would have prohibited tax credits for health plans offered by an employer that include elective abortion coverage. Individuals would still be able to purchase separate abortion coverage, but would not be able to receive a tax credit or cost-sharing subsidy. H.R. 7 also would have prohibited OPM-contracted multi-state plans from including elective abortion coverage. [Note: The ACA permits exchange applicants to obtain premium tax credits and cost-sharing subsidies to help purchase health plans that cover elective abortions; however, the law prohibits the use of those federal funds to pay for abortion services and requires plans to collect an abortion surcharge from enrollees to pay for such services. The ACA also specifies that at least one multi-state plan offered in an exchange must not include elective abortion coverage.] The House passed the same measure in January 2014 (see H.R. 7 in the 113th Congress).

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 33 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act.** Passed the House by a vote of 401-0 on January 12, 2015. H.R. 33 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted toward the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Last year the IRS has ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 33 would codify that ruling.] The House passed the same measure in March 2014 (see H.R. 3979 in the 113th Congress). *The Senate took up H.R. 33 and substituted language to provide continuing FY2015 appropriations for the Department of Homeland Security. As amended by the Senate, H.R. 33 passed both chambers and was signed into law (P.L. 114-3).*
H.R. 30 (Young, T.)	**Save American Workers Act of 2015.** Passed the House by a vote of 252-172 on January 8, 2015. H.R. 30 would have amended the ACA's definition of full-time employees to those who work on average at least 40 hours a week. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Full-time employees are defined as those who work on average at least 30 hours a week. The House passed the same measure in 2014; see H.R. 2575 below.]
H.R. 22 (Davis, R.)	**Hire More Heroes Act of 2015.** Passed the House by a vote of 412-0 on January 6, 2015. H.R. 22 would have excluded employees who receive health care through the Department of Veterans Affairs or TRICARE from an employer's FTE count. The House first passed the Hire More Heroes Act in 2014; see H.R. 3474 below. [Note: The Hire More Heroes Act was incorporated into P.L. 114-41; see **Table 1**.] *H.R. 22 was used as the legislative vehicle for the Fixing America's Surface Transportation (FAST) Act, which passed both chambers and was signed into law (P.L. 114-94).*
	113th Congress
H.R. 3522 (Cassidy)	**Employer Health Care Protection Act of 2014.** Passed the House by a vote of 247-167 on September 11, 2014. H.R. 3522 would have permitted health insurance companies to continue to offer group coverage that was in effect on any date during 2013, even if the coverage does not meet the ACA's essential health benefit standards and other market reforms that took effect at the beginning of 2014. Insurers could offer such coverage to existing or new enrollees through December 31, 2018, but could not offer the coverage through health insurance exchanges. [Note: The House passed a comparable measure in 2013; see H.R. 3350 below.]
H.R. 4414 (Carney)	**Expatriate Health Coverage Clarification Act of 2014.** Passed the House by a vote of 268-150 on April 29, 2014. H.R. 4414 would have exempted from certain ACA requirements expatriate health care plans offered to individuals working outside the United States. These plans are often used by corporate executives, nongovernmental organization employees, foreign aid workers, contractors, and others working abroad. U.S. insurance companies offering these plans are required to comply with the ACA whereas foreign insurance companies are not. [Note: A modified version of this legislation was enacted into law as Division M of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235).]
H.R. 4194 (Issa)	**Government Reports Elimination Act of 2014.** Passed the House by voice vote on April 28, 2014. Among its provisions, H.R. 4194 would have modified the ACA's requirement for periodic reviews and evaluations of all federal disease prevention and health promotion programs. Instead of joint reviews conducted by the HHS and GAO, the reviews would be conducted by HHS alone. *H.R. 4194 subsequently passed the Senate, amended, by unanimous consent on September 16, 2014.*
H.R. 2575 (Young, T.)	**Save American Workers Act of 2014.** Passed the House by a vote of 248-179 on April 3, 2014. H.R. 2575 would have amended the ACA's definition of full-time employees to those who work on average at least 40 hours a week. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Full-time employees are defined as those who work on average at least 30 hours a week.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 4015 (Burgess)	**SGR Repeal and Medicare Provider Payment Modernization Act of 2014.** Passed the House by a vote of 238-181 on March 14, 2014. H.R. 4015 would have replaced the Sustainable Growth Rate (SGR) formula, which determines the annual updates to Medicare's payment rates for physician services, with new systems for establishing those payment rates. To help pay for its cost, H.R. 4015 would have delayed enforcement of the ACA's individual mandate by five years by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2019. CBO estimated that this would result in 13 million fewer Americans with health insurance coverage in 2018 relative to current-law projections.
