The Patient Protection and Affordable Care Act (PPACA),[7] commonly called Obamacare[8][9] (or the federal health care law), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.[10]

PPACA is aimed primarily at decreasing the number of uninsured Americans and reducing the overall costs of health care. It provides a number of mechanisms—including mandates, subsidies, and tax credits—to employers and individuals in order to increase the coverage rate.[11][12] Additional reforms are aimed at improving healthcare outcomes and streamlining the delivery of health care. PPACA requires insurance companies to cover all applicants...
and offer the same rates regardless of pre-existing conditions or gender. The Congressional Budget Office projected that PPACA will lower both future deficits and Medicare spending.

On June 28, 2012, the United States Supreme Court upheld the constitutionality of most of PPACA in the case *National Federation of Independent Business v. Sebelius*.

**Overview**

PPACA includes numerous provisions to take effect over several years beginning in 2010. Policies issued before particular provisions take effect are grandfathered from many of these provisions, while other provisions may affect existing policies.

- Guaranteed issue will require policies to be issued regardless of any medical condition, and partial community rating will require insurers to offer the same premium to all applicants of the same age and geographical location without regard to gender or most pre-existing conditions (excluding tobacco use).

- A shared responsibility requirement, commonly called an individual mandate, requires that all individuals not covered by an employer sponsored health plan, Medicaid, Medicare or other public insurance programs, purchase and comply with an approved private insurance policy or pay a penalty, unless the applicable individual is a member of a recognized religious sect exempted by the Internal Revenue Service, or waived in cases of financial hardship.

- Health insurance exchanges will commence operation in each state, offering a marketplace where individuals and small businesses can compare policies and premiums, and buy insurance (with a government subsidy if eligible).

- Low income individuals and families above 100% and up to 400% of the federal poverty level will receive federal
subsidies\textsuperscript{27} on a sliding scale if they choose to purchase insurance via an exchange (those at 150% of the poverty level would be subsidized such that their premium cost would be 2% of income, or $50 per month for a family of four).\textsuperscript{28} 

- The text of the law expands Medicaid eligibility to include all individuals and families with incomes up to 133% of the poverty level, and simplifies the CHIP enrollment process. In \textit{National Federation of Independent Business v. Sebelius}, the Supreme Court effectively allowed states to opt out of the Medicaid expansion, and some states have stated their intention to do so. In states that choose to reject the Medicaid expansion, individuals and families at or below 133% of the poverty line, but above their state's existing Medicaid threshold, will not be eligible for coverage; additionally, subsidies are not available to those below 100% of the poverty line. As many states have eligibility thresholds significantly below 133% of the poverty line, and many do not provide any coverage for childless adults, this may create a coverage gap in those states.\textsuperscript{29}\textsuperscript{30}\textsuperscript{31} 

- Minimum standards for health insurance policies are to be established and annual and lifetime coverage caps will be banned.\textsuperscript{32}\textsuperscript{33}\textsuperscript{34} 

- Firms employing 50 or more people but not offering health insurance will also pay a shared responsibility requirement if the government has had to subsidize an employee's health care.\textsuperscript{35} 

- Very small businesses will be able to get subsidies if they purchase insurance through an exchange.\textsuperscript{36} 

- Co-payments, co-insurance, and deductibles are to be eliminated for select health care insurance benefits considered to be part of an "essential benefits package"\textsuperscript{37} for Level A or Level B preventive care.\textsuperscript{38}\textsuperscript{39} 

- Changes are enacted that allow a restructuring of Medicare reimbursement from "fee-for-service" to "bundled payments."\textsuperscript{40}\textsuperscript{41} 

\section*{Summary of funding}

PPACA's provisions are intended to be funded by a variety of taxes and offsets. Major sources of new revenue include a much-broadened Medicare tax on incomes over $200,000 and $250,000, for individual and joint filers respectively, an annual fee on insurance providers, and a 40% excise tax on "Cadillac" insurance policies. The income levels are not adjusted for inflation, leaving the possibility of increased taxes on incomes over 250,000 inflation-adjusted dollars after more than two decades without indexing through bracket creep.\textsuperscript{42} There are also taxes on pharmaceuticals, high-cost diagnostic equipment, and a 10% federal sales tax on indoor tanning services. Offsets are from intended cost savings such as changes in the Medicare Advantage program relative to traditional Medicare.\textsuperscript{43} 

\textbf{Summary of tax increases: (ten year projection)}

- Increase Medicare tax rate by .9% and impose added tax of 3.8% on unearned income for high-income taxpayers: $210.2 billion
- Charge an annual fee on health insurance providers: $60 billion
- Impose a 40% excise tax on health insurance annual premiums in excess of $10,200 for an individual or $27,500 for a family: $32 billion
• Impose an annual fee on manufacturers and importers of branded drugs: $27 billion
• Impose a 2.3% excise tax on manufacturers and importers of certain medical devices: $20 billion
• Raise the 7.5% Adjusted Gross Income floor on medical expenses deduction to 10%: $15.2 billion
• Limit annual contributions to flexible spending arrangements in cafeteria plans to $2,500: $13 billion
• All other revenue sources: $14.9 billion

Summary of spending offsets: (ten year projection)
• Reduce funding for Medicare Advantage policies: $132 billion
• Reduce Medicare home health care payments: $40 billion
• Reduce certain Medicare hospital payments: $22 billion

Original budget estimates included a provision to require information reporting on payments to corporations, which had been projected to raise $17 billion, but the provision was repealed.\(^{[44]}\)

**Provisions**

PPACA is divided into 9 titles\(^{[45]}\) and contains provisions that became effective immediately, 90 days after enactment, and six months after enactment, as well as provisions phased in through to 2020.\(^{[46][47]}\) Below are some of the key provisions of PPACA. For simplicity, the amendments in the Health Care and Education Reconciliation Act of 2010 are integrated into this timeline.\(^{[48][49]}\)

**Effective at enactment**

• The Food and Drug Administration is now authorized to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.\(^{[50]}\)
• The Medicaid drug rebate (paid by drug manufacturers to the states) for brand name drugs is increased to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%), and the rebate is extended to Medicaid managed care plans; the Medicaid rebate for non-innovator, multiple source drugs is increased to 13% of average manufacturer price.\(^{[50]}\)
• A non-profit Patient-Centered Outcomes Research Institute is established, independent from government, to undertake comparative effectiveness research.\(^{[50]}\) This is charged with examining the “relative health outcomes, clinical effectiveness, and appropriateness” of different medical treatments by evaluating existing studies and conducting its own. Its 19-member board is to include patients, doctors, hospitals, drug makers, device manufacturers, insurers, payers, government officials and health experts. It will not have the power to mandate or even endorse coverage rules or reimbursement for any particular treatment. Medicare may take the Institute’s research into account when deciding what procedures it will cover, so long as the new research is not the sole justification and the agency allows for public input.\(^{[51]}\) The bill forbids the Institute to develop or employ “a dollars per quality adjusted life year” (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended. This makes it different from the UK’s National Institute for Health and Clinical Excellence.
• Creation of task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.\(^{[50]}\)
• The Indian Health Care Improvement Act is reauthorized and amended.\(^{[50]}\)
• Chain restaurants and food vendors with 20 or more locations are required to display the caloric content of their foods on menus, drive-through menus, and vending machines. Additional information, such as saturated fat, carbohydrate, and sodium content, must also be made available upon request.\(^{[52]}\) But first, the Food and Drug Administration has to come up with regulations, and as a result, calories disclosures may not appear until 2013 or 2014.\(^{[52]}\)
• States can apply for a 'State Plan Amendment” to expand family planning eligibility to the same eligibility as pregnancy related care (above and beyond Medicaid level eligibility), through a state option rather than having to
apply for a federal waiver.\textsuperscript{[53][54][55]}

