



Budget Control Act: Potential Impact of Automatic Spending Reduction Procedures on Health Reform Spending

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Summary

The Budget Control Act of 2011 (BCA; P.L. 112-25) established new budget enforcement mechanisms for reducing the federal deficit by at least \$2.1 trillion over the 10-year period FY2012-FY2021. The BCA placed statutory limits, or caps, on discretionary spending for each of those 10 fiscal years, which will save an estimated \$0.9 trillion during that period. In addition, it created a Joint Select Committee on Deficit Reduction (Joint Committee) with instructions to develop legislation to reduce the federal deficit by at least another \$1.5 trillion through FY2021. On November 21, 2011, the Joint Committee announced that it was unable to agree on a legislative package of deficit cuts, which raises the likelihood of automatic annual spending reductions beginning in FY2013. Under the BCA, the reductions would be achieved by a combination of sequestration—an automatic across-the-board cancellation of budgetary resources (i.e., spending cuts) for nonexempt direct spending programs—and lowering the caps on discretionary spending.

The potential impact of spending reductions triggered by the BCA on health reform spending under the Patient Protection and Affordable Care Act (ACA) would appear to be somewhat limited. ACA sought to increase access to affordable health insurance by expanding the Medicaid program and by restructuring the private health insurance market. It set minimum standards for private insurance coverage, created a mandate for most U.S. residents to obtain coverage, and provided for the establishment by 2014 of state-based insurance exchanges for the purchase of health insurance. Certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing coverage through the exchanges. The new law included direct spending to subsidize the purchase of health insurance coverage through the exchanges, as well as increased outlays for the Medicaid expansion. Under the rules governing sequestration, Medicaid spending would be exempt from any reduction, and cuts to Medicare would be capped at 2%.

ACA also included numerous mandatory appropriations that provide billions of dollars to support temporary programs to increase coverage and funding for targeted groups, provide funds to states to plan and establish exchanges, and support many other research and demonstration programs and activities. These appropriations would, in general, be subject to direct spending reductions under a sequestration order. However, for any given fiscal year in which sequestration was ordered, only new budget authority for that year (including advance appropriations that first become available for obligation in that year) would be reduced. Unobligated balances carried over from previous fiscal years would be exempt from sequestration.

ACA is likely to affect discretionary spending subject to the annual appropriations process. The law reauthorized appropriations for numerous existing discretionary grant programs and activities authorized under the Public Health Service Act, permanently reauthorized funding for the Indian Health Service (IHS), and created a number of new grant programs and provided for each an authorization of appropriations. In addition, the Congressional Budget Office projected that both the Department of Health and Human Services and the Internal Revenue Service will incur substantial administrative costs to implement the policies and programs established by ACA. Those costs will have to be funded largely through the annual appropriations process. Most of the ACA-related discretionary spending would be subject to automatic spending reductions triggered by the BCA.

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Introduction

The Budget Control Act of 2011 (BCA), which was enacted on August 2, 2011,¹ was the product of negotiations between the President and Congress to raise the nation's debt ceiling and avoid the federal government reaching its borrowing limit. The BCA gave the President the authority to increase the debt limit by at least \$2.1 trillion (and up to \$2.4 trillion) in three installments, and established a process by which Congress could block the second and third installments by passing a joint resolution disapproving the debt limit increase.²

In addition, the BCA established a process for reducing the federal deficit by at least \$2.1 trillion over the 10-year period FY2012-FY2021. First, the law placed statutory limits, or caps, on discretionary spending for each of the next 10 fiscal years.³ For FY2012 and FY2013, separate caps for security and nonsecurity spending will be in effect.⁴ For each of the remaining eight fiscal years (i.e., FY2014-FY2021), a single cap will apply to total discretionary spending. The Congressional Budget Office (CBO) estimated that adhering to the discretionary spending limits, which grow by approximately 2% each year, will reduce federal spending by \$917 billion between FY2012 and FY2021, compared to the projected level of spending if annual appropriations were to grow at the rate of inflation.⁵

Second, the BCA created a Joint Select Committee on Deficit Reduction (Joint Committee), composed of an equal number of Democrats and Republicans from the House and Senate. The Joint Committee was instructed to develop legislation to reduce the federal deficit by at least another \$1.5 trillion through FY2021.⁶ It had until November 23, 2011, to approve a bill and have it considered by the House and Senate under special procedures that prevent amendments and limit debate in both chambers. If, by January 15, 2012, Congress and the President failed to enact a Joint Committee bill reducing the deficit by at least \$1.2 trillion over the period FY2012-FY2021, then automatic annual spending reductions would be triggered beginning in FY2013.