H.R. 3979 (Barletta)	**Protecting Volunteer Firefighters and Emergency Responders Act of 2014.** Passed the House by a vote of 410-0 on March 11, 2014. H.R. 3979 would have excluded the hours worked by volunteer firefighters and emergency medical responders from being counted towards the ACA's 30-hour-a-week benchmark that determines whether an employee is classified as full-time. [Note: The ACA requires employers with at least 50 FTEs to offer affordable health coverage or risk paying a penalty if at least one full-time worker gets a premium tax credit for coverage purchased at an exchange. Prior to passage of H.R. 3979, the IRS ruled that it will not require volunteer emergency responders to count towards these ACA requirements. H.R. 3979 would have codified that ruling.] *The Senate passed H.R. 3979 by a vote of 59-38 on April 7, 2014, after adding a five-month extension of unemployment benefits to the bill, among other provisions, and renaming it the Emergency Unemployment Compensation Act of 2014. No further action was taken on that measure. H.R. 3979 subsequently was used as the legislative vehicle for the FY2015 National Defense Authorization Act (P.L. 113-291).*
H.R. 3474 (Davis, R.)	**Hire More Heroes Act of 2014.** Passed the House by a vote of 406-1 on March 11, 2014. H.R. 3474 would have permitted an employer to exclude employees who receive health care through the Department of Veterans Affairs or TRICARE from its FTE count.
H.R. 1814 (Schock)	**Equitable Access to Care and Health (EACH) Act.** Passed the House by voice vote on March 11, 2014. H.R. 1814 would have expanded the religious exemption in the ACA by exempting from the law's insurance mandate any individual who objects to purchasing health coverage because of sincerely held religious beliefs. [Note: The ACA's religious exemption applies only to religious sects that are recognized by the Social Security Administration as being conscientiously opposed to accepting all insurance benefits, including Medicare and Social Security (e.g., Amish).]
H.R. 4118 (Jenkins)	**Suspending the Individual Mandate Penalty Law Equals (SIMPLE) Fairness Act.** Passed the House by a vote of 250-160 on March 5, 2014. H.R. 4118 would have delayed enforcement of the ACA's individual mandate by one year by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2015. [Note: The House passed similar legislation in 2013; see H.R. 2668 below.]
H.R. 7 (Smith, C.)	**No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2014.** Passed the House by a vote of 227-188 on January 28, 2014. H.R. 7 would have prohibited exchange applicants from obtaining premium tax credits or cost-sharing subsidies to help purchase health plans that cover elective abortions, and would have prohibited tax credits for health plans offered by an employer that include elective abortion coverage. Individuals would still be able to purchase separate abortion coverage, but would not be able to receive a tax credit or cost-sharing subsidy. H.R. 7 also would have prohibited OPM-contracted multi-state plans from including elective abortion coverage. [Note: The ACA permits exchange applicants to obtain premium tax credits and cost-sharing subsidies to help purchase health plans that cover elective abortions; however, the law prohibits the use of those federal funds to pay for abortion services and requires plans to collect an abortion surcharge from enrollees to pay for such services. The ACA also specifies that at least one multi-state plan offered in an exchange must not include elective abortion coverage.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 3362 (Lee)	**Exchange Information Disclosure Act.** Passed the House by a vote of 259-154 on January 16, 2014. H.R. 3362 would have required the HHS Secretary to submit to Congress and make public a detailed weekly report, through March 2015, on (1) consumer interactions with healthcare.gov (or subsequent sites) and efforts undertaken to remedy problems that impact consumers; and (2) calls to the federal consumer service call center, including the number of calls received by the call center, problems identified by users, and referrals of those calls. The Secretary also would have been required to make public a list (with contact information) of all navigators and certified application counselors trained and certified by exchanges, and a list of all agents and brokers trained and certified by the federally facilitated exchange. Both lists would have to be updated weekly through March 2015.
H.R. 3811 (Pitts)	**Health Exchange Security and Transparency Act of 2014.** Passed the House by a vote of 291-122 on January 10, 2014. H.R. 3811 would have required the HHS Secretary to notify affected individuals within two business days of a breach of their personally identifiable information maintained by an exchange.
H.R. 3350 (Upton)	**Keep Your Health Plan Act of 2013.** Passed the House by a vote of 261-157 on November 15, 2013. H.R. 3350 would have permitted health insurance companies to continue to offer individual coverage that was in effect as of January 1, 2013, even if the coverage did not meet the ACA's essential health benefit standards and other market reforms that took effect at the beginning of 2014. Insurers could offer such coverage to existing or new enrollees at any time during 2014, but could not offer the coverage through health insurance exchanges. [Note: This legislation was prompted by the decision of insurers to send cancellation notices to individuals and small businesses with health plans in the individual and small group markets. The Administration also has taken steps to address this issue. On November 14, 2013, it announced a transitional policy under which insurers may choose, subject to the approval of state insurance regulators, to renew noncompliant health plans that have been cancelled, or are slated for cancellation. Under the ACA, insurers are not permitted to sell noncompliant coverage to new enrollees. H.R. 3350 would allow insurers to sell such coverage in the individual market during 2014.]
