Am J Clin Exp Obstet Gynecol 2017;4(5):48-50
www.ajceog.us /ISSN:2330-1899/AJCE0G0062275

Original Article

The septennial congressional quest to repeal the ACA: a study in intransigence

Eli Y Adashi, Neesha Nama

The Warren Alpert Medical School, Brown University, Providence, RI, USA

Received January 20, 2017; Accepted September 6, 2017; Epub September 10, 2017; Published September 15, 2017

Abstract: By most accounts, the 115th Congress will likely repeal and/or replace the Patient Protection and Affordable Care Act (ACA) as soon as such becomes feasible. In so doing, the 115th Congress will have accomplished what four of its immediate predecessors have doggedly attempted but failed to do. From the time of its inception on March 23, 2010, the ACA has been the subject of persistent congressional efforts to upend its implementation. Now, 25 statutes later, substantial elements of the law have been delayed, defunded, amended, or outright repealed. The cumulative loss of functionality over the 7 years of piecemeal dismantlement has been consequential. Further compromise by additional 45 House-passed bills did not come to pass due to failure to enact. The impact of United States House of Representatives v. Burwell is pending. In this commentary we trace the evolution of the four relevant congressional constellations, delineate the provisions enacted during their respective terms, discuss their attendant harm, and reflect on the wisdom of continuing down this path.

Keywords: Repeal, replace, ACA, affordable care act

By most accounts, the 115th Congress will likely repeal and/or replace the *Patient Protection and Affordable Care Act* (ACA) as soon as such becomes feasible [1]. In so doing, the 115th Congress will have accomplished what four of its immediate predecessors have doggedly attempted but failed to do. From the time of its inception on March 23, 2010, the ACA has been the subject of persistent congressional efforts to upend its implementation [2, 3]. Now, 25 statutes later, substantial elements of the law have been delayed, defunded, amended, or outright repealed. The cumulative loss of functionality over the 7 years of piecemeal dismantlement has been consequential [2, 3]. Further compromise by additional 45 House-passed bills did not come to pass due to failure to enact [2]. The impact of *United States House of Representatives v. Burwell* is pending [4]. In this *commentary* we trace the evolution of the four relevant congressional constellations, delineate the provisions enacted during their respective terms, discuss their attendant harm, and reflect on the wisdom of continuing down this path.

The deep-seated partisan divisions unleashed by the passage of the health care law cast a constant pall over four sequential congressional constellations. With Democrats still in control of both chambers in the 111th Congress, a modicum of bipartisanship saw to the enactment of a number of technical adjustments to the law. That dynamic however shifted markedly in the wake of the 2010 midterm elections. No sooner had the House reverted to Republican control in the 112th and 113th Congress, multiple ACA-constraining bills have come to be sponsored including some which would have seen to the repeal of the law in its entirety. Throughout this time, the Senate, still under Democratic control, considered few of the aforementioned House initiatives. In yet another shift prompted by the 2014 midterm elections, Republicans assumed control of both houses of Congress for the first time since the 109th Congress. With Republicans in control of both chambers in the 114th Congress, the drive to repeal the heath care law has been further accelerated due to greater collaboration between the House and the Senate. In the

course of this most recent congressional session, a total of 20 ACA-disabling bills have been sponsored of which 6 have been signed into law [2, 3].

Relying on authorizing legislation, Congress has enacted a total of 17 ACA-modifying statutes since 2010 [2]. The 111th Congress limited itself to the task of addressing several oversights of the law, namely, that health care provided under TRICARE and the Department of Veterans Affairs conforms to the "Essential Health Benefits" requirement. The 112th Congress for its part repealed the massive if flawed Community Living Assistance Services and Supports (CLASS) Act which would have established a public long-term care insurance program. In addition, the 112th Congress repealed the revenue-monitoring if onerous requirement that businesses file an annual IRS Form 1099 for purchases of >$600 and rectified the formula designed to shield Louisiana from a reduction in its Federal Medicaid Assistance Percentage (FMAP) in the wake of Hurricane Katrina. Most importantly, the 112th Congress rescinded 90% of the remaining unobligated funds of the Consumer Operated and Oriented Plan (CO-OP) program and reduced the appropriation for the Prevention and Public Health Fund (PPHF) by a total of $6.25 billion. Finally, under pressure from the small business lobby, the 113th and the 114th assemblies repealed the requirement that employers with ≥200 employees provide all new full-time employees with health insurance and amended the small employer definition to mean ≤50 rather than ≤100 employees. Many of the aforementioned provisions and others which remain unmentioned have had a significant cumulative effect on the funding of the ACA and on the realization of its vision. Most disruption has likely been effected by defunding the PPHF upon which the Centers for Medicare and Medicaid Services (CMS) and the Internal Revenue Service (IRS) have relied for the implementation of the law. The defunding of the CO-OP program likely proved just as disruptive given its intended role in assuring a competitive insurance marketplace.