On November 21, 2011, the co-chairs of the Joint Committee announced that the group had been unable to reach agreement on a legislative proposal to cut the deficit, raising the likelihood that

¹ P.L. 112-25, 125 Stat. 240. For a more detailed examination of all the provisions in the BCA, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

² The President has exercised this authority and raised the debt ceiling by a total of \$2.1 trillion, from \$14.294 trillion to \$16.394 trillion. The initial \$400 billion increase in the debt limit took effect immediately upon enactment of the BCA. The second increase of \$500 billion became effective on September 22, 2011, after the Senate rejected a motion to proceed to consider a joint resolution of disapproval (S.J.Res. 25) by a vote of 45-52. Following the action taken by the Senate, the House passed its own disapproval resolution (H.J.Res. 77) by a vote of 232-186. The third (and final) increase in the debt limit of \$1.2 trillion took effect on January 30, 2012, after the Senate once again rejected a motion to proceed to consider a joint resolution of disapproval (H.J.Res. 98) by a vote of 44-52. Prior to the Senate's vote, the House passed H.J.Res. 98 by a vote of 239-176.

³ Discretionary spending refers to outlays from budget authority (i.e., the authority to incur financial obligations that result in government expenditures) that is provided in and controlled by the annual appropriations acts.

⁴ Security spending comprises discretionary appropriations for the Department of Defense, the Department of Homeland Security, the Department of Veterans Affairs, and other related activities. Nonsecurity spending comprises all discretionary appropriations not included in the security category.

⁵ U.S. Congressional Budget Office, *Analysis of Budget Control Act*, August 1, 2011. Available at <http://www.cbo.gov/ftpdocs/123xx/doc12357/BudgetControlActAug1.pdf>.

⁶ The BCA placed no specific policy restrictions or requirements on the Joint Committee. The committee could recommend changes in federal revenues, spending, or both.

automatic spending reductions will be triggered.⁷ Under the BCA, the spending reductions would be equally divided between defense spending and all other spending (i.e., nondefense spending).⁸ The amount of reduction required in each category would then be divided proportionately between discretionary spending and mandatory spending (also known as direct spending).⁹ The reductions would be achieved (1) by an automatic across-the-board cancellation of budgetary resources (i.e., spending cuts)—a process known as sequestration—for nonexempt direct spending programs over the FY2013-FY2021 period, and for discretionary spending in FY2013; and (2) by lowering the annual caps on discretionary spending for FY2014-FY2021.

Health Reform Spending

There is considerable interest in how automatic spending reductions triggered by the BCA would affect implementation of the Patient Protection and Affordable Care Act (ACA), the health reform law enacted in March 2010.¹⁰ Among its many provisions, ACA restructured the private health insurance market, set minimum standards for private insurance coverage, created a mandate for most U.S. residents to obtain coverage, and provided for the establishment by 2014 of state-based insurance exchanges for the purchase of health insurance. Certain individuals and families will be able to receive federal subsidies to reduce the cost of purchasing coverage through the exchanges. The new law also expanded eligibility for Medicaid; amended the Medicare program in ways that are intended to reduce the growth in Medicare spending that had been projected under preexisting law; imposed an excise tax on insurance plans found to have high premiums; and made numerous other changes to the tax code, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and many other federal programs.¹¹

ACA is projected to have a significant impact on federal direct spending and revenues. The law included direct spending to subsidize the purchase of health insurance coverage through the exchanges, as well as increased outlays for the expansion of the Medicaid program. ACA also included numerous mandatory appropriations to fund temporary programs to increase access and funding for targeted groups, provide funding to states to plan and establish exchanges, and

⁷ The Joint Committee's statement is at <http://www.deficitreduction.gov/public/index.cfm/2011/11/statement-from-co-chairs-of-the-joint-select-committee-on-deficit-reduction>.

⁸ The annual discretionary spending caps for FY2012-FY2021 would be revised if automatic spending reductions were triggered. The overall discretionary spending limit for each fiscal year would remain unchanged, but that amount would be divided between defense discretionary spending and all other (i.e., nondefense) discretionary spending. See, also, footnote 22.

⁹ Mandatory, or direct, spending generally refers to budget authority that is provided in laws other than the annual appropriations acts. Mandatory spending includes entitlement authority (e.g., Medicare, Social Security).

¹⁰ 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), which amended multiple health care and revenue provisions in ACA. Several other bills that were subsequently enacted during the 111th Congress made more targeted changes to specific ACA provisions. All references to ACA in this report refer to the law as amended. Note that previous CRS reports on the Patient Protection and Affordable Care Act used the acronym PPACA to refer to the law. CRS is now using the more common acronym ACA.

¹¹ More information on the ACA provisions may be found in the following CRS products: CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead; CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.; CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis; and CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Erin D. Williams.

support many other research and demonstration programs and activities. The costs of expanding public and private health insurance coverage and other spending are offset by revenues from new taxes and fees, and by savings from payment and health care delivery system reforms designed to slow the growth in spending on Medicare and other federal health care programs.

Implementing ACA also is likely to affect discretionary spending, which is provided in and controlled by annual appropriations acts. The law established numerous new grant programs and provided for each an authorization of appropriations. It also reauthorized appropriations for many existing grant programs. While the authorization of appropriations for most of these existing programs expired prior to ACA's enactment, typically they continued to receive an annual appropriation.