**Effective June 21, 2010**

- Adults with existing conditions became eligible to join a temporary high-risk pool, which will be superseded by the health care exchange in 2014.\textsuperscript{[47][56]} To qualify for coverage, applicants must have a pre-existing health condition and have been uninsured for at least the past six months.\textsuperscript{[57]} There is no age requirement.\textsuperscript{[57]} The new program sets premiums as if for a standard population and not for a population with a higher health risk. Allows premiums to vary by age (4:1), geographic area, and family composition. Limit out-of-pocket spending to $5,950 for individuals and $11,900 for families, excluding premiums.\textsuperscript{[57][58][59]}

**Effective July 1, 2010**

- The President established, within the Department of Health and Human Services (HHS), a council to be known as the *National Prevention, Health Promotion and Public Health Council* to help begin to develop a National Prevention and Health Promotion Strategy. The Surgeon General shall serve as the Chairperson of the new Council.\textsuperscript{[60][61]}
- A 10% sales tax on indoor tanning took effect.\textsuperscript{[62]}

**Effective September 23, 2010**

- Insurers are prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays, in new policies issued.\textsuperscript{[63]}
- Dependents (children) will be permitted to remain on their parents' insurance plan until their 26th birthday,\textsuperscript{[64]} and regulations implemented under PPACA include dependents that no longer live with their parents, are not a dependent on a parent's tax return, are no longer a student, or are married.\textsuperscript{[65][66]}
- Insurers are prohibited from excluding pre-existing medical conditions (except in grandfathered individual health insurance plans) for children under the age of 19.\textsuperscript{[67][68]}
- All new insurance plans must cover preventive care and medical screenings\textsuperscript{[69]} rated Level A or B \textsuperscript{[70]} by the U.S. Preventive Services Task Force.\textsuperscript{[71]} Insurers are prohibited from charging co-payments, co-insurance, or deductibles for these services.\textsuperscript{[72]}
- Individuals affected by the Medicare Part D coverage gap will receive a $250 rebate, and 50% of the gap will be eliminated in 2011.\textsuperscript{[73]} The gap will be eliminated by 2020.
- Insurers' abilities to enforce annual spending caps will be restricted, and completely prohibited by 2014.\textsuperscript{[47]}
- Insurers are prohibited from dropping policyholders when they get sick.\textsuperscript{[47]}
- Insurers are required to reveal details about administrative and executive expenditures.\textsuperscript{[47]}
- Insurers are required to implement an appeals process for coverage determination and claims on all new plans.\textsuperscript{[47]}
- Enhanced methods of fraud detection are implemented.\textsuperscript{[47]}
- Medicare is expanded to small, rural hospitals and facilities.\textsuperscript{[47]}
- Medicare patients with chronic illnesses must be monitored/evaluated on a 3-month basis for coverage of the medications for treatment of such illnesses.
- Companies which provide early retiree benefits for individuals aged 55–64 are eligible to participate in a temporary program which reduces premium costs.\textsuperscript{[47]}
- A new website installed by the Secretary of Health and Human Services will provide consumer insurance information for individuals and small businesses in all states.\textsuperscript{[47]}
- A temporary credit program is established to encourage private investment in new therapies for disease treatment and prevention.\textsuperscript{[47]}
- All new insurance plans must cover childhood immunizations and adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP) without charging co-payments, co-insurance, or
deductibles when provided by an in-network provider.\textsuperscript{74}

**Effective January 1, 2011**

- Insurers must spend 80\% (for individual or small group insurers) or 85\% (for large group insurers) of premium dollars on health costs and claims, leaving only 20\% or 15\% respectively for administrative costs and profits, subject to various waivers and exemptions. If an insurer fails to meet this requirement, there is no penalty, but a rebate must be issued to the policy holder. This policy is known as the 'Medical Loss Ratio'.\textsuperscript{75}\textsuperscript{76}\textsuperscript{77}\textsuperscript{78}
- The Centers for Medicare and Medicaid Services is responsible for developing the Center for Medicare and Medicaid Innovation and overseeing the testing of innovative payment and delivery models.\textsuperscript{79}
- Flexible spending accounts, Health reimbursement accounts and health savings accounts cannot be used to pay for over-the-counter drugs, purchased without a prescription, except insulin.\textsuperscript{80}

**Effective September 1, 2011**

- All health insurance companies must inform the public when they want to increase health insurance rates for individual or small group policies by an average of 10\% or more. This policy is known as 'Rate Review'. States are provided with Health Insurance Rate Review Grants to enhance their rate review programs and bring greater transparency to the process.\textsuperscript{81}\textsuperscript{82}

**Effective January 1, 2012**

- Employers must disclose the value of the benefits they provided beginning in 2012 for each employee's health insurance coverage on the employee's annual Form W-2's.\textsuperscript{83} This requirement was originally to be effective January 1, 2011, but was postponed by IRS Notice 2010–69 on October 23, 2010.\textsuperscript{84}\textsuperscript{85} Reporting is not required for any employer that was required to file fewer than 250 Forms W-2 in the preceding calendar year.\textsuperscript{85}
- New tax reporting changes were to come in effect. Lawmakers originally felt these changes would help prevent tax evasion by corporations. However, in April 2011, Congress passed and President Obama signed the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 repealing this provision, because it was burdensome to small businesses.\textsuperscript{86}\textsuperscript{87} Before PPACA businesses were required to notify the IRS on form 1099 of certain payments to individuals for certain services or property over a reporting threshold of $600.\textsuperscript{88}\textsuperscript{89} Under the repealed law, reporting of payments to corporations would also be required.\textsuperscript{90}\textsuperscript{91} Originally it was expected to raise $17 billion over 10 years.\textsuperscript{92} The amendments made by Section 9006 of PPACA were designed to apply to payments made by businesses after December 31, 2011, but will no longer apply because of the repeal of the section.\textsuperscript{87}\textsuperscript{89}

**Effective August 1, 2012**

- All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. Women's Preventive Services – including: well-woman visits; gestational diabetes screening; human papillomavirus (HPV) DNA testing for women age 30 and older; sexually transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraceptive methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling - will be covered without cost sharing.\textsuperscript{93} This is also known as the contraceptive mandate.\textsuperscript{69}\textsuperscript{94}
Effective by October 1, 2012

- The Centers for Medicare & Medicaid Services (CMS) will begin the Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).[95] Starting in October, an estimated total of 2,217 hospitals across the nation will be penalized; however, only 307 of these hospitals will receive this year's maximum penalty, i.e., 1 percent off their base Medicare reimbursements. The penalty will be deducted from reimbursements each time a hospital submits a claim starting Oct. 1. The maximum penalty will increase after this year, to 2 percent of regular payments starting in October 2013 and then to 3 percent the following year. As an example, if a hospital received the maximum penalty of 1 percent and it submitted a claim for $20,000 for a stay, Medicare would reimburse it $19,800. Together, these 2,217 hospitals will forfeit more than $280 million in Medicare funds over the next year, i.e., until October 2013, as Medicare and Medicaid begin a wide-ranging push to start paying health care providers based on the quality of care they provide. The $280 million in penalties comprises about 0.3 percent of the total amount hospitals are paid by Medicare.[96]

Effective by January 1, 2013

- Income from self-employment and wages of single individuals in excess of $200,000 annually will be subject to an additional tax of 0.9%. The threshold amount is $250,000 for a married couple filing jointly (threshold applies to joint compensation of the two spouses), or $125,000 for a married person filing separately.[97] In addition, an additional Medicare tax of 3.8% will apply to unearned income, specifically the lesser of net investment income or the amount by which adjusted gross income exceeds $200,000 ($250,000 for a married couple filing jointly; $125,000 for a married person filing separately).[98]
- Beginning January 1, 2013, the limit on pre-tax contributions to flexible spending accounts will be capped at $2,500 per year.[99][100][101]