Apart and distinct from leveraging authorizing legislation to constrain the law, Congress took to incorporating disabling provisions into a total of 8 appropriation bills during FY2011-FY2017 [3]. For its part, the 112th Congress rescinded $2.6 billion of the $6 billion appropriation for the CO-OP program. In addition, at the urging of the business lobby, the 112th Congress repealed the free choice voucher program (an-employee-empowering health insurance measure). The 112th Congress also rescinded the annual $10 million appropriation for the Independent (Medicare) Payment Advisory Board (IPAB) in what became a recurring pattern. In a move destined to destabilize the insurance marketplace, the 113th Congress prohibited CMS from issuing risk corridor payments to eligible parties from its Program Management account. Most importantly however, the 113th Congress (as well as its 114th successor) denied CMS any additional discretionary funding to implement the ACA inclusive of the federally run exchange. The IRS has been similarly rebuffed in its quest to enforce the tax provisions of the law. Finally, the 114th Congress proscribed several revenue-reducing measures under pressure from affected constituencies. Specifically, the 114th Congress approved a 2-year delay of the Cadillac tax (an excise tax on high-premium employer-sponsored health plans), mandated a 1-year moratorium on the collection of annual fees from health insurance providers, and established a temporary 2-year moratorium on the medical device excise tax. Viewed in hindsight, the denial of operational funds to CMS and to the IRS likely constituted the most detrimental congressional action. Equally significant was the hamstringing of the risk corridor program which by many accounts contributed to a growing destabilization of the insurance market.

Viewed in perspective, the impending repeal of the health care law is but another step in an unforgiving congressional campaign the precise rationale of which has never been fully clarified. The decision to repeal is hardly a trivial one [1, 5]. Neither is its aftermath [1, 5]. Resurgent uninsurance and market disruption replete with political blowback must all be considered [1]. The last time this drastic a step has been taken was in 1989 when Congress repealed the *Medicare Catastrophic Coverage Act* [6]. And yet, expectations raised by long-standing rhetoric on and off campaign trails may compel just such an action [7]. One cannot help but wonder about the wisdom of dismantling a well-thought out if inevitably flawed health care law which is not beyond repair. One is further left to ponder what might be achieved

by gutting a health care law that can rightly claim to have accomplished near universal health insurance. Further befuddlement arises when one realizes that the health care law makes heavy use of tried and true conservative market principles such as consumer choice, means-tested subsidies, and competitive private insurance exchanges to name a few. Whether or not "revise and repair" as opposed to "repeal and replace" is to receive any consideration at this late hour remains to be seen. Such would be the only responsible path to be taken by elected custodians of the public welfare.

Address correspondence to: Dr. Eli Y Adashi, The Warren Alpert Medical School, Brown University, Providence, RI, USA. E-mail: eli_adashi@brown.edu

References

[1] Doherty R. The demise of the affordable care act? Not so fast. Ann Intern Med 2017; 166: 144-145.

[2] Redhead CS and Kinzer J. Legislative actions in the 112th, 113th, and 114th congresses to repeal, defund, or delay the affordable care act. 2013.

[3] Redhead CS and Cornell AS. Use of the annual appropriations process to block implementation of the affordable care act (FY2011-FY2017). 2017.

[4] United states house of representatives v. Burwell (united states court of appeals for the district of columbia circuit 2016).

[5] Wilensky GR. The future of the ACA and health care policy in the united states. JAMA 2017; 317: 21-22.

[6] Medicare catastrophic coverage repeal act of 1989, H.R. 3607 (1989).

[7] Gostin LO, Hyman DA and Jacobson PD. The affordable care act: moving forward in the coming years. JAMA 2017; 317: 19-20.