H.R. 2775 (Black)	**No Subsidies Without Verification Act.** Passed the House by a vote of 235-191 on September 12, 2013. H.R. 2775 would have required the HHS Inspector General to certify to Congress that a program was in place to verify the household income of exchange applicants before making any premium tax credits or cost-sharing subsidies available. [Note: H.R. 2775 became the legislative vehicle for the FY2014 Continuing Appropriations Act, P.L. 113-46. That act incorporated a modified version of the language in H.R. 2775.]
H.R. 2009 (Price)	**Keep the IRS Off Your Health Care Act of 2013.** Passed the House by a vote of 232-185 on August 2, 2013. H.R. 2009 would have prohibited the Internal Revenue Service (IRS) from implementing or enforcing any provisions of the ACA.
H.R. 2668 (Young)	**Fairness for American Families Act.** Passed the House by a vote of 251-174 on July 17, 2013. H.R. 2668 would have delayed enforcement of the ACA's individual mandate by one year by shifting the schedule of penalties for individuals who do not comply with the mandate (or obtain an exemption) to begin in 2015. It also would have incorporated the provisions in H.R. 2667 (see below) to delay the employer mandate and related reporting requirements.
H.R. 2667 (Griffin)	**Authority for Mandate Delay Act.** Passed the House by a vote of 264-161 on July 17, 2013. H.R. 2667 would have delayed for one year certain ACA reporting requirements for insurers and employers as well as the penalties for employers who do not offer affordable coverage. [Note: H.R. 2667 would have essentially codified the Administration's announcement on July 2, 2013, that it was delaying the ACA employer mandate and related reporting requirements.]
H.R. 45 (Bachmann)	**A bill to repeal the Patient Protection and Affordable Care Act.** Passed the House by a vote of 229-195 on May 16, 2013. H.R. 45 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
	112th Congress
H.R. 6684 (Cantor)	**Spending Reduction Act of 2012.** Passed the House by a vote of 215-209 on December 20, 2012. H.R. 6684 would have eliminated the FY2013 sequestration of direct defense spending (as required under the Budget Control Act of 2011), reduced the FY2013 overall discretionary cap by $19 billion, and implemented numerous other mandatory spending reductions. Among its provisions, H.R. 6684 would have (1) repealed the authority and appropriations for the exchange planning and establishment grants and rescinded all unobligated funds; (2) repealed the authority and permanent annual appropriation for the PPHF and rescinded all unobligated funds; (3) rescinded all remaining unobligated funds for the Consumer Operated and Oriented Plan (CO-OP) program; and (4) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount.
H.R. 6079 (Cantor)	**Repeal of Obamacare Act.** Passed the House by a vote of 244-185 on July 11, 2012. H.R. 6079 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.
H.R. 436 (Paulsen)	**Health Care Cost Reduction Act of 2012.** Passed the House by a vote of 270-146 on June 7, 2012. H.R. 436 would have (1) repealed the ACA's 2.3% excise tax on medical devices; (2) repealed the law's restrictions on using tax-preferred accounts to pay for over-the-counter drugs; (3) allowed individuals to recoup up to $500 of unused funds remaining in their flexible spending account (FSA) after the end of the plan year; and (4) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount.
H.R. 5652 (Ryan)	**Sequester Replacement Reconciliation Act of 2012.** Passed the House by a vote of 218-199 on May 10, 2012. H.R. 5652, which was introduced pursuant to the reconciliation instructions in the House FY2013 budget resolution (H.Con.Res. 112), would have eliminated the FY2013 sequestration of direct defense spending (as required under the Budget Control Act of 2011), reduced the FY2013 overall discretionary cap by $19 billion, and implemented a series of mandatory program savings recommended by six House committees. Among its many provisions, H.R. 5652 would have (1) eliminated all limits on repayment of any premium credit overpayment, making individuals liable for the full amount; (2) repealed the authority and appropriations for the exchange planning and establishment grants and rescinded all unobligated funds; (3) repealed the authority and permanent annual appropriation for the PPHF and rescinded all unobligated funds; (4) rescinded all remaining unobligated funds for the CO-OP program; (5) extended by one year the disproportionate share hospital (DSH) allotment reduction imposed by the ACA; and (6) repealed the ACA's Medicaid maintenance of effort requirements.
H.R. 4628 (Biggert)	**Interest Rate Reduction Act.** Passed the House by a vote of 215-195 on April 27, 2012. H.R. 4628 would have postponed by one year a scheduled increase in Stafford education loan rates and, to offset the costs of that adjustment, repealed the authority and appropriations for the PPHF and rescinded all unobligated funds. [Note: The one-year Stafford loan rate extension was incorporated as Division F, Title III of MAP-21, the surface transportation reauthorization bill (see entry for P.L. 112-141 in **Table 1**). The provision in H.R. 4628 to repeal the PPHF and rescind all unobligated funds was not included in MAP-21.]
H.R. 5 (Gingrey)	**Protecting Access to Healthcare Act.** Passed the House by a vote of 223-181 on March 22, 2012. Title II of H.R. 5 would have repealed the authority and appropriations for IPAB.
H.R. 1173 (Boustany)	**Fiscal Responsibility and Retirement Security Act of 2012.** Passed the House by a vote of 267-159 on February 1, 2012. H.R. 1173 would have repealed Title VIII of the ACA, the Community Living Assistance Services and Supports (CLASS) Act. [Note: P.L. 112-240, enacted January 2, 2013, included a repeal of the CLASS Act; see **Table 1**.]

