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Affordable care call: President Barack Obama chats with someone who gained health care coverage through the Affordable Care Act as health and human services secretary Sylvia Mathews Burwell looks on in this White House photo from February 17, 2015. The law continues to face challenges in 2016 as the president tries to solidify the legacy of the landmark health care reform in his final year in office.

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A Critical Year For The Affordable Care Act

Although challenges remain, 2016 promises to be a watershed year for the health care law and its supporters.

BY TIMOTHY S. JOST

In 2016 the Affordable Care Act (ACA) celebrates its sixth birthday, as many of the law's health insurance accessibility and affordability reforms experience their third year. The law continues to mature after overcoming early implementation kinks. But challenges remain, and new issues are arising as implementation proceeds. This is the last year in which the Obama administration can put its mark on health care reform. And by the end of the year, following the presidential election, there should be some indication of where the next administration plans to take the ACA.

To date, the ACA has been a success in many respects. The number and percentage of Americans who remain uninsured have dropped to historically low levels.[1] People newly covered by the ACA report high levels of satisfaction.[2] Health care cost growth has also slowed dramatically compared to the years preceding the ACA, and growth remains moderate despite rapid coverage expansions.[3] The quality of health care continues to improve as ACA quality initiatives are implemented.[4]

As enrollment in qualified health plans through the health insurance Marketplaces continues into its third year, such plans have become the new normal for millions of Americans. Enrollment and reenrollment has functioned reasonably smoothly so far during the third open enrollment period, with new enrollment tools that have made shopping for plans more streamlined and reliable. The "back end" of the Marketplaces—where they interact electronically with insurers—should finally be stable by early 2016, after two years of improvisation, with both Marketplaces and the insurers able to follow the status of individual enrollees.

A Complex Process

As individuals file their 2015 taxes in 2016, those who received advance premium tax credits, which covered part of the cost of their monthly insurance premiums, will be required for the second year to reconcile the credits they received in advance (based on their projected income and household composition) with the credits to which they were actually entitled (given their actual income and household composition during the year). This is a complex process, and it may take time before it becomes routine. However, once it becomes manifest that thousands of people who received premium credits for 2014 will be unable to receive tax credits for 2016 until they file and reconcile for 2014, the importance of the filing and reconciling should become more obvious.

PENALTIES FOR LACK OF COVERAGE

Early in 2016 Americans will for the first time receive either IRS Form 1095-B (from their insurer or self-insured employer or from the government program that covers them) or IRS Form 1095-C (if

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they work for a large employer). These forms will inform taxpayers and the IRS (which is sent copies of the forms) whether individuals had minimum essential coverage and whether employers offered it for 2015. Large employers that failed to offer that coverage to their full-time employees will for the first time be subject to a tax penalty for each full-time employee if any of their employees received premium tax credits through the Marketplace. Employers that offered coverage that was not both affordable and adequate will be subject to a tax penalty for each full-time employee who actually received premium tax credits through the Marketplace. Individuals who forgo coverage and do not qualify for one of many exemptions from the coverage requirement will have to pay the IRS an individual shared-responsibility tax. For 2016 that tax is over twice as large as it was for 2015 and over seven times as large as it was in 2014, and it is likely to get more attention.

AFFORDABILITY The affordability and value of Marketplace qualified health plans continue to vary based on income and geography. The premium tax credits make coverage more or less affordable for eligible families, but financial assistance phases out rapidly as income rises and ends completely when income reaches 400 percent of the federal poverty level—$47,080 for an individual.[5]

Many people who must purchase individual insurance policies without tax credits will face higher premiums in 2016 than in the past, as their "transitional" plans (plans that do not meet 2014 ACA insurance reform standards but are allowed to continue until 2017) are phased out. In some states consumers will face premiums that have increased dramatically over the previous year, although in other states overall premium increases have been moderate. As people in transitional plans enter the ACA-compliant insurance pool, however, the risk pool should improve, and premium growth may slow.