Effective by August 1, 2013

- Religious organizations that were given an extra year to implement the contraceptive mandate are no longer exempt. Certain non-exempt, non-grandfathered group health plans established and maintained by non-profit organizations with religious objections to covering contraceptive services may take advantage of a one-year enforcement safe harbor (i.e., until the first plan year beginning on or after August 1, 2013) by timely satisfying certain requirements set forth by the U.S. Department of Health & Human Services.[102]
Effective by January 1, 2014

- Insurers are prohibited from discriminating against or charging higher rates for any individuals based on gender or pre-existing medical conditions. [103]
- Impose an annual penalty of $95, or up to 1% of income over the filing minimum, [104] whichever is greater, on individuals who are not covered by an acceptable insurance policy; this will rise to a minimum of $695 ($2,085 for families), or 2.5% of income over the filing minimum, [104] by 2016. [25][105] Exemptions to the mandatory coverage provision and penalty are permitted for religious reasons or for those for whom the least expensive policy would exceed 8% of their income. [106]
- Insurers are prohibited from establishing annual spending caps. [47]
- In participating states, Medicaid eligibility is expanded; all individuals with income up to 133% of the poverty line qualify for coverage, including adults without dependent children. [25][107] As written, PPACA withheld all Medicaid funding from states declining to participate in the expansion. However, the Supreme Court ruled, in National Federation of Independent Business v. Sebelius, that this withdrawal of funding was unconstitutionally coercive, and that individual states had the right to opt out of the Medicaid expansion without losing pre-existing Medicaid funding from the federal government. As of July 10, 2012, the governors of five states: Texas, Florida, Mississippi, Louisiana, and South Carolina, had announced that they would decline to participate in the Medicaid expansion. [108]
- Two years of tax credits will be offered to qualified small businesses. In order to receive the full benefit of a 50% premium subsidy, the small business must have an average payroll per full-time equivalent (“FTE”) employee, excluding the owner of the business, of less than $25,000 and have fewer than 11 FTEs. The subsidy is reduced by 6.7% per additional employee and 4% per additional $1,000 of average compensation. As an example, a 16 FTE firm with a $35,000 average salary would be entitled to a 10% premium subsidy. [109]
- Impose a $2,000 per employee penalty on employers with more than 50 employees who do not offer health insurance to their full-time workers (as amended by the reconciliation bill). [110]
- For employer sponsored plans, set a maximum of $2,000 annual deductible for a plan covering a single individual or $4,000 annual deductible for any other plan (see 111HR3590ENR, section 1302). These limits can be increased under rules set in section 1302.
- The CLASS Act provision would have created a voluntary long-term care insurance program, but in October 2011 the Department of Health and Human Services announced that the provision was unworkable and would be dropped, although an Obama administration official later said the President does not support repealing this provision. [111][112][113][114]
- Pay for new spending, in part, through spending and coverage cuts in Medicare Advantage, slowing the growth of Medicare provider payments (in part through the creation of a new Independent Payment Advisory Board), reducing Medicare and Medicaid drug reimbursement rate, cutting other Medicare and Medicaid spending. [149][115]
• Revenue increases from a new $2,500 limit on tax-free contributions to flexible spending accounts (FSAs), which allow for payment of health costs.\[^{116}\]

• Establish health insurance exchanges, and subsidization of insurance premiums for individuals in households with income up to 400% of the poverty line. To qualify for the subsidy, the beneficiaries cannot be eligible for other acceptable coverage.\[^{107}\][\[^{117}\][\[^{118}\][\[^{119}\]]\] Section 1401(36B) of PPACA explains that the subsidy will be provided as an advanceable, refundable tax credit\[^{120}\] and gives a formula for its calculation.\[^{121}\] Refundable tax credit is a way to provide government benefit to people even with no tax liability\[^{122}\] (example: Earned Income Credit). The formula was changed in the amendments (HR 4872) passed March 23, 2010, in section 1001. According to DHHS and CRS, in 2014 the income-based premium caps for a "silver" healthcare plan for family of four would be the following:

### Health Insurance Premiums and Cost Sharing under PPACA for average family of 4\[^{19}\][\[^{123}\][\[^{124}\][\[^{125}\][\[^{126}\]]\]

<table>
<thead>
<tr>
<th>Income % of Federal Poverty Level</th>
<th>Premium Cap as a Share of Income</th>
<th>Income $ (Family of 4)[^{a}]</th>
<th>Max Annual Out-of-Pocket Premium</th>
<th>Premium Savings[^b]</th>
<th>Additional Cost-Sharing Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>133%</td>
<td>3% of income</td>
<td>$31,900</td>
<td>$992</td>
<td>$10,345</td>
<td>$5,040</td>
</tr>
<tr>
<td>150%</td>
<td>4% of income</td>
<td>$33,075</td>
<td>$1,323</td>
<td>$9,918</td>
<td>$5,040</td>
</tr>
<tr>
<td>200%</td>
<td>6.3% of income</td>
<td>$44,100</td>
<td>$2,778</td>
<td>$8,366</td>
<td>$4,000</td>
</tr>
<tr>
<td>250%</td>
<td>8.05% of income</td>
<td>$55,125</td>
<td>$4,438</td>
<td>$6,597</td>
<td>$1,930</td>
</tr>
<tr>
<td>300%</td>
<td>9.5% of income</td>
<td>$66,150</td>
<td>$6,284</td>
<td>$4,628</td>
<td>$1,480</td>
</tr>
<tr>
<td>350%</td>
<td>9.5% of income</td>
<td>$77,175</td>
<td>$7,332</td>
<td>$3,512</td>
<td>$1,480</td>
</tr>
<tr>
<td>400%</td>
<td>9.5% of income</td>
<td>$88,200</td>
<td>$8,379</td>
<td>$2,395</td>
<td>$1,480</td>
</tr>
</tbody>
</table>

a. Note: In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for family of four.\[^{127}\][\[^{128}\] See Subsidy Calculator for specific dollar amount.\[^{129}\] b. DHHS and CBO estimate the average annual premium cost in 2014 to be $11,328 for family of 4 without the reform.\[^{123}\]

• The U.S. Department of Health and Human Services (DHHS) and Internal Revenue Service (IRS) on May 23, 2012, issued joint final rules regarding implementation of new state-based health insurance exchanges to cover how the exchanges will determine eligibility for uninsured individuals and employees of small businesses seeking to buy insurance on the exchanges, as well as how the exchanges will handle eligibility determinations for low-income individuals applying for newly expanded Medicaid benefits.\[^{126}\][\[^{130}\]

• Members of Congress and their staff will only be offered health care plans through the exchange or plans otherwise established by the bill (instead of the Federal Employees Health Benefits Program that they currently use).\[^{131}\]

• A new excise tax goes into effect that is applicable to pharmaceutical companies and is based on the market share of the company; it is expected to create $2.5 billion in annual revenue.\[^{105}\]

• Most medical devices become subject to a 2.3% excise tax collected at the time of purchase. (Reduced by the reconciliation act from 2.6% to 2.3%).\[^{132}\]

• Health insurance companies become subject to a new excise tax based on their market share; the rate gradually rises between 2014 and 2018 and thereafter increases at the rate of inflation. The tax is expected to yield up to $14.3 billion in annual revenue.\[^{105}\]

• The qualifying medical expenses deduction for Schedule A tax filings increases from 7.5% to 10% of earned income.\[^{133}\]

• Consumer Operated and Oriented Plans (CO-OP), which are member-governed non-profit insurers, entitled to a 5-year federal loan, are permitted to start providing health care coverage.\[^{134}\]
Effective by October 1, 2014

• Federal payments to so-called 'disproportionate share hospitals', which treat large numbers of indigent patients, are to be reduced and subsequently allowed to rise based on the percentage of the population that is uninsured in each state.\footnote{135}

Effective by January 1, 2015

• CMS begins using the Medicare fee schedule to give larger payments to physicians who provide high-quality care compared with cost.\footnote{136}

Effective by October 1, 2015

• States are allowed to shift children eligible for care under the Children's Health Insurance Program to health care plans sold on their exchanges, as long as HHS approves.\footnote{137}

