The Affordable Care Act: Where Are We Now?

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Signed into law by President Barack Obama in March 2010, the Patient Protection and Affordable Care Act (ACA)[1] fundamentally altered the regulation of health insurance in the United States. Now, nearly eight years after it became law, the ACA has remained intact in important ways, while a number of its fundamental provisions have either been repealed or are the subject of ongoing legal challenge. The ACA's provisions have faced their most consistent attacks in the first year of the Trump administration, where Republicans in both Congress and the administration have succeeded in weakening the law on a number of fronts. Through agency rulemaking, executive orders, and legislative efforts, Republicans have steadily altered the ACA, setting the stage for additional uncertainty in the years ahead.

The Obama Administration

The ACA put in place a panoply of health insurance protections aimed at improving both access to coverage and quality of coverage. For one, health insurance plans can no longer refuse to cover people or charge them more because they have a pre-existing condition. Premium rates for certain types of coverage must be set on a communitywide basis and not underwritten on an individual basis, and insurers must guarantee the sale of coverage to all buyers during open and special enrollment periods. Young adults can stay on their parents' insurance plan until they turn 26. Individual and group policies sold to small employers must also cover a minimum set of essential health benefits, and all types of coverage (individual, small, and large group) can no longer be capped at an annual or lifetime dollar limit for any essential health benefits.[2] Significantly, health insurance marketplaces, known as exchanges, now exist in every state, allowing individuals and families to compare and buy health insurance.[3] Importantly, the federal government subsidizes premiums for lower-income individuals and families purchasing insurance on the marketplace.[4] And finally, large employers face penalties for failing to offer minimum essential coverage to their employees,[5] although beginning in 2019 individuals will no longer face the decision of obtaining health insurance or paying a penalty.[6]

Since its enactment, the ACA has survived a number of high-profile legal challenges. In a landmark decision in *National Federation of Independent Business v. Sebelius*,[7] the U.S. Supreme Court upheld several of the major provisions of the ACA. While the decision limited the law's expansion of Medicaid, it upheld the constitutionality of the individual mandate, effectively ensuring the ACA's survival at a time of fierce political opposition. Later, in *King v. Burwell*,[8] the Supreme Court held that the ACA allows the federal government to provide premium subsidies even in states that did not create their own exchange, despite statutory language arguably indicating otherwise. The decision allowed exchange customers, about 85 percent of whom qualify for assistance, to continue receiving premium subsidies even if the federal government operated the marketplace in their state.[9]

A series of key events has also shaped the ACA's implementation, keeping the law at the forefront of American political debates. In 2013, after a months-long negotiation with groups opposing the ACA's so-called "contraceptive mandate," the Obama administration finalized a regulation requiring insurers and most employers to cover birth control without cost sharing. Later that year, the Internal Revenue Service delayed by one year the requirement that large companies offer their employees affordable policies or face significant penalties.[10] Finally, in late 2013, the HealthCare.gov federal exchange famously experienced technical difficulties, causing the site to be only intermittently available until it was fixed several weeks later, making it very difficult for people to sign up for coverage.

Since these early difficulties and challenges, and despite ongoing political and legal challenges, the ACA and its marketplaces have made significant strides in reducing the number of uninsured Americans, with 9.2 million Americans being covered through exchange coverage in 2017 and 8.8 million having enrolled for coverage in 2018.[11] These gains in coverage, however, continue to face the ongoing threat of insurers exiting certain marketplaces, with many counties offering coverage from only a single insurer on their ACA exchanges. While the

structure of the ACA's benefits mandates and subsidy programs will continue to be subject to criticism as a political matter, insurers and employers will continue to face myriad compliance issues as the bulk of the ACA's requirements remain the law of the land.

The Trump Administration

Within hours of his inauguration, President Donald Trump affirmed his campaign pledge to dismantle the ACA by signing an executive order that directed the secretary of the U.S. Department of Health & Human Services (HHS) and the heads of all other agencies to minimize the financial impact of the ACA and to provide greater flexibility to the states.[12] While the order was in many ways symbolic—the president cannot erase the ACA's statutory provisions and numerous regulations unilaterally with the stroke of a pen—it did set the stage for agencies to weaken enforcement and loosen their grip on the states' regulation of the ACA by providing increased state flexibility.[13] For example, a number of states now have Medicaid waivers pending at the Centers for Medicare & Medicaid Services (CMS) that would require recipients to demonstrate employment and to submit to drug testing—two requests not previously approved.[14]