Premiums in the individual market are also affected by the expiration after 2016 of the temporary reinsurance program, which for the first three years of the individual market expansions backstopped insurers that covered high-cost individuals. The ACA also created a temporary risk corridor program to stabilize

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premium risk for Marketplace insurers. But Congress limited funding for the program in 2014, and as a result many insurers received dramatically smaller payouts than they expected. This contributed to the shuttering of numerous Consumer Operated and Oriented Plans (known by the acronym "CO-OPs") that had depended on full funding of the risk corridor program.

These losses, in addition to the proposed merger of larger insurers,[6] will likely contribute to further growth in premiums in the individual market in 2016. However, recent reports indicate that competition remains lively in the Marketplaces, with about as many new insurers entering the Marketplaces for 2016 as are exiting, even after accounting for recent CO-OP failures.[7]

ACCESS Even families that can afford health insurance face continued problems with accessing health care services. The ACA provides cost-sharing reductions for Marketplace plans and thus makes health care affordable for families with very low incomes. However, the reductions phase out quickly as income rises, and they no longer reduce cost sharing significantly once income reaches 200 percent of poverty—$23,540 for an individual. Individuals and families with incomes of about 200 percent of poverty may need to pay several thousand dollars in deductibles before they receive any help from their insurers.[8]

People insured in the individual market (and in a growing number of employer-sponsored plans) must also contend with narrow provider networks and formularies that restrict access to pharmaceuticals. Narrow networks can be beneficial to consumers if they include high-quality providers and reduce premium costs. But excessively narrow networks can restrict access to needed care and—intentionally or unintentionally—cause consumers to incur charges from out-of-network providers not covered by insurance, a practice known as balance billing.

The increasing dominance of plans offering narrow provider networks and formularies that restrict access to pharmaceuticals increases the need for greater plan transparency so that consumers can find plans that include their providers and drugs before enrolling. With that in mind, the federal Marketplace is providing more information on network providers and formularies for 2016 than in the past. And 2016 will likely see the adoption of new state laws and regulations aimed at increasing the transparency of networks and formularies, better ensuring the adequacy of available providers, and protecting consumers from unexpected balance billing.

Medicaid And Medicare

The ACA expanded eligibility for Medicaid to all adults under age sixty-five with incomes not exceeding 138 percent of poverty. However, in 2012, in *National Federation of Independent Business v. Sebelius*, the US Supreme Court held that Congress could not constitutionally require states to expand Medicaid. Many states decided to expand Medicaid nonetheless, but by the end of 2015 expansion had stalled. Twenty states had not expanded coverage—including Florida and Texas, which have the largest numbers of uninsured residents who could qualify for Medicaid if it were expanded.[9]

The federal government has been reimbursing expansion states 100 percent of their costs for the Medicaid expansion population. However, beginning in 2017 the level of reimbursements will start to be phased down, reaching 90 percent by 2020. Even at 90 percent, the states receive much more federal assistance for the expansion population than for their regular Medicaid enrollees. Medicaid expansion also allows states to reduce costs that they have traditionally borne for services for the mentally ill and incarcerated and for compensating providers for caring for the uninsured, as expanded Medicaid covers uninsured adults as well as some mental health services and services for the incarcerated.

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The ACA has also significantly changed the Medicare and Medicaid programs. Further Medicare and Medicaid payment reforms are likely in 2016, driven not only by the ACA but also by the Medicare Access and CHIP Reauthorization Act of 2015, which replaced the Medicare Sustainable Growth Rate program—which was supposed to limit the growth of Medicare physician expenditures but failed to do so. The Centers for Medicare and Medicaid Services also recently finalized regulations that require states to review and justify the adequacy of their Medicaid provider payment rates[10] and should soon finalize regulations that increase oversight of Medicaid managed care plans.

The last major provision of the ACA, the so-called Cadillac plan excise tax, is scheduled to take effect in 2018. It would impose a 40 percent excise tax on generous employer-sponsored coverage that costs more than specified amounts, which vary based on the age, sex, and occupational category of an employer's workforce. Even now, two years before it takes effect, there is widespread support for repealing or altering the Cadillac tax. However, the threat of its implementation has already led many employers to raise employee cost sharing and may incentivize some to drop or restrict flexible spending arrangements or health reimbursement arrangements.