Effective by January 1, 2016

• States are permitted to form health care choice compacts and allows insurers to sell policies in any state participating in the compact.\footnote{138}
• The threshold for itemizing medical expenses increases from 7.5% of income to 10% for seniors.\footnote{139}

Effective by January 1, 2017

• A state may apply to the Secretary of Health & Human Services for a "waiver for state innovation" provided that the state passes legislation implementing an alternative health care plan meeting certain criteria. The decision of whether to grant the waiver is up to the Secretary (who must annually report to Congress on the waiver process) after a public comment period.\footnote{140} A state receiving the waiver would be exempt from some of the central requirements of the ACA, including the individual mandate, the creation by the state of an insurance exchange, and the penalty for certain employers not providing coverage.\footnote{141,142} The state would also receive compensation equal to the aggregate amount of any federal subsidies and tax credits for which its residents and employers would have been eligible under the ACA plan, but which cannot be paid out due to the structure of the state plan.\footnote{140} In order to qualify for the waiver, the state plan must provide insurance at least as comprehensive and as affordable as that required by the ACA, must cover at least as many residents as the ACA plan would, and cannot increase the federal deficit. The coverage must continue to meet the consumer protection requirements of the ACA, such as the prohibition on increasing premiums because of pre-existing conditions.\footnote{143} A bipartisan bill sponsored by Senators Ron Wyden and Scott Brown, and supported by President Obama, proposes making waivers available in 2014 rather than 2017, so that, for example, states that wish to implement an alternative plan need not set up an insurance exchange only to dismantle it a short time later.\footnote{141} In April 2011 Vermont announced its intention to pursue a waiver in order to implement the single-payer system enacted in May 2011.\footnote{144,145,146,147} In September 2011 Montana announced it would also be seeking a waiver to set up its own single payer healthcare system.\footnote{148}
• States may allow large employers and multi-employer health plans to purchase coverage in the Exchange.
• Two federally regulated 'multi-state plan' (MSP) insurers, with one being non-profit and the other being forbidden for providing coverage for abortion services, will be available to all states. They will have to oblige by the same federal regulations as required by individual state's qualified health plans available on the exchanges and must provide the same identical cover privileges and premiums in all states. MSPs will be phased in nationally, being available in 60% of all states in 2014, 70% in 2015, 85% in 2016 with full national coverage in 2017.\footnote{149}
Effective by January 1, 2018

- All existing health insurance plans must cover approved preventive care and checkups without co-payment.\[47\]
- A 40% excise tax on high cost ("Cadillac") insurance plans is introduced. The tax (as amended by the reconciliation bill)\[150\] is on insurance premiums in excess of $27,500 (family plans) and $10,200 (individual plans), and it is increased to $30,950 (family) and $11,850 (individual) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation; employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.\[105][151\]

Effective by January 1, 2019

- Medicaid extends coverage to former foster care youths who were in foster care for at least six months and are under 25 years old \[152\]

Effective by January 1, 2020

- The Medicare Part D coverage gap (a.k.a., "donut hole") would be completely phased out and hence closed.

Legislative history

Background

Health care reform was a major topic of discussion during the 2008 Democratic presidential primaries. As the race narrowed, attention focused on the plans presented by the two leading candidates, New York Senator Hillary Clinton and the eventual nominee, Illinois Senator Barack Obama. Each candidate proposed a plan to cover the approximately 45 million Americans estimated to be without health insurance at some point during each year. One point of difference between the plans was that Clinton’s plan was to require all Americans to obtain coverage (in effect, an individual health insurance mandate), while Obama’s was to provide a subsidy but not create a direct requirement.

During the general election campaign between Obama and the Republican nominee, Arizona Senator John McCain, Obama said that fixing health care would be one of his four priorities if he won the presidency.\[153\] After his inauguration, Obama announced to a joint session of Congress in February 2009 that he would begin working with Congress to construct a plan for health care reform.\[154\] On March 5, 2009, Obama formally began the reform process and held a conference with industry leaders to discuss reform and requested reform be enacted before the Congressional summer recess; but the reform was not passed by the requested date.\[155\] In July 2009, a series of bills were approved by committees within the House of Representatives.\[156\] Beginning June 17, 2009, and extending through September 14, 2009, three Democratic and three Republican Senate Finance Committee Members met for a series of 31 meetings to discuss the development of a health care reform bill. Over the course of the next three months, this group, Senators Max Baucus (D-Montana), Chuck Grassley (R-Iowa), Kent Conrad (D-North Dakota), Olympia Snowe (R-Maine), Jeff Bingaman (D-New Mexico), and Mike Enzi (R-Wyoming), met for more than 60 hours, and the principles that they discussed became the foundation of the Senate's health care reform bill.\[157\] The meetings were held in public and broadcast by C-SPAN and can be seen on the C-SPAN web site or at the Committee's own web site.\[159\] During the August 2009 congressional recess, many members went back to their districts and entertained town hall meetings to solicit public opinion on the proposals. During the summer recess, the Tea Party movement organized protests and many conservative groups and individuals targeted congressional town hall meetings to voice their opposition to the proposed reform bills.\[155][160\]

Away from the televised meetings, the legislation became a "bonanza" for lobbyists,\[161][162\] including secret deals that were initially denied but subsequently confirmed.\[163][164\] The Sunlight Foundation documented many of the reported ties between "the healthcare lobbyist complex" and politicians in both major parties.\[165\]
President Obama delivered a speech to a joint session of Congress supporting reform and again outlining his proposals. On November 7, the House of Representatives passed the Affordable Health Care for America Act on a 220–215 vote and forwarded it to the Senate for passage. The Senate bill, the Patient Protection and Affordable Care Act, bore similarities to prior healthcare reform proposals introduced by Republicans. In 1993 Senator John Chafee introduced the Health Equity and Access Reform Today Act which contained a "Universal Coverage" requirement with a penalty for non-compliance. Advocates for the 1993 bill which contained the "individual mandate" included prominent Republicans who today oppose the mandate, namely Orrin Hatch (R-UT), Charles Grassley (R-IA), Robert Bennett (R-UT), and Christopher Bond (R-MO). In 1994 Senator Don Nickles introduced the Consumer Choice Health Security Act which also contained an individual mandate with a penalty provision. However, Nickles removed the mandate from the act shortly after introduction, stating that they had decided "that government should not compel people to buy health insurance." Many experts of healthcare policy have pointed out that the "individual mandate" requirement to buy health insurance was contained in many previous Republican/conservative proposals for healthcare legislation, going back as far as 1989. Other experts have pointed out that the healthcare legislation that emerged from Congress in 2009 and 2010 is patterned, largely, after former Republican Governor of Massachusetts Mitt Romney's state healthcare plan which also contains the individual mandate.

The idea that the Obama healthcare legislation was a "government takeover of healthcare", pushed by the Tea Party movement and Congressional Republicans in 2010, earned this characterization of PPACA the "Lie of the Year for 2010" by PolitiFact.

There were many threats made against members of Congress and many were assigned extra protection.

**Senate**

The Senate failed to take up debate on the House bill and instead took up H.R. 3590, a bill regarding housing tax breaks for service members. As the United States Constitution requires all revenue-related bills to originate in the House, the Senate took up this bill since it was first passed by the House as a revenue-related modification to the Internal Revenue Code. The bill was then used as the Senate's vehicle for their health care reform proposal, completely revising the content of the bill. The bill as amended incorporated elements of earlier proposals that had been reported favorably by the Senate Health and Finance committees.