Report Roadmap

This report examines how automatic spending reductions triggered by the BCA might affect health reform implementation under ACA. It must be emphasized that the details of such a process will depend in large measure on the statutory interpretations and actions of the Office of Management and Budget (OMB). Each year, OMB would be responsible for determining the proportional allocation of required cuts to discretionary and nonexempt direct spending in both the defense and nondefense categories. It would also have exclusive authority in applying the exemptions and special rules related to sequestration.

The report is divided into two sections. The first section provides an overview of ACA and describes the budgetary effects of its insurance coverage and other key spending provisions, based on CBO's estimates of the impact of ACA implementation on federal direct spending and revenues. The second section discusses which of those provisions would likely be subject to, or exempt from, BCA spending reductions. A summary of that discussion appears in **Table 1** at the end of the report. This product will be updated to reflect important legislative and other developments.

Patient Protection and Affordable Care Act

The primary goal of ACA is to increase access to affordable health insurance for the millions of Americans without coverage and make health insurance more affordable for those already covered. In addition, ACA makes numerous changes in the way health care is financed, organized, and delivered. These provisions are intended to slow the growth in health care costs and improve the quality of care by aligning payment incentives to increase efficiency and achieve savings; organizing care delivery systems to promote accountable, patient-centered, and coordinated care; and establishing benchmarks for better health outcomes.

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

Coverage Expansions and Market Reforms Prior to 2014

ACA created 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 small employers with fewer than 25 full-time equivalents (FTEs) and average annual wages below \$50,000 that choose to offer health insurance.

In addition, several of ACA's private insurance market reforms have taken effect. Health plans may not impose lifetime limits on the dollar value of essential benefits, rescind coverage (except in cases of fraud), or deny coverage to children up to age 19 based on a preexisting condition. Also, young adults up to age 26 generally must be allowed to remain on their parents' plans. Finally, plans must cover recommended preventive services and immunizations without any cost-sharing.

Coverage Expansions and Market Reforms Beginning in 2014

The major expansion and reform provisions in ACA take effect in 2014. State Medicaid programs will be required to expand coverage to all eligible non-pregnant, nonelderly 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 extends CHIP appropriations through FY2015.¹²

Also beginning in 2014, states are expected to establish health insurance exchanges through which eligible individuals and small employers will be able to purchase coverage from private health insurance plans offering standardized benefit and cost-sharing packages. 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. Refundable tax credits will be available to individuals and families with incomes between 133% and 400% of the FPL to help offset the cost of purchasing insurance coverage through the exchanges. In addition, certain individuals and families receiving the premium credit will be eligible for a subsidy to lower their cost-sharing (i.e., out-of-pocket costs such as deductibles and co-pays).

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

Most U.S. citizens and legal residents will be required to have insurance. Those who remain uninsured may have to pay a penalty. As plans will no longer be able to restrict coverage of individuals with health problems, ACA's individual insurance mandate is intended to ensure that healthy individuals participate in the insurance market rather than waiting until they need health care services. Increasing the number of healthy persons in the risk pool helps spread the risk.

¹² For more details on ACA's changes to the Medicaid and CHIP programs, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

ACA requires employers with more than 200 full-time employees that offer health insurance benefits to automatically enroll new employees in a coverage plan, though employees must be given adequate notice and the opportunity to opt out. Employers with 50 or more full-time employees that have at least one employee who is enrolled in an exchange plan and receiving a premium tax credit may be subject to penalties, whether or not they provide health insurance coverage to their employees.¹³

Estimated Impact and Costs of Coverage Expansions

The February 2011 baseline budget projections, prepared by CBO and the Joint Committee on Taxation (JCT), estimated that insurance coverage expansion under ACA will result in gross costs of \$1,390 billion over the 10-year period FY2012-FY2021. Gross costs include the exchange subsidies and related spending, increased spending on Medicaid and CHIP, and tax credits for certain small employers. CBO and JCT further estimated that those costs will be partially offset by an estimated \$348 billion from penalties paid by uninsured individuals and employers, an excise tax on high-premium insurance plans, and net savings from other effects that coverage expansion is expected to have on tax revenues and outlays. Thus, CBO and JCT projected in the February 2011 baseline that ACA's insurance coverage provisions will result in net costs of \$1,042 billion over the FY2012-FY2021 period.¹⁴

The net costs of coverage expansion under ACA are offset by (1) new revenue sources from taxes and fees (other than those related to insurance coverage, mentioned above); and (2) direct spending savings from payment and delivery system reform provisions that are designed to slow the rate of growth of federal health care spending, primarily for Medicare, and improve outcomes and the quality of care. In the February 2011 baseline, CBO and JCT projected that the new revenues and direct spending savings—described briefly below—will total \$1,252 billion over the 10-year period FY2012-FY2021. Based on those projections, CBO and JCT estimated that ACA implementation will reduce federal deficits by \$210 billion over the FY2012-FY2021 period.¹⁵

CBO and JCT's recently released March 2012 baseline projections include updated estimates of the gross and net costs of insurance coverage expansion under ACA, but do not include an update of the February 2011 estimates of the law's offsetting revenues and direct spending savings. The March 2012 baseline now projects gross costs of \$1,496 billion, an increase of \$106 billion over the February 2011 estimate. It also projects higher offsets, resulting in estimated net costs of \$1,083 billion for insurance coverage expansion over the 10-year period FY2012-FY2021, which is \$41 billion more than the February 2011 estimate.¹⁶ Readers should note that the discussion of

¹³ For more details on the employer penalties, see CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey.