Congress And The Courts

Republican-led efforts in Congress to repeal or replace the ACA will continue unabated during 2016. However, the threat of filibusters led by Senate Democrats and of a veto by President Barack Obama mean that significant changes in the ACA are unlikely before 2017. Funding of the Marketplaces and other ACA initiatives is likely to be a focus of appropriations battles, however, and riders that Congress may try to add to appropriations bills may cause some damage to ACA initiatives.

Appropriations will become even more of a focus of contention if the courts rule for the House of Representatives in *United States House of Representatives v. Burwell*. The lawsuit claims that the Obama administration violated the Constitution when it reimbursed insurers for cost-sharing reductions given to low-income Marketplace enrollees without an explicit annual congressional appropriation.[11] This program cost almost $3 billion in 2014.[12]

The affordability and value of Marketplace qualified health plans continue to vary based on income and geography.

The district court judge in this case ruled that the court had jurisdiction to hear the House's claim and will soon rule on the merits of that claim. Regardless of what the district court decides, however, the case will certainly be appealed to the District of Columbia appellate court, which may very well follow established precedent and hold that the courts cannot hear disputes between members of Congress and the administration. The case is unlikely to be resolved by the appellate court until late in 2016, at the earliest.

In another legal challenge to an ACA regulation, the US Supreme Court will rule in 2016 on whether religious organizations that object to contraceptives can refuse to notify the government of their objection if the notification would allow the government to ensure contraceptive coverage for the organizations' employees and students. This decision addresses an issue that is marginal to the ACA but of great importance to women who need contraceptive coverage and to religious groups that oppose it.

Litigation also continues in various lawsuits brought by states that oppose the ACA and that are challenging its insurance provider tax and reinsurance tax and the role of state insurance regulators in the transitional plan program. The Supreme Court clearly stated in 2015 in its ruling on *King v. Burwell* that it is not inclined to undermine the legislative plan of the ACA further, and the courts will likely continue to dismiss ACA challenges.

November 2016 And Beyond

The biggest challenge facing the ACA is the 2016 election. To date, the act has played a only minor role in the presidential debates. Republican candidates pay lip service to repealing the act, but few of them have offered concrete plans for a replacement. Proposals that have been offered would repeal some of the least popular provisions, such as the individual or employer mandates; replace the ACA's income-tested tax credits with fixed-dollar tax credits; and expand tax subsidies for health savings accounts.

Republican proposals might also repeal the ban on preexisting condition exclusions in favor of other approaches, such as state high-risk pools or continuous coverage requirements. Republican approaches would also eliminate the essential health benefit coverage requirements and allow insurers to offer plans with higher cost sharing and less generous benefits than the essential health benefits that the ACA requires individual and small-group plans to cover.

In the aggregate, Republican proposals are likely to reduce access to coverage and care for lower-income people, although they may provide more assistance to higher-income people. Republicans also advocate giving the states more flexibility in administering their Medicaid programs and Marketplaces.

Democrats are likely to stay the course on the ACA and may try to expand its benefits—for example, by reducing cost sharing for moderate-income enrollees. If the Democrats regain control of the Senate and retain the presidency, they are likely to be able to continue to secure some funding for the ACA. In any event, as long as the Democrats retain forty-one seats in the Senate, they are likely to be able to block repeal of the ACA.

Finally, as of 2017, states will be able to seek waivers under section 1332 of the ACA to allow them to opt out of certain ACA requirements—such as the individual and employer mandates or Marketplace, premium tax credit, and essential health benefit provisions—and pursue their own reforms with the federal funds that otherwise would have been spent in their states under the ACA. Section 1332 waivers may be accompanied with Medicaid waivers that increase state flexibility.

However, the federal government can approve only those section 1332 waivers that achieve the coverage goals of the ACA without increasing federal spending. The Obama administration is unlikely to grant states waivers that sub-

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stantially undermine ACA reforms, and whether states will be permitted to do so going forward will depend largely on the result of the 2016 presidential elections. ■

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