Passage in the Senate was temporarily blocked by a filibuster threat by Nebraska Senator Ben Nelson, who sided with the Republican minority. Nelson's support for the bill was won after it was amended to
offer a higher rate of Medicaid reimbursement for Nebraska.\textsuperscript{155} The compromise was derisively referred to as the "Cornhusker Kickback"\textsuperscript{190} (and was later repealed by the reconciliation bill). On December 23, the Senate voted 60–39 to end debate on the bill, eliminating the possibility of a filibuster by opponents. The bill then passed by a vote of 60–39 on December 24, 2009, with all Democrats and two Independents voting for, all but one Republican voting against and one senator (Jim Bunning, R-Ky.) not voting.\textsuperscript{191}

On January 19, 2010, Massachusetts Republican Scott Brown was elected to the Senate, having campaigned on giving the Republican minority the 41st vote needed to sustain a filibuster, even famously signing autographs as "Scott 41."\textsuperscript{155}\textsuperscript{192}\textsuperscript{193}

**House**

Although White House Chief of Staff Rahm Emanuel argued for a less ambitious bill, House Speaker Nancy Pelosi pushed back, dismissing Emanuel's scaled-down approach as "Kiddie Care."\textsuperscript{194}\textsuperscript{195} Obama's siding with comprehensive reform and the news that Anthem Blue Cross in California intended to raise premium rates for its patients by as much as 39% gave him a new line of argument for reform.\textsuperscript{194}\textsuperscript{195} Obama unveiled a health care reform plan of his own, drawing largely from the Senate bill. On February 22 he laid out a "Senate-leaning" proposal to consolidate the bills.\textsuperscript{196} On February 25, he held a meeting with leaders of both parties urging passage of a reform bill.\textsuperscript{155} The summit proved successful in shifting the political narrative away from the Massachusetts loss back to health care policy.\textsuperscript{195}

The most viable option for the proponents of comprehensive reform was for the House to abandon its own health reform bill, the Affordable Health Care for America Act, and to instead pass the Senate's bill, and then pass amendments to it with a different bill allowing the Senate to pass the amendments via the reconciliation process.\textsuperscript{194}\textsuperscript{197}

Initially, there were not enough supporters to pass the bill, thus requiring its proponents to negotiate with a group of pro-life Democrats, led by Congressman Bart Stupak. The group found the possibility of federal funding for abortion was substantive enough to cause their opposition to the bill. Instead of requesting inclusion of additional language specific to their abortion concerns in the bill, President Obama issued Executive Order 13535, reaffirming the principles in the Hyde Amendment. This concession won the support of Stupak and members of his group and assured passage of the bill.\textsuperscript{198}

The House passed the bill with a vote of 219 to 212 on March 21, 2010, with 34 Democrats and all 178 Republicans voting against it.\textsuperscript{199} The following day, Republicans introduced legislation to repeal the bill.\textsuperscript{200} Obama signed the original bill into law on March 23, 2010.\textsuperscript{201}
Impact

Public policy impact

Change in number of uninsured

CBO originally estimated the legislation will reduce the number of uninsured residents by 30 million, leaving 25 million uninsured residents in 2019 after the bill’s provisions have all taken effect. A July 2012 CBO estimate raised the expected number of uninsured by 6 million, reflecting the successful legal challenge to PPACA’s expansion of Medicaid.

Among the people in this uninsured group will be:

- Illegal immigrants, estimated to be around eight million – they will be ineligible for insurance subsidies and Medicaid; they will also be exempt from the health insurance mandate and will remain eligible for emergency services under the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA).
- Citizens not enrolled in Medicaid despite being eligible.
- Citizens not otherwise covered and opting to pay the annual penalty instead of purchasing insurance – mostly younger and single Americans.
- Citizens whose insurance coverage would cost more than 8% of household income and are exempt from paying the annual penalty.
- Citizens who live in states that opt out of the Medicaid expansion and who qualify for neither existing Medicaid coverage nor subsidized coverage through the states’ new insurance exchanges.

Early experience under PPACA was that, as a result of the tax credit for small businesses, some businesses offered health insurance to their employees for the first time. On September 13, 2011, the Census Bureau released a report showing that the number of uninsured 19- to 25-year-olds (now eligible to stay on their parents’ policies) had declined by 393,000, or 1.6%. Due to the effect of the U.S. Supreme court ruling, states can opt-in or out of the expansion of Medicaid. Arkansas, California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Rhode Island, Vermont, and Washington are implementing the expansion; Florida, Louisiana, Mississippi, Georgia, South Carolina, and Texas are not.

Effects on insurance premiums

For the effect on health insurance premiums, the CBO referred to its November 2009 analysis and stated that the effects would “probably be quite similar” to that earlier analysis. That analysis forecast that by 2016, for the non-group market comprising 17% of the market, premiums per person would increase by 10 to 13% but that over half of these insureds would receive subsidies that would decrease the premium paid to “well below” premiums charged under current law. For the small group market, 13% of the market, premiums would be impacted 1 to –3% and –8 to –11% for those receiving subsidies; for the large group market comprising 70% of the market, premiums would be impacted 0 to –3%, with insureds under high premium plans subject to excise taxes being charged –9 to –12%. The analysis was affected by various factors, including increased benefits particularly for the nongroup markets, more healthy insureds due to the mandate, administrative efficiencies related to the health exchanges, and insureds under high-premium plans reducing benefits in response to the tax.

The Associated Press reported that, as a result of PPACA’s provisions concerning the Medicare Part D coverage gap, individuals falling in this “donut hole” would save about 40 percent. Almost all of the savings came because, with regard to brand-name drugs, PPACA secured a discount from pharmaceutical companies. The change benefited more than two million people, most of them in the middle class.

The non-partisan Congressional Budget Office estimates that “about 4 million” (3.9 million or 1.2% of the population) will pay the penalty in 2016. In September 2012, the CBO estimated that nearly six million will pay a $1,200 penalty in 2016. Also, nearly 80 percent of those who will face the penalty would be making up to or less
than five times the federal poverty level. This would work out to $55,850 or less for an individual and $115,250 or less for a family of four.\[220\]

**Federal deficit impact**

**CBO deficit reduction estimates**

The 2011 comprehensive CBO estimate projected a net deficit reduction of more than $200 billion during the period 2012–2021.\[221\][222\] CBO estimated in March 2011 that for the 2012–2021 period, the law would result in net receipts of $813 billion, offset by $604 billion in outlays, resulting in a $210 billion reduction in the deficit.\[221\]

In 2012, the CBO updated its cost estimates for a portion of the bill, but did not update its estimate of the net deficit impact of the whole bill (which was still estimated to reduce budget deficits overall).\[223\] The ACA’s provisions related to insurance coverage were projected earlier in 2012 to have a net cost of $1,252 billion over the 2012–2022 period; that amount represented a gross cost to the federal government of $1,762 billion, offset in part by $510 billion in receipts and other budgetary effects (primarily revenues from penalties and other sources). The addition of 2022 to the projection period had the effect of increasing the costs of the coverage provisions of the ACA relative to those projected in March 2011 for the 2012-2021 period because that change added a year in which the expansion of eligibility for Medicaid and the subsidies for health insurance purchased through the exchanges would have been in effect. This estimate was made prior to the Supreme Court’s ruling regarding the expansion of Medicaid program to the individual states however.\[205\] CBO and JCT now estimate that the insurance coverage provisions of the ACA will have a net cost of $1,168 billion over the 2012–2022 period—compared with $1,252 billion projected in March 2012 for that 11-year period—for a net reduction of $84 billion. (Those figures do not include the budgetary impact of other provisions of the ACA, which in the aggregate reduce budget deficits.)\[224\]

As of the bill’s passage into law in 2010, CBO estimated the legislation would reduce the deficit by $143 billion\[225\] over the first decade, but half of that was due to expected premiums for the C.L.A.S.S. Act, which has since been abandoned.\[226\] Although the CBO generally does not provide cost estimates beyond the 10-year budget projection period (because of the great degree of uncertainty involved in the data) it decided to do so in this case at the request of lawmakers, and estimated a second decade deficit reduction of $1.2 trillion.\[216\][227\] CBO predicted deficit reduction around a broad range of one-half percent of GDP over the 2020s while cautioning that "a wide range of changes could occur".\[228\]

CBO also initially stated that the bill would "substantially reduce the growth of Medicare's payment rates for most services; impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs."\[216\] A commonly heard criticism of the CBO cost estimates is that CBO was required to exclude from its initial estimates the effects of likely "doc fix" legislation that would increase Medicare payments by more than $200 billion from 2010 to 2019;\[229\][230][231][232][233\] however, the "doc fix" remains a separate piece of legislation.\[234\] Subject to the same exclusion, the CBO initially estimated the
federal government's share of the cost during the first decade at $940 billion, $923 billion of which takes place during the final six years (2014–2019) when the spending kicks in;[^235][^236] with revenue exceeding spending during these six years.^[237]

### Healthcare spending trends

In a May 2010 presentation on "Health Costs and the Federal Budget", CBO stated:

Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.