Bill (Sponsor)	Bill Title, House Vote, Summary of ACA Provisions
H.R. 358 (Pitts)	**Protect Life Act.** Passed the House by a vote of 251-172 on October 13, 2011. H.R. 358 would have prohibited using any funds authorized or appropriated by the ACA to pay for an abortion or to pay for any part of the costs of a health plan that covers abortions, except if the pregnancy is the result of rape or incest, or the life of the pregnant female is at risk unless an abortion is performed. It would have required insurers that offer plans through the exchanges that cover abortion services to offer identical plans that do not cover abortion services. It also would have prohibited federal, state, or local government programs that receive ACA funding from discriminating against health care entities that refuse to provide abortion services or abortion training.
H.R. 1216 (Guthrie)	**A bill to convert funding for graduate medical education (GME) in qualified teaching health centers (THCs) to an authorization of appropriations.** Passed the House by a vote of 234-185 on May 25, 2011. H.R. 1216 would have replaced the appropriation for GME payments to THCs with an authorization of appropriations for each of FY2012 through FY2015, and rescinded all unobligated funds. It would have prohibited the GME funds from being used to provide abortions, except in cases of rape or incest or when the woman's life is in danger.
H.R. 1214 (Burgess)	**A bill to repeal ACA funding for school-based health center (SBHC) construction.** Passed the House by a vote of 235-191 on May 4, 2011. H.R. 1214 would have repealed the authority and appropriations for SBHC construction grants and rescinded all unobligated funds.
H.R. 1213 (Upton)	**A bill to repeal ACA funding for health insurance exchanges.** Passed the House by a vote of 238-183 on May 3, 2011. H.R. 1213 would have repealed the authority and appropriations for state exchange planning and establishment grants and rescinded all unobligated funds.
H.R. 1217 (Pitts)	**A bill to repeal the Prevention and Public Health Fund (PPHF).** Passed the House by a vote of 236-183 on April 13, 2011. H.R. 1217 would have repealed the authority and permanent annual appropriation for the PPHF and rescinded all unobligated funds.
H.R. 2 (Cantor)	**Repealing the Job-Killing Health Care Law Act.** Passed the House by a vote of 245-189 on January 19, 2011. It was offered as an amendment during Senate floor debate on an unrelated bill (S. 223) and rejected on a procedural motion by a vote of 47-51. H.R. 2 would have repealed the ACA in its entirety and restored the provisions of law amended or repealed by the ACA as if it had not been enacted.

Source: Prepared by the Congressional Research Service based on the text of the bills listed in the table.

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

Vetoed by President Obama on January 8, 2016

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

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

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

Author Contact Information

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

Janet Kinzer
Senior Research Librarian
jkinzer@crs.loc.gov, 7-7561