¹⁴ U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, 112th Cong., 1st sess., March 30, 2011. Available at <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>. See Table 1, which also includes CBO's original March 2010 estimates of the costs of insurance coverage expansion under ACA.

¹⁵ Ibid. See Table 1, which also includes CBO's original March 2010 estimates of ACA's offsetting revenues and direct spending savings.

¹⁶ U.S. Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012. Available at <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>. See Table 1. CBO's 2012 estimates differ from the 2011 projections as a result of (1) changes in the economic outlook, (2) new laws enacted in 2011 that modified ACA's insurance coverage provisions, (continued...)

the potential impact of automatic spending reductions on insurance coverage expansion in the final section of this report uses the March 2012 cost estimates.

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

Revenues

The increase in revenues, totaling an estimated \$520 billion over the period FY2012-FY2021, is achieved largely by raising taxes on high-income households and by imposing fees on insurers and on manufacturers and importers of pharmaceuticals and medical devices.¹⁸

Savings from Payment and Delivery System Reforms

ACA included numerous Medicare payment provisions intended to reduce the rate of growth in spending. They include reductions in Medicare Advantage (MA) plan payments and a lowering of the annual payment update for hospitals and certain other providers.¹⁹ ACA established an Independent Payment Advisory Board (IPAB) to make recommendations for achieving specific Medicare spending reductions if costs exceed a target growth rate. IPAB's recommendations will take effect unless Congress overrides them, in which case Congress would be responsible for achieving the same level of savings.²⁰ Also, ACA provided tools to help reduce fraud, waste, and abuse in both Medicare and Medicaid.

Other provisions establish pilot, demonstration, and grant programs to test integrated models of care, including accountable care organizations (ACOs), medical homes that provide coordinated care for high-need individuals, and bundling payments for acute-care episodes (including hospitalization and follow-up care). ACA created the Center for Medicare and Medicaid

(...continued)

(3) reduced growth in private health care spending, and (4) technical changes in the estimating procedures used by CBO and JCT.

¹⁷ Ibid., see Table 3.

¹⁸ U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, 112th Cong., 1st sess., March 30, 2011. Available at <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>. See Table 1. For more information about the revenue provisions in ACA, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey.

¹⁹ For more information about the Medicare provisions in ACA, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

²⁰ For more information about IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

Innovation (CMMI) to pilot payment and service delivery models, primarily for Medicare and Medicaid beneficiaries. The law also established new pay-for-reporting and pay-for-performance programs within Medicare that will pay providers based on the reporting of, or performance on, selected quality measures.

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

Overall, CBO estimated that the health care payment and delivery system reform provisions in ACA will result in a net reduction in direct health care spending of \$732 billion over the period FY2012-FY2021.²¹

Impact of Automatic Spending Reductions on Health Reform

As noted in the introduction to this report, the BCA instructed the Joint Committee to develop legislation that would reduce the federal budget deficit by a total of at least \$1.5 trillion over the period FY2012-FY2021. If Joint Committee legislation estimated to produce at least \$1.2 trillion in deficit reduction were not enacted by January 15, 2012, then automatic procedures for cutting both discretionary and mandatory (direct) spending would take effect beginning in FY2013. The November 21, 2011, announcement by the Joint Committee that it was unable to agree on deficit-reduction legislation means that automatic spending reductions totaling \$1.2 trillion (including an allowance for reduced interest payments on the debt) are all but certain to take effect, absent any further action by Congress and the President to modify or repeal the BCA.

The automatic spending reductions would take the form of equal cuts (in dollar terms) in defense and nondefense spending for each fiscal year over the period FY2013-FY2021. The annual amount of spending cuts required in each of these two categories would be divided proportionately between discretionary and nonexempt direct spending. Direct spending reductions—both defense and nondefense—would be executed through sequestration (i.e., an across-the-board cancellation of budgetary resources). Importantly, the BCA exempts many direct spending programs from sequestration and places a 2% limit on cuts to most Medicare spending.