That effort, of course, remained secondary to congressional Republicans' quest to repeal and replace the ACA. In March 2017, House Republicans introduced the American Health Care Act (AHCA), a budget reconciliation bill that, among other things, sought to eliminate both the individual and employer mandates, repeal a host of tax provisions, and roll back the ACA's Medicaid expansion.[15] After the measure passed the House narrowly in May (having been previously pulled), Senate Republicans took up their own version of the bill, which emerged onto the Senate floor as a much narrower "skinny repeal" bill. The measure failed shortly thereafter, 51 to 49, as Sen. John McCain famously returned to the Senate to cast a dramatic "no" vote.[16] Republicans would thereafter make one last attempt at a comprehensive repeal—the so-called Graham-Cassidy bill—but it, too, fell short.[17]

As congressional Republicans failed on the legislative front, the Trump administration continued to press forward with its dismantlement strategy. In August 2017, CMS slashed spending on ACA advertising by 90 percent and cut funding for enrollment assistance by 41 percent. To make up the difference, grassroots organizations and insurers began purchasing radio time, setting up online tools, and, in at least one case, enticing enrollees with puppies.[18] And their efforts appear to have paid dividends: More than 8.8 million Americans enrolled in ACA health plans for 2018 using HealthCare.gov, nearly matching the total for 2017 and setting an all-time high for the number of new enrollees signing up in a single week.[19]

Elsewhere, Republicans enjoyed greater success, not least, of course, through the repeal of the individual mandate. Republicans repealed the individual mandate penalty as part of their wide-ranging tax reform bill in December 2017, potentially increasing the number of uninsured individuals by 4 million in 2019 and 13 million in 2027, according to the Congressional Budget Office (CBO). The CBO also projects that the repeal will reduce federal deficits by $338 million over the next 10 years.[20] Always the least popular provision of the law,[21] the individual mandate represented one of the central pillars of the ACA; by repealing it, Republicans undoubtedly dealt the law a heavy blow.

Still, health policy experts remain divided about the true effect of repealing the mandate, particularly because of the lack of enforcement and it is not clear precisely which aspect of the ACA most strongly motivates people to purchase health insurance. As it stands (before the repeal goes into effect in 2019), the individual mandate imposes a minimum fine of $695 per adult, or 2.5 percent of household income above the federal tax filing threshold, whichever is higher.[22] Some analysts consider that incentive too small, arguing instead that the decision to buy health insurance is influenced more by costs, federal subsidies, and the extent to which individuals value health insurance. Take, for example, those who purchase insurance on the exchanges. Roughly 85 percent receive federal subsidies that limit the total cost to a given percentage of income, and more than 50 percent receive additional subsidies to help lessen out-of-pocket expenses.[23] Because these subsidies offer them such a good deal, they remain strongly incentivized to buy health insurance regardless of any penalty.[24]

Indeed, the ineffectiveness of the individual mandate has been one of the central criticisms of the ACA. Because the law requires insurers to cover people with pre-existing conditions, the ACA's drafters put the individual mandate in place to keep down costs; by incentivizing healthy people to buy insurance, the mandate serves to offset the costs of insuring people with health problems. But the mandate failed to entice enough healthy people to enroll, causing insurers to cover too many people with high medical expenses relative to healthy people. In theory, removing the individual mandate entirely will only exacerbate this effect. That may explain why the CBO projects premiums to rise by 10 percent as a result of the repeal.[25]

In light of the failure to pass a wide-ranging repeal of the ACA, President Trump took additional action seeking to fundamentally alter the impacts of the ACA. On Oct. 12, 2017, President Trump issued an executive order entitled "Promoting Healthcare Choice and Competition Across the United States."[26] The executive order directs the Department of the Treasury, Department of Labor (DOL), and HHS (collectively, the "departments") to consider issuing sweeping new health care rules and regulations in the wake of Congress' inability to pass legislation to reform the ACA.

The issuance of the executive order was followed late in the evening of the same day by press reports, which have since been substantiated by the administration, that funding for ACA cost-sharing reduction (CSR) payments will cease.

The Executive Order

The executive order focuses on policy changes in three types of coverage: (1) broadening the ability of small employers to purchase association health plans (AHPs) and the selling of insurance across state lines; (2) expanding the use and availability of health reimbursement arrangements (HRAs); and (3) lengthening the duration of, and allowing consumers to renew, short-term, limited-duration insurance (STLDI).