CBO further observed that "a substantial share of current spending on health care contributes little if anything to people's health" and concluded, "Putting the federal budget on a sustainable path would almost certainly require a significant reduction in the growth of federal health spending relative to current law (including this year's health legislation)."^[238]

### Expenditure estimates

In 2012, the Congressional Budget Office (CBO) projected PPACA will require more than $1.7 trillion in gross federal spending over the period 2012–2022, some of which will be offset by penalties and tax increases related to coverage, resulting in net spending of more than $1.2 trillion for the insurance portion of the bill. However, this is only a partial accounting for the impact of the bill, excluding some offsetting expense reductions and revenue increases that result in a net deficit reduction.[^204][^205][^223][^239]

According to the Centers for Medicare and Medicaid Services, by 2019 PPACA will increase expenditures on Medicaid and individual subsidies by $165 billion annually while reducing Medicare expenditures by $125 billion annually.[^240]

### Other financing-related debate and opinion

There was mixed opinion about the CBO estimates from others.

Uwe Reinhardt, a health economist at Princeton, wrote that "The rigid, artificial rules under which the Congressional Budget Office must score proposed legislation unfortunately cannot produce the best unbiased forecasts of the likely fiscal impact of any legislation", but went on to say "But even if the budget office errs significantly in its conclusion that the bill would actually help reduce the future federal deficit, I doubt that the financing of this bill will be anywhere near as fiscally irresponsible as was the financing of the Medicare Modernization Act of 2003."[^241]

Douglas Holtz-Eakin, a CBO director during the George W. Bush administration, who later served as the chief economic policy adviser to U.S. Senator John McCain's 2008 presidential campaign, opined that the bill would increase the deficit by $562 billion.[^242]

Republican House leadership and the Republican majority on the House Budget Committee estimate the law would increase the deficit by more than $700 billion in its first 10 years.[^243][^244]

Democratic House leadership and the Democratic minority on the House Budget Committee say the claims of budget gimmickry are false[^245] and that repeal of the legislation would increase the deficit by $230 billion over the same period,[^246] pointing to the CBO's 2011 analysis of the impact of repeal.[^247]

*The New Republic* editors Noam Scheiber (an economist) and Jonathan Cohn (a noted health care policy analyst), countered critical assessments of the law's deficit impact, arguing that it is as likely, if not more so, for predictions to have underestimated deficit reduction than to have overestimated it. They noted that it is easier, for example, to account for the cost of definite levels of subsidies to specified numbers of people than account for savings from preventive health care, and that the CBO has a track record of consistently overestimating the costs of, and underestimating the savings of health legislation;[^248][^249] "innovations in the delivery of medical care, like greater use of electronic medical records,[^250] and financial incentives for more coordination of care among doctors, would
produce substantial savings while also slowing the relentless climb of medical expenses... But the CBO would not consider such savings in its calculations, because the innovations hadn't really been tried on such large scale or in concert with one another – and that meant there wasn't much hard data to prove the savings would materialize.\textsuperscript{[249]}

David Walker, former U.S. Comptroller General now working for The Peter G. Peterson Foundation, has stated that the CBO estimates are not likely to be accurate, because it is based on the assumption that Congress is going to do everything they say they're going to do.\textsuperscript{[251]} On the other hand, a Center on Budget and Policy Priorities analysis said that Congress has a good record of implementing Medicare savings. According to their study, Congress implemented the vast majority of the provisions enacted in the past 20 years to produce Medicare savings.\textsuperscript{[252],[253]}

**Coverage for contraceptives**

With the exception of churches and houses of worship, PPACA's contraceptive coverage mandate applies to all employers and educational institutions. The mandate applies to all new health insurance plans effective August 2012. It controversially includes Christian hospitals, Christian charities, Catholic universities, and other enterprises owned or controlled by religious organizations that oppose contraception on doctrinal grounds. Regulations\textsuperscript{[254]} made under PPACA rely on the recommendations of the Institute of Medicine, which concluded that access to contraception is medically necessary "to ensure women's health and well-being."\textsuperscript{[255]}

**Effect on national spending**

The United States Department of Health and Human Services reported that the bill would increase "total national health expenditures" by more than $200 billion from 2010 to 2019.\textsuperscript{[256],[257]} The report also cautioned that the increases could be larger, because the Medicare cuts in the law may be unrealistic and unsustainable, forcing lawmakers to roll them back. The report projected that Medicare cuts could put nearly 15% of hospitals and other institutional providers into debt, "possibly jeopardizing access" to care for seniors.\textsuperscript{[258],[259]}

Surgeon Atul Gawande has noted the bill contains a variety of pilot programs that may have a significant impact on cost and quality over the long-run, although these have not been factored into CBO cost estimates. He stated these pilot programs cover nearly every idea healthcare experts advocate, except malpractice/tort reform. He argued that a trial and error strategy, combined with industry and government partnership, is how the U.S. overcame a similar challenge in the agriculture industry in the early 20th century.\textsuperscript{[260]}

The Business Roundtable, an association of CEOs, commissioned a report from the consulting company Hewitt Associates that found that the legislation "could potentially reduce that trend line by more than $3,000 per employee, to $25,435" with respect to insurance premiums. It also stated that the legislation "could potentially reduce the rate of future health care cost increases by 15% to 20% when fully phased in by 2019". The group cautioned that this is all assuming that the cost-saving government pilot programs both succeed and then are wholly copied by the private market, which is uncertain.\textsuperscript{[261]}

After the bill was signed, AT&T, Caterpillar, Verizon, and John Deere issued financial reports showing large charges against earnings, up to US$1 billion in the case of AT&T, attributing the additional expenses to tax changes in the new health care law.\textsuperscript{[262]} Under the new law, starting in 2013 companies can no longer deduct a subsidy for prescription drug benefits granted under Medicare Part D.\textsuperscript{[263]}
**Political impact**

**Public opinion**

Polls indicate American public opinion shifted over time from general support for health care reform to gradual opposition. Specific elements were very popular across the political spectrum, with the notable exception of the mandate to purchase insurance. Democrats favored the law, while Republicans and Independents did not. For example, a Reuters-Ipsos poll during June 2012 indicated the following:

- 56% of Americans overall were against the law, with 44% supporting it. By party affiliation, 75% of Democrats, 27% of Independents, and 14% of Republicans favored the law overall.
- 82% favored banning insurance companies from denying coverage to people with pre-existing conditions.
- 61% favored allowing children to stay on their parents' insurance until age 26.
- 72% supported requiring companies with more than 50 employees to provide insurance for their employees.
- 61% opposed requiring all U.S. residents to own health insurance. By party affiliation, 19% of Republicans, 27% of Independents, and 41% of Democrats favored the mandate that all Americans buy health insurance.[264]
- Other topics receiving majority support among all three affiliations included: creation of insurance pools so small businesses and the uninsured had access to insurance exchanges to take advantage of large group pricing benefits; and providing subsidies on a sliding scale to aid individuals and families who cannot afford health insurance.[265][266]

Other specific ideas that showed majority support, such as purchasing drugs from Canada, limiting malpractice awards, and reducing the age to qualify for Medicare, were not enacted.[267]