Discretionary spending reductions in FY2013 also would be achieved through a sequestration of nonexempt discretionary appropriations. The BCA exempts a few discretionary programs from sequestration, notably veterans health care spending, and caps at 2% any reduction in funding for

²¹ U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, “CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010,” Statement of Douglas W. Elmendorf, Director, 112th Cong., 1st sess., March 30, 2011. Available at <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>. See Table 1.

health centers and the Indian Health Service (see discussion below under “Discretionary Spending”). However, for each of the remaining fiscal years (i.e., FY2014-FY2021) discretionary spending reductions would be achieved through a downward adjustment of the statutory spending limits.²²

The sequestration process was first established in 1985 by the Balanced Budget and Emergency Deficit Control Act (BBEDCA), commonly known as the Gramm-Rudman-Hollings Act.²³ Initially, sequestration was tied to annual maximum deficit targets. If the budget deficit exceeded those target levels, then automatic across-the-board spending cuts would be triggered. The BBEDCA has been amended several times, notably by the Budget Enforcement Act of 1990,²⁴ which tied sequestration to new statutory spending limits, and most recently by the BCA. As already noted, the sequestration process is subject to exemptions and special rules, which are specified in Sections 255 and 256, respectively, of the BBEDCA.²⁵ Several of those provisions relate to health spending under ACA and are discussed below.

Insurance Coverage Expansion

It appears that most of ACA’s projected spending on expanding insurance coverage would not be subject to sequestration in the event that spending reductions are triggered under the BCA. First, the Medicaid and CHIP programs are both exempt from a sequestration order.²⁶ According to CBO and JCT’s March 2012 estimate, Medicaid and CHIP outlays are projected to account for \$795 billion, or 53%, of the gross costs of \$1,496 billion for coverage expansion over the FY2012-FY2021 period (see **Table 1**).²⁷

Second, the refundable tax credits available to individuals and families with incomes between 133% and 400% of the FPL for purchasing insurance coverage through the exchanges also would likely be exempt from a sequestration order.²⁸ These premium tax credits have the effect of limiting the cost of purchasing coverage to a specified percentage of income. According to CBO and JCT’s March 2012 estimate, the premium tax credits are projected to account for approximately \$578 billion (85%) of ACA’s total exchange subsidies and related spending of

²² As already noted (see footnote 8), the annual discretionary spending caps for FY2012-FY2021 would be revised if automatic spending reductions were triggered. The overall discretionary spending limit for each fiscal year would remain unchanged, but that amount would be divided between defense discretionary spending and all other (i.e., nondefense) discretionary spending. Discretionary spending reductions, whether by sequestration (FY2013) or through a downward adjustment of the revised spending caps (FY2014-FY2021), would be applied to both defense and nondefense spending categories.

²³ P.L. 99-177, Title II, 99 Stat. 1038.

²⁴ P.L. 101-508, Title XIII, 104 Stat. 1388-573.

²⁵ For an overview of the BBEDCA exemptions and special rules, see CRS Report R42050, *Budget “Sequestration” and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

²⁶ Low-income programs, including Medicaid and CHIP, that are exempt from sequestration are listed in BBEDCA Section 255(h). 2 U.S.C. §905(h).

²⁷ U.S. Congressional Budget Office, “Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act,” March 2012. Available at <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>. See Table 1.

²⁸ While the ACA premium tax credits are not specifically exempted from sequestration, BBEDCA Section 255(d) provides a general exemption for refundable individual tax credits. It reads as follows: “Payments to individuals made pursuant to provisions of the Internal Revenue Code of 1986 establishing refundable tax credits shall be exempt from reduction under any order issued under this part.” 2 U.S.C. §905(d).

\$681 billion over the FY2012-FY2021 period (see **Table 1**), which represents about 46% of the \$1,496 billion in gross costs for coverage expansion.²⁹

In addition to the premium tax credits for purchasing coverage through an exchange, certain individuals and families receiving the credits are also eligible for coverage with lower cost-sharing (i.e., out-of-pocket costs such as deductibles and co-pays) than otherwise required under the law. This is achieved through a cost-sharing subsidy, which is paid directly to the insurer to cover the extra costs associated with lower patient cost-sharing. The cost-sharing subsidies would presumably be subject to a sequestration order.³⁰ According to CBO and JCT's March 2012 estimate, the subsidies are projected to account for approximately an additional \$100 billion (15%) of ACA's exchange subsidies and related spending over the FY2012-FY2021 period (see **Table 1**).³¹

Finally, the tax credits available to certain small employers to offset the cost of purchasing health insurance for their employees also would presumably be subject to a sequestration order.³² These credits are available to for-profit and nonprofit employers with fewer than 25 FTEs and average annual wages of less than \$50,000.³³ According to CBO and JCT's March 2012 estimate, the small employer tax credits are projected to cost \$21 billion over the FY2012-FY2021 period, or about 1% of the \$1,496 billion in gross costs for coverage expansion (see **Table 1**).³⁴

In general, federal administrative expenses are subject to sequestration, regardless of whether they are incurred in connection with a program or activity that is otherwise exempt or subject to a special rule.³⁵ Thus, while the ACA refundable tax credits may be exempt from sequestration, the federal administrative expenses associated with the program would not be exempt. However, federal payments to state and local governments that match or reimburse these governments for their administrative costs are not considered federal administrative expenses and are subject to sequestration, but only to the extent that the relevant federal program is subject to sequestration.³⁶ For example, federal payments to state Medicaid programs for administrative costs would be exempt from sequestration because the Medicaid program as a whole is exempt.