The executive order directs the departments to consider proposing regulations or revising guidance in relatively short time frames—within 60 days for AHP and STLDI rules, and within 120 days for HRA rules—with respect to these three types of coverage, as briefly summarized below.

Association Health Plans and Selling Insurance Across State Lines

AHPs and the sale of insurance across state lines have been highly publicized issues and have long been advocated for by many Repub-

licans on Capitol Hill. The executive order directs the DOL, within 60 days, to consider proposing rules or revising guidance to permit more employers, including (but apparently not limited to) small businesses, to participate in AHPs. Pursuant to this executive order, the DOL could expand certain conditions that satisfy the commonality-of-interest requirements under current DOL advisory opinions that address the definition of "employer" under ERISA § 3(5). The executive order notes that the DOL should consider ways to promote AHP formation on the basis of common geography or industry, which could further expand the breadth of AHPs and enable the sale of insurance across state lines. A set of questions and answers accompanying the executive order notes that these changes could result in "employers in the same line of business anywhere in the country [being able] to join together to offer health care coverage to their employees and any employers within a single state or a multistate metropolitan area [being able] to join together to offer health care coverage to their employees."

AHPs may be treated as large group coverage under federal law, and large group coverage is not required to comply with certain requirements under the ACA, including essential health benefits and community rating. Therefore, allowing more small employers to join AHPs could essentially exempt more groups from certain provisions of the ACA and would likely weaken the small group insurance market. Notably, the executive order also contemplates both fully insured and self-insured AHPs and mentions that expanding access to AHPs can help small businesses "by allowing them to group together to self-insure or to purchase large group health insurance."

Health Reimbursement Arrangements

The executive order also directs the departments, within 120 days, to consider proposing rules or revising guidance to increase the usability of HRAs, expand employers' ability to offer HRAs to employees, and allow HRAs to be used in conjunction with non-group coverage.

The departments' current position, as set forth in IRS Notice 2013-54 and subsequent guidance, is generally that HRAs for active employees that are not "integrated" with another group health plan (i.e., stand-alone HRAs) violate the ACA market reforms and may not be used to reimburse premiums for non-group coverage. Notably, the 21st Century Cures Act,[27] which was enacted in late 2016, does permit certain small employers to offer their employees non-integrated HRAs to purchase non-group coverage in certain circumstances.

The executive order appears likely to result in the departments pulling back on their existing guidance related to the use of non-integrated HRAs. Depending on how the HRA is treated under any new guidance, the departments will need to address a series of related questions, including whether or the extent to which (1) a stand-alone HRA constitutes minimum essential coverage for purposes of the employer and individual mandate requirements; (2) how a stand-alone HRA can be used for the purchase of individual insurance; and (3) whether stand-alone HRA coverage, even where such coverage is a low-dollar value, could firewall an individual from eligibility for federal tax credits and cost-sharing subsidies.

Short-Term, Limited-Duration Insurance

Lastly, the executive order directs the departments, within 60 days, to consider proposing regulations or revising guidance to expand the availability of STLDI. While STLDI is not an excepted benefit, it is exempt from the ACA market reform requirements because it is not considered individual health insurance coverage. Previously, the departments defined STLDI as health insurance coverage that expires less than 12 months after the original effective date. However, last year, the departments finalized rules shortening the permitted duration of STLDI to less than three months, including any period for which the policy may be renewed.[28]

This executive order directs the departments to consider allowing STLDI to cover "longer periods" and be renewed, but it is not clear whether the departments will revive the original requirement that STLDI be offered for less than 12 months or whether longer periods of coverage will be allowed by permitting renewals.

Since the length of coverage for STLDI is not defined in statute, the departments have broad latitude to define it. Therefore, the departments could expand this timeframe through regulation, which could have major implications for the individual market. Since STLDI is exempt from the ACA market reforms, the coverage might not necessarily be as comprehensive as individual market coverage that is subject to the ACA and the Public Health Service Act.[29] Therefore, while STLDI coverage could have cheaper premiums, it could be less robust. STLDI could disproportionately attract younger, healthier individuals, which could ultimately result in a less favorable risk pool for the ACA-compliant individual market. Consequently, premiums for the individual market could increase.

Nevertheless, at least under current law, STLDI is not considered minimum essential coverage, so having STLDI alone would not satisfy the individual mandate, potentially tempering the extent of individuals leaving the individual market to purchase STLDI (at least for 2018 while the individual mandate is still in effect). Importantly, