



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

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Summary

In March 2010, the 111th Congress passed health reform legislation, the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly referred to as PPACA, the law 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 Medicare and Medicaid spending. Implementation of PPACA, which 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 PPACA, state attorneys general and others have brought a number of lawsuits challenging provisions of PPACA, including the individual mandate, on constitutional grounds.

This report provides a brief summary of major PPACA provisions, implementation and oversight activities, and current legal challenges. For more detailed information on the topics included in this report, and other information about PPACA, CRS has produced a series of comprehensive reports. The information provided in these reports ranges from broad overviews of PPACA provisions, such as Medicare provisions, to more narrowly focused topics, such as grandfathered health plans. CRS reports relating to health reform are available at <http://www.crs.gov>.

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The 111th Congress passed major health reform legislation, the Patient Protection and Affordable Care Act (P.L. 111-148), which was amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA. This report provides a brief summary of major PPACA provisions, implementation and oversight activities, and current legal challenges. For more detailed information on the topics included in this report, and other information about PPACA, CRS has produced a series of comprehensive reports. The information provided in these reports ranges from broad overviews of PPACA provisions, such as Medicare provisions, to more narrowly focused topics, such as grandfathered health plans. CRS reports relating to health reform are available at <http://www.crs.gov>.

Overview of Health Reform Law

PPACA 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. PPACA increases access to health insurance coverage by expanding Medicaid eligibility, extending funding for the Children's Health Insurance Program (CHIP), and subsidizing private insurance premiums and cost-sharing for certain lower-income individuals enrolled in exchange plans, among other provisions. These costs are projected to be offset by increased taxes and other revenues and reduced Medicare and Medicaid spending. The law also includes measures designed to enhance delivery and quality of care.

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 to voluntarily expand their Medicaid programs.

Some private health insurance market reforms also take effect prior to 2014, such as extending coverage to children up to age 26 and not allowing children up to age 19 to be denied insurance and benefits based on a preexisting condition. Major medical plans can no longer impose any lifetime dollar limits on essential benefits, and plans may only restrict annual dollar limits to defined amounts. Plans must cover preventive care with no cost-sharing, and they cannot rescind coverage, except for 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

¹ For more information on the private health insurance provisions in PPACA, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette (continued...)

Coverage Expansions and Market Reforms: Beginning in 2014

The major expansion and reform provisions in PPACA take effect 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 may be required to also pay a penalty if any of their full-time workers enroll in exchange plans and receive premium subsidies.

PPACA's federal health insurance requirements are further expanded in 2014, with no annual dollar limits allowed on essential health benefits and no exclusions for preexisting conditions allowed regardless of age. Plans offered within the exchanges and certain other plans must also meet essential benefit standards, covering services such as emergency services, hospital care, physician services, preventive services, prescription drugs, and mental health and substance use disorder services, among others. Premiums may vary by limited amounts, but only based on age, family size, geographic area, and tobacco use. Additionally, plans must sell and renew policies to all individuals and may not discriminate based on health status.

Health Care Quality and Payment Incentives

PPACA contains a number of provisions to create and/or study payment incentives and service delivery models that are designed to improve quality of health and health care and to reduce expenditures. The law establishes 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). PPACA establishes the Center for Medicare and

(...continued)

Fernandez, and Mark Newsom.

² For more information about the Medicaid provisions in PPACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, coordinated by Julie Stone.

Medicaid Innovation, 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, PPACA 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. In addition, 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. PPACA also requires the Secretary of Health and Human Services (HHS) to develop a national strategy for health care quality to improve care delivery, patient outcomes, and population health.

Cost Containment and Financing of Health Reform

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) estimated the direct spending and revenue effects of PPACA.³ CBO projects that PPACA will reduce federal deficits by \$143 billion over the 10-year period of 2010-2019 and, by 2019, will insure 94% of the non-elderly, legally present U.S. population.

The costs of the coverage expansions under the law are offset by provisions designed to (1) slow the rate of growth of federal health care spending and (2) increase revenues through taxes and penalties.⁴ PPACA incorporates numerous Medicare payment provisions to slow the rate of growth in federal health care costs, including reductions in Medicare Advantage (MA) plan payments and a lowering of the annual payment update for hospitals and certain other providers.⁵ PPACA also establishes 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. Finally, PPACA provides tools to help reduce fraud, waste, and abuse in both Medicare and Medicaid.

PPACA increases revenue using several mechanisms. Individuals who do not have health insurance, as well as large employers who do not comply with the law's requirements to provide such insurance, may be subject to penalties. PPACA 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). PPACA also creates an excise tax on high-cost plans. The law 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.

³ CBO's and JCT's final estimate of PPACA dated March 20, 2010, includes the provisions in both, P.L. 111-148 and the amendments in P.L. 111-152. It is available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁴ For more information on the revenue provisions in PPACA, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey.

⁵ For more information about the Medicare provisions in PPACA, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

In calculating its estimates of the cost and savings of PPACA, CBO projected that the law will reduce the number of uninsured by 32 million people, leaving 23 million residents uninsured by 2019. Those without coverage will include those who choose not to purchase health insurance and are subject to the penalty for non-compliance and those who are exempt from the individual mandate for religious or other reasons, as well as about 7-8 million illegal immigrants.

Implementation and Oversight

Implementation of PPACA, which 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. While the HHS Secretary is responsible for implementation and oversight of many of PPACA'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 (e.g., promulgate regulations) 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. PPACA 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 PPACA implementation. The law makes changes to the employer-based system under which millions of 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, PPACA 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 a center to test innovative payment and service delivery models. PPACA creates three multi-billion dollar trust funds to support health centers and health workforce programs, comparative effectiveness research, and public health programs. Finally, the law authorizes funding for numerous new and existing discretionary grant programs. Obtaining funds for such programs and activities requires action by congressional appropriators.

Rulemaking

PPACA is being implemented in a variety of ways, including new agency programs, grants, demonstration projects, guidance documents, and regulations. Of these, only regulations have the force of law and can compel action by non-federal individuals and organizations. The federal rulemaking process is governed by the Administrative Procedure Act (APA, 5 U.S.C. §551 et seq.), other statutes, and executive orders, with agencies generally required to publish proposed rules, take comments from the public, and then publish a final rule. Agencies' compliance with the APA is subject to judicial review. More than 40 provisions in PPACA require or permit

agencies to issue rules, with some allowing the agencies to “prescribe such regulations as may be necessary.” As of December 2010, federal agencies had issued about 20 final rules to implement the legislation, and indicated that they planned to issue more than three dozen proposed and final rules in 2011.⁶

Congressional Oversight

Congress has a range of options as it oversees the implementation of PPACA, including oversight hearings, confirmation hearings for agency officials, letters to and meetings with agency officials, and commenting on proposed or final rules. Congress, committees, and individual Members can also request that the Government Accountability Office or federal agency inspectors general evaluate agencies’ actions to implement PPACA. The Congressional Review Act (5 U.S.C. §801 et seq.) requires that all final rules be submitted to Congress before they can take effect, and provides expedited procedures (primarily in the Senate) by which Congress can disapprove agencies’ rules. A congressional resolution of disapproval must be signed by the President for it to take effect. Congress can also include provisions in the text of agencies’ appropriations bills directing or preventing the development or enforcement of particular regulations.

Legal Challenges

Following enactment of PPACA, state attorneys general and others have brought a number of lawsuits challenging provisions of PPACA, including the individual mandate, on constitutional grounds. For example, in *Florida v. HHS*, attorneys general and governors in 26 states as well as others have brought an action against the Secretaries of Health and Human Services, the Treasury, and Labor, seeking relief from the individual mandate and other PPACA requirements. In *Virginia ex rel. Cuccinelli v. Sebelius*, the Virginia attorney general filed a separate lawsuit challenging the federal requirement to purchase health insurance. Many expect that one or more of these cases will reach the Supreme Court.⁷

Constitutional Issues

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 is whether the requirement to purchase health insurance is a valid regulation of economic activity or an unconstitutional attempt to regulate inactivity. 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

⁶ For more information about regulations in PPACA, see CRS Report R41586, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act*, by Curtis W. Copeland and Maeve P. Carey, and CRS Report R41346, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act*, by Curtis W. Copeland.

⁷ 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*, by Jennifer Staman et al.

requiring a private individual to purchase health insurance would be an unprecedented expansion of Congress' 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 PPACA provisions, most often the individual mandate.⁸

Legislation attempting to nullify selected provisions of PPACA has been enacted in several states. In addition, voters in some states recently approved state constitutional amendments intended to 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."⁹

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⁸ For a discussion of states' rights issues in the context of health care, see CRS Report R40846, *Health Care: Constitutional Rights and Legislative Powers*, by Kathleen S. Swendiman.

⁹ U.S. Const. Art. VI, cl. 2.