Public opinion supported healthcare reform proposals in 2008, but turned negative when the plan changed in 2009, and remains opposed to the final version that was signed in 2010.[268][269] Though in 2008 then-Senators Barack Obama and Joseph Biden campaigned against requiring adults to buy insurance,[270] in 2009 President Obama reportedly changed his mind and agreed with insurance industry and Democratic Congressional proposals to include an individual mandate.[271][272] Public opinion of the legislation turned negative when the individual mandate proposal was announced, and remains opposed by a margin of 10 percentage points.[268][269][273]

In March 2010, pollsters probed the reasons for opposition. In a CNN poll, 62% of respondents said PPACA would "increase the amount of money they personally spend on health care," 56% said the bill "gives the government too much involvement in health care," and only 19% said they and their families would be better off with the legislation.[274] In *The Wall Street Journal*, pollsters Scott Rasmussen and Doug Schoen wrote, "One of the more amazing aspects of the health-care debate is how steady public opinion has remained... 81% of voters say it's likely the plan will end up costing more than projected [and 59%] say that the biggest problem with the health-care system is the cost: They want reform that will bring down the cost of care. For these voters, the notion that you need to spend an additional trillion dollars doesn't make sense."[275] *USA Today* found opinions were starkly divided by age, with a solid majority of seniors opposing the bill and a solid majority of those younger than 40 in favor.[276]

A September 2010 Politico article reported that five House Democrats had run political ads highlighting their "no" votes on the bill, while there had not been any political ads highlighting a "yes" vote since April, when Harry Reid ran one. The article also reported a Kaiser Family Foundation poll "which showed 43 percent of the public supports the overhaul and 45 percent are opposed. Much of the disagreement falls along party lines."[277]

As of February 2012, 72% of registered voters believe PPACA's individual mandate is unconstitutional, while 20% say it is permissible.[278] By a margin of 50% to 39%, Americans say the Supreme Court should overturn the entire statute.[279] The Supreme Court hearings occasioned public demonstrations including prayer vigils coordinated by the White House[280] and Tea Party Protests.[281]

A June 2012 Reuters-Ipsos poll indicated that much of the opposition to the law was because Americans wanted more reform, not less. About one-third of Republicans and independents who oppose the law did so because it did not go far enough to fix healthcare. 71% of Republican opponents reject it overall, while 29% believed it did not go
far enough, while independent opponents are divided 67% to 33%. Among Democratic opponents, 49% reject it overall, and 51% wanted the measure to go further.[264]

A poll released in July 2012 showed that "most Americans (56%) want to see critics of President Obama's health care law drop efforts to block it and move on to other national issues."[282]

**Term "Obamacare"**

The term "Obamacare" was originally coined by opponents, notably Mitt Romney in 2007, as a pejorative term. However by mid-2012 it was the common term used by both sides.[283] Use of the term in a positive sense was suggested by Democratic politicians such as John Conyers (D-MI).[284] President Obama said subsequently, "I have no problem with people saying Obama cares. I do care."[285] Because of the number of "Obamacare" search engine queries, the Department of Health and Human Services purchased Google advertisements, triggered by the term, to direct people to the official HHS site.[286] In March 2012, the Obama reelection campaign embraced the term "Obamacare", urging Obama's supporters to post Twitter messages that begin, "I like #Obamacare because...". [287] According to an analysis by the Sunlight Foundation, the term "Obamacare" has been used nearly 3,000 times in Congressional speeches since its debut as a phrase on Capitol Hill in July 2009.[8]

According to *The New York Times*, the term was first put in print in March 2007, when health care lobbyist Jeanne Schulte Scott penned it in a health industry journal. "We will soon see a 'Giuliani-care' and 'Obama-care' to go along with 'McCain-care,' 'Edwards-care,' and a totally revamped and remodeled 'Hillary-care' from the 1990s",

Schulte Scott wrote.[8][288] The expression Obamacare first was used in early 2007 generally by writers describing the candidate's proposal for expanding coverage for the uninsured according to research by Elspeth Reeve at *The Atlantic* magazine.[283] The word was first uttered in a political campaign by Mitt Romney in May 2007 in Des Moines, Iowa. Romney said: "In my state, I worked on health care for some time. We had half a million people without insurance, and I said, 'How can we get those people insured without raising taxes and without having government take over health care'. And let me tell you, if we don't do it, the Democrats will. If the Democrats do it, it will be socialized medicine; it'll be government-managed care. It'll be what's known as Hillarycare or Barack Obamacare, or whatever you want to call it."[8]

**Impact on child-only policies**

In September 2010, some insurance companies announced that in response to the law, they would end the issuance of new child-only policies.[289][290] Kentucky Insurance Commissioner Sharon Clark said the decision by insurers to stop offering such policies was a violation of state law and ordered insurers to offer an open enrollment period in January 2011 for Kentuckians under 19.[291] An August 2011 Congressional report found that passage of the health care law prompted health insurance carriers to stop selling new child-only health plans in many states. Of the 50 states, 17 reported that there were currently no carriers selling child only health plans to new enrollees. Thirty-nine states indicated at least one insurance carrier exited the child-only market following enactment of the health care laws.[292]

**Legal challenges**

Opponents of the Patient Protection and Affordable Care Act have turned to the federal courts to challenge the constitutionality of the legislation.[293][294] The Supreme Court upheld the individual mandate, perhaps the most controversial provision of the law, but limited the expansion of Medicaid initially proposed under PPACA. All provisions of PPACA will continue in effect or will take effect as scheduled, with some limits on the Medicaid expansion.[295]
Repeal efforts

111th Congress

Reps. Steve King of Iowa and Michele Bachmann of Minnesota, both Republicans, introduced bills in the House to repeal PPACA shortly after it was passed, as did Sen. Jim DeMint in the Senate. None of the three bills were considered by either body.

112th Congress

In 2011, the Republican-controlled House of Representatives voted 245–189 to approve a bill entitled "Repealing the Job-Killing Health Care Law Act" (H.R.2), which, if enacted, would repeal the Patient Protection and Affordable Care Act and the health-care-related text of the Health Care and Education Reconciliation Act of 2010. All Republicans and 3 Democrats voted for repeal. In the Senate, the bill was offered as an amendment to an unrelated bill, and was subsequently voted down. Before votes in both houses of the Congress took place, President Obama stated that he would veto the bill should it pass both chambers. Democrats in the House proposed that repeal not take effect until a majority of the Senators and Representatives had opted out of the Federal Employees Health Benefits Program. The Republicans voted down this measure.

On June 28, 2012, following the law being ruled as constitutional by the Supreme Court, House Majority Leader Eric Cantor stated that the House would again vote to repeal the law in July when Congress returns from recess. On July 11, 2012, the House of Representatives voted to repeal the law with 5 Democrats and all 239 Republicans voting in favor of the repeal. This was the 31st effort by the House of Representatives to repeal the bill in the 112th Congress. With President Obama's reelection and the Democrats expanding their majority in the Senate following the 2012 elections, Republicans conceded that repeal almost certainly will not occur.

Job consequences of repeal

A spokesman for Eric Cantor stated, "This is a job-killing law, period. Anyone who argues otherwise is ignoring the construct of the health care law and the widely accepted facts." The House Republican leadership justified its use of the term "job killing" by contending that PPACA would lead to a loss of 650,000 jobs, and attributing that figure to a report by the Congressional Budget Office. However, the CBO report specifically stated that the negative effect on jobs was because people would voluntarily choose to work less once they have health insurance outside of their jobs. FactCheck noted that the 650,000 figure was not in the CBO report, and said that the Republican statement "badly misrepresents what the Congressional Budget Office has said about the law. In fact, CBO is among those saying the effect will probably be small."

The Republicans also cited a study by the National Federation of Independent Business, but PolitiFact.com said that the 2009 NFIB study had concerned an earlier version of the bill that differed significantly from what was enacted. PolitiFact rated the Republican statement as False.