²⁹ U.S. Congressional Budget Office, "Health Insurance Exchanges: CBO's March 2012 Baseline." Available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43057_HealthInsuranceExchanges.pdf.

³⁰ The impact of such an order is unclear. ACA entitles certain low-income exchange enrollees to coverage with reduced cost-sharing and requires the participating insurers to provide that coverage. Sequestration would not change that requirement. In the event of a sequestration order, insurers presumably would still have to provide required coverage to qualifying enrollees but they would not receive the full subsidy to cover their increased costs.

³¹ U.S. Congressional Budget Office, "Health Insurance Exchanges: CBO's March 2012 Baseline." Available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43057_HealthInsuranceExchanges.pdf.

³² Among the programs and activities listed as being exempt from a sequestration order, BBEDCA Section 255 includes payments to individuals in the form of tax credits (see previous footnote). It does not include small employer tax credits.

³³ For more details on the small employer tax credit, see CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey and Hinda Chaikind.

³⁴ U.S. Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012. Available at <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>. See Table 1.

³⁵ BBEDCA Section 256(h)(1), 2 U.S.C. §906(h)(1).

³⁶ BBEDCA Section 256(h)(3), 2 U.S.C. §906(h)(3).

Mandatory Appropriations

ACA included numerous mandatory appropriations that provide billions of dollars to support new and existing grant programs and other activities. Many of the provisions are annual appropriations of specified amounts for one or more fiscal years. A few of them are multiple-year appropriations, in which the amount appropriated is available for obligation for a definite period of time in excess of one fiscal year (e.g., for the period FY2011-FY2014). Often the provision includes additional language stating that the funds are to remain available “until expended” or “without fiscal year limitation.”

ACA appropriated billions of dollars for temporary programs for targeted groups, including (1) \$5 billion for the Pre-Existing Condition Insurance Plan (PCIP), a temporary insurance program to provide health insurance coverage for uninsured individuals with a preexisting condition; (2) \$5 billion for a temporary reinsurance program to reimburse employers for a portion of the costs of providing health benefits to early retirees aged 55-64; and (3) \$6 billion for the Consumer Operated and Oriented Plan (CO-OP) program, to establish temporary health insurance cooperatives.³⁷ ACA also included money for states to plan and establish health insurance exchanges. The law provided \$10 billion for the FY2011-FY2019 period—and \$10 billion for each subsequent 10-year period—for the CMMI to test and implement innovative payment and service delivery models, and it funded an independent board (i.e., IPAB) to provide Congress with proposals for reducing Medicare cost growth and improving quality of care for Medicare beneficiaries.

ACA created four special funds and appropriated substantial amounts to each. First, the Community Health Center Fund (CHCF) will provide a total of \$11 billion over five years (FY2011-FY2015) in supplemental funding for community health center operations and the National Health Service Corps. (A separate ACA appropriation provided \$1.5 billion for health center construction and renovation.) Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) will support comparative effectiveness research through FY2019 with a mix of appropriations and fund transfers. Third, the Prevention and Public Health Fund (PPHF), for which an annual appropriation is provided in perpetuity, is intended to support prevention, wellness, and other public health-related programs and activities authorized under the Public Health Service Act (PHSA).³⁸ Finally, ACA provided \$1 billion to the Health Insurance Reform Implementation Fund (HIRIF) to help cover the administrative costs of implementing the law.

In addition, ACA appropriated \$2.4 billion for maternal and child health programs. Overall, the law included more than \$100 billion in direct appropriations over the 10-year period FY2010-FY2019 (see **Table 1**).³⁹

³⁷ Section 1857 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10, 125 Stat. 38) canceled \$2.2 billion of the \$6 billion appropriation for the CO-OP program. Section 524 in Division F of the Consolidated Appropriations Act, 2012 (P.L. 112-74, 125 Stat. 786) rescinded an additional \$400 million from the CO-OP appropriation.

³⁸ Section 3205 of the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) reduced ACA’s appropriations to the PPHF over the period FY2013-FY2021 by a total of \$6.25 billion. Under ACA, the PPHF would have received a total of \$16.75 billion over that nine-year period; P.L. 112-96 reduced that amount to \$10.50 billion.

³⁹ For more details on all of ACA’s mandatory appropriations, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by C. Stephen Redhead.

A few of the appropriations in ACA are included in CBO and JCT's estimate of the costs of coverage expansion (e.g., funding for high-risk pools for individuals with preexisting conditions). All the remaining amounts—including funding for community health centers, health workforce programs, and public health activities—are captured in CBO's overall estimate of the impact of the law's payment and delivery system reform provisions on direct spending.

The mandatory appropriations in ACA would, in general, be subject to direct spending reductions under a sequestration order. However, for any given fiscal year in which sequestration was ordered, only new budget authority for that year (including advance appropriations that first become available for obligation in that year) would be reduced. Unobligated balances (non-defense only) carried over from previous fiscal years are exempt from a sequestration order.⁴⁰ Thus, an FY2013 sequestration order to reduce direct spending would not apply to unobligated ACA funds that had been appropriated in a prior fiscal year (i.e., FY2010-FY2012) and were still available for obligation.

The exemption for unobligated balances carried over from prior fiscal years is a potentially important one that would apply to a number of ACA appropriations. As already mentioned, the appropriation provision often specifies that the funds are to remain available “until expended” or “without fiscal year limitation.” One example is the PCIP program to provide health insurance coverage for eligible individuals who have been uninsured for six months and have a preexisting condition. The program terminates on January 1, 2014. ACA appropriated \$5 billion in FY2010, to remain available without fiscal year limitation, to pay claims against the PCIP that are in excess of the premiums collected from enrollees. Any unobligated PCIP funds in FY2013 would be exempt from sequestration.⁴¹

Discretionary Spending

ACA implementation will affect not only direct spending and revenues but also discretionary spending, which is provided in and controlled by annual appropriations acts. The law reauthorized appropriations for numerous existing discretionary grant programs and activities authorized under the PHSA, and permanently reauthorized appropriations for programs and services provided by the Indian Health Service (IHS). While the authorizations of appropriations for most programs had expired prior to their reauthorization in ACA, most of them continued to receive an annual appropriation. ACA also created a number of new grant programs and provided for each an authorization of appropriations.⁴²

Many of ACA's discretionary spending provisions authorized annual appropriations of specified amounts for one or more fiscal years. Other provisions authorized the appropriation of specified amounts for FY2010 or FY2011 and unspecified amounts—such sums as may be necessary, or

⁴⁰ An exemption for non-defense unobligated balances is provided in BBEDCA Section 255(e). It reads as follows: “Unobligated balances of budget authority carried over from prior fiscal years, except balances in the defense category, shall be exempt from reduction under any order issued under this part.” 2 U.S.C. §905(e).

⁴¹ Table 2 in CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, shows all the ACA appropriations by fiscal year over the period FY2010-FY2019 and, for each provision, indicates whether the funds are to remain available for an indefinite period of time (i.e., until expended, or without fiscal year limitation), subject to any requirement that the program terminate on a specific date.

⁴² For more details on all of ACA's discretionary spending provisions, see CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

SSAN—for later years. A few provisions authorized multi-year appropriations, available for obligation for a period in excess of one fiscal year. Numerous other provisions simply authorized the appropriation of SSAN, in a few cases without specifying any fiscal years.

Funding for all these discretionary programs depends on actions taken by congressional appropriators, a process that may lead to greater or smaller amounts than the sums authorized by ACA. With Congress now operating under BCA's discretionary spending limits, it may prove difficult to secure funding for new programs and activities. To date, it appears that none of the new discretionary programs authorized by ACA have received funding through the annual appropriations process, though a handful have received funding from the PPHF. Even maintaining current funding levels for existing programs with an established appropriations history may prove a challenge under growing pressure to reduce federal discretionary spending.

CBO estimated that ACA's discretionary spending provisions, if fully funded by future appropriations acts, would result in appropriations of almost \$100 billion over the period FY2012-FY2021 (see **Table 1**).⁴³ However, most of that funding—about \$85 billion—would be for programs that were in existence prior to, and were reauthorized by, ACA; namely, the National Health Service Corps, the health centers program, and the IHS.

In addition, CBO projected that both HHS and the Internal Revenue Service (IRS) will incur substantial administrative costs to implement the policies and programs established by ACA. Most of these costs will have to be funded through the annual appropriations process, once the HIRIF funds are all obligated.⁴⁴ CBO estimated that the costs to the IRS of implementing the eligibility determination, documentation, and verification processes for premium and cost-sharing subsidies will probably total between \$5 billion and \$10 billion over 10 years. It further estimated that the costs to HHS for implementing the changes in Medicare, Medicaid, and CHIP, as well as some of the reforms to the private insurance market, will require similar amounts over 10 years.⁴⁵

Most of the discretionary spending arising from authorizations of appropriations in ACA would be subject to automatic spending reductions triggered by the BCA. As noted earlier, discretionary spending reductions in FY2013 would be achieved through a sequestration of nonexempt discretionary appropriations, with any reduction in funding for health centers and the IHS capped at 2%.⁴⁶ For each of the remaining years (i.e., FY2014-FY2021), discretionary spending

⁴³ U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, 112th Cong., 1st sess., March 30, 2011. Available at <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>. See p. 16. CBO's estimate of discretionary spending includes (1) amounts specified in ACA, plus estimated amounts for subsequent years (adjusted for anticipated inflation) where ACA specified an amount for the first year and authorized SSAN for subsequent years; and (2) estimated amounts for subsequent years (adjusted for anticipated inflation) where there was an appropriation under existing law for FY2010, and ACA authorized the appropriation of SSAN for later years. The CBO estimate does not include new ACA programs for which the law provided only an authorization for the appropriation of SSAN.

⁴⁴ In its FY2013 budget, HHS projects that all the HIRIF funds will have been obligated by the end of FY2012.

⁴⁵ Ibid., see p. 15.

⁴⁶ BBEDCA Section 256(e), 2 U.S.C. §906(e). This subsection identifies the health centers program (i.e., PHSA Section 330), which is administered by the Health Resources and Services Administration (HRSA), using the budget account identification code (75-0350-0-1-550) that applies to HRSA and all its discretionary programs and activities. But ACA, in addition to reauthorizing discretionary funding for the health centers program, provides a mandatory appropriation of \$9.5 billion over five years (FY2011-FY2015) in supplemental funds for the program through the CHCF. While any BCA-triggered reduction in discretionary spending for the health centers program would be subject to the 2% cap, it is unclear whether the CHCF mandatory funds for health centers would be affected by the cap. OMB (continued...)

reductions would be achieved through a downward adjustment of the revised statutory spending limits. In contrast to the automatic spending reductions achieved through sequestration, lowering the annual discretionary spending limits allows Congress and the President to determine through the annual appropriations process which accounts are to be reduced, and by how much, in order to meet those limits.⁴⁷ Lowering the annual spending limits also would make it that much more of a challenge to maintain funding levels for existing programs.

(...continued)

might decide to include both the discretionary and mandatory funds for health centers under the 2% cap, as both sources of funding are being used for the same program. To that end, it should be noted that the CHCF funding is included under HRSA's budget account (75-0350-0-1-550) in the Administration's FY2013 budget tables.

⁴⁷ It is important to note, however, that the revised discretionary spending limits for FY2014-FY2021 would be enforced through a sequestration process. If discretionary appropriations within either category (i.e., defense or nondefense) exceeded the spending limit for that category, then across-the-board cuts would be triggered in nonexempt discretionary appropriation accounts, within the category in which the breach occurred, by an amount necessary to eliminate the breach.

Table I. Impact of the Budget Control Act's Automatic Spending Reduction Procedures on Health Reform Spending Under the Affordable Care Act

Type of Spending	Estimated Cost FY2012-FY2021 (\$ billions)	Potential Impact of Spending Reductions
Insurance Coverage Expansion		
Medicaid/CHIP	\$795	The Medicaid and CHIP programs would both be exempt from a sequestration order. ^a
Premium tax credit	\$578	The refundable tax credits available to individuals and families with incomes between 133% and 400% of the federal poverty level to offset the cost of purchasing insurance coverage through the exchanges would likely be exempt from a sequestration order. ^b
Cost-sharing subsidy	\$100	The cost-sharing subsidies available to certain individuals and families receiving the premium tax credit would presumably be subject to a sequestration order.
Small employer tax credit	\$21	The tax credits available to certain small businesses and small tax-exempt organizations to offset the cost of covering their employees would presumably be subject to a sequestration order. ^c
Mandatory Appropriations	>\$100 ^d	The mandatory appropriations in ACA would, in general, be subject to direct spending reductions under a sequestration order. However, for any given fiscal year in which sequestration was ordered, only new budget authority for that year (including advance appropriations that first become available for obligation in that year) would be reduced. Unobligated balances carried over from previous fiscal years would be exempt from a sequestration order. ^e
Discretionary Spending	≈\$100 ^f	Most of the discretionary spending arising from authorizations of appropriations in ACA would be subject to automatic spending reductions. Discretionary spending reductions in FY2013 would be achieved through a sequestration of appropriations, with any reduction in funding for community health centers and the IHS capped at 2%. ^g Spending reductions in later years (i.e., FY2014-FY2021) would be achieved through a downward adjustment of the revised discretionary spending limits.

Source: Table prepared by the Congressional Research Service based on CBO's March 2012 baseline budget projections for the Affordable Care Act's insurance coverage provisions, unless otherwise noted.

- a. Medicaid and CHIP are among the exempted low-income programs listed in BBEDCA Section 255(h).
- b. While the ACA premium tax credits are not specifically exempted from sequestration, BBEDCA Section 255(d) provides a general exemption for refundable individual tax credits.
- c. BBEDCA Section 255 does not include small employer tax credits among the list of programs and activities that are exempt from sequestration.
- d. Note that this estimate refers to the 10-year period FY2010-FY2019. It is not possible to determine the total amount appropriated by ACA because several appropriations are for unspecified amounts (i.e., such sums as may be necessary) or contingent upon a formula or revenues from industry fees. For more details on all of ACA's mandatory appropriations, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)*, by C. Stephen Redhead.

- e. An exemption for non-defense unobligated balances is provided in BBEDCA Section 255(e).
- f. This figure is CBO's estimate assuming that all ACA's discretionary spending provisions are fully funded by future appropriations acts. For more details on all of ACA's discretionary spending provisions, see CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.
- g. See footnote 46.

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