Effect of repeal proposals on federal budget projections

The non-partisan Congressional Budget Office (CBO) estimated that repealing the entire PPACA (including both its taxing and spending provisions) would increase the net 2011–2021 federal deficit by $210 billion. Republican politicians disagreed, arguing that estimate was based on unrealistic assumptions; House Speaker John Boehner said, "I don't think anyone in this town believes that repealing Obamacare is going to increase the deficit." In May 2011, CBO analyzed proposals to prevent the use of appropriated funds to implement the legislation, and wrote that "a temporary prohibition, extending through the remainder of fiscal year 2011, would reduce the budget deficit by about $1.4 billion in 2011 but would increase deficits by almost $6 billion over the 2011–2021 period... CBO cannot determine whether changes in spending under a permanent prohibition would produce net costs or net savings relative to its baseline projection, which assumes full implementation."
Revised CBO accounting, based on the latest repeal effort passed in the House of Representatives (H.R. 6079) on July 11, 2012 and taking into account the Supreme Court's ruling concerning the expansion of Medicaid by the States, that, on balance, the direct spending and revenue effects of enacting the Repeal of Obamacare Act legislation would cause a net increase in federal budget deficits of $109 billion over the 2013–2022 period. Specifically, CBO estimates that H.R. 6079 would reduce direct spending by $890 billion and reduce revenues by $1 trillion between 2013 and 2022, thus adding $109 billion to federal budget deficits over that period.[305][314]

**Temporary waivers**

Interim regulations have been put in place for a specific type of employer-funded insurance, the so-called "mini-med" or limited-benefit plans, which are low-cost to employers who buy them for their employees, but cap coverage at a very low level. Such plans are sometimes offered to low-paid and part-time workers, for example in fast food restaurants or purchased direct from an insurer. Most company-provided health insurance policies starting on or after September 23, 2010 and before September 23, 2011 may not set an annual coverage cap lower than $750,000,[315] a lower limit that is raised in stages until 2014, by which time no insurance caps are allowed at all. By 2014, no health insurance, whether sold in the individual or group market, will be allowed to place an annual cap on coverage. The waivers have been put in place to encourage employers and insurers offering mini-med plans not to withdraw medical coverage before the full regulations come into force (by which time small employers and individuals will be able to buy non-capped coverage through the exchanges) and are granted only if the employer can show that complying with the limit would mean a significant decrease in employees' benefits coverage or a significant increase in employees' premiums.[315]

Among those receiving waivers were employers, large insurers, such as Aetna and Cigna, and union plans covering about one million employees. McDonald's, one of the employers that received a waiver, has 30,000 hourly employees whose plans have annual caps of $10,000. The waivers are issued for one year and can be reapplied for.[316][317] Referring to the adjustments as "a balancing act", Nancy-Ann DeParle, director of the Office of Health Reform at the White House, said, "The president wants to have a smooth glide path to 2014.'[316] On January 26, 2011, HHS said it had to date granted a total of 733 waivers for 2011, covering 2.1 million people, or about 1% of the privately insured population.[318] In June 2011, the Obama Administration announced that all applications for new waivers and renewals of existing ones have to be filed by September 22 of that year, and no new waivers would be approved after this date.[319]

**References**

Note: Language in the law concerning this provision has been described as ambiguous, but representatives of the insurance industry have indicated they will comply with regulations to be issued by the Secretary of Health and Human Services reflecting this interpretation.


- "Medical Loss Ratio Ratio" (http://companyprofiles.healthcare.gov/MirQA). .


[131] Public Law 111 – 148 (http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.html), section 1312: ":... the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are (I) created under this Act (or an amendment made by this Act); or (II) offered through an Exchange established under this Act (or an amendment made by this Act)."


today that more than 10 members of Congress have received threats in the wake of the health reform vote"


Further reading


Preliminary CBO documents

- Patient Protection And Affordable Care Act, Incorporating The Manager's Amendment (http://www.cbo.gov/doc.cfm?index=10868) – December 19, 2009
- Effects Of The Patient Protection And Affordable Care Act On The Federal Budget And The Balance In The Hospital Insurance Trust Fund (December 23, 2009)
- Estimated Effect Of The Patient Protection And Affordable Care Act (Incorporating The Manager's Amendment) On The Hospital Insurance Trust Fund (December 23, 2009)

↑ (The Additional and/or Related CBO reporting that follows can be accessed from the above link)
- Estimated Distribution Of Individual Mandate Penalties (November 20, 2009)
- Estimated Effects On Medicare Advantage Enrollment And Benefits Not Covered By Medicare (November 21, 2009)
- Estimated Effects On The Status Of The Hospital Insurance Trust Fund (November 21, 2009)
- Estimated Average Premiums Under Current Law (December 5, 2009)
- Additional Information About Employment-Based Coverage (December 7, 2009)
- Budgetary Treatment Of Proposals To Regulate Medical Loss Ratios (December 13, 2009)

Centers for Medicare and Medicaid Services (CMS) Estimates of the impact of P.L. 111-148

Centers for Medicare and Medicaid Services (CMS) Estimates of the impact of H.R. 3590


External links

• Video: Obama signs Healthcare Bill (http://www.wtsp.com/video/1711079319001/1/Video-obama-signs-health-care-bill)

• Supreme Court Ruling on the ACA-June 28, 2012 (http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf)

• Remarks by the President on Supreme Court Ruling on the Affordable Care Act-June 28, 2012 (http://www.whitehouse.gov/the-press-office/2012/06/28/remarks-president-supreme-court-ruling-affordable-care-act)

• HealthCare.gov (http://www.healthcare.gov/) - Department of Health and Human Services website on the law


• Health Reform (http://topics.wsj.com/subject/H/health-reform/1662) collected news and commentary at The Wall Street Journal


• Timeline of the health care law (http://edition.cnn.com/2012/06/17/healthcare-timeline/index.html?iid=article_sidebar) as provided by CNN June 17, 2012


• Three Days of Argument: Obamacare On Trial Audiobook (http://www.castlibary.com/free_books) – Complete coverage of the arguments to the Supreme Court regarding Obamacare


• HealthReformGPS.org (http://www.healthreformgps.org/) – Tracking and explanation of the law – as it is implemented – by analysts at the Hirsh Health Law and Policy program of the George Washington University School of Public Health and Health Services.


Copies of the proposed bill hosted online or readily downloadable

• PDF (http://docs.house.gov/energycommerce/ppacacon.pdf) of the Patient Protection and Affordable Care Act (“PPACA”; Public Law 111–148) after consolidating the amendments made by Title X of PPACA itself and
by the Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111–152) into one revision.

- Plain Text or PDF formats of H. R. 3590 (Public Law 111-148) (http://www.gpo.gov/fdsys/search/pagedetails.action?packageId=PLAW-111publ148), as engrossed or passed by the Senate and printed via FDsys.
- The Patient Protection and Affordable Care Act (http://dpc.senate.gov/dpcissue-sen_health_care_bill.cfm), full text, summary, background, provisions and more, via Democratic Policy Committee (Senate.gov)
- Entry for H.R. 3590 (http://www.govtrack.us/congress/bill.xpd?bill=h111-3590) at GovTrack
- "Lines Crossed: Separation of Church and State. Has the Obama Administration Trampled on Freedom of Religion and Freedom of Conscience?" Hearing before the Congressional Committee on Oversight and Government Reform February 16, 2012
  - Lines Crossed: Separation of Church and State – Part 1 (http://www.youtube.com/watch?v=9nJRUxj-HUY)
  - Lines Crossed: Separation of Church and State – Part 2 (http://www.youtube.com/watch?v=uj1l8suF68)
  - "Where Are the Women?!: Lawmakers Walk Out on Contraception Rule Hearing After Female Witness Barred" (https://www.democracynow.org/2012/2/17/where_are_the_women_lawmakers_walk)

Democracy Now! February 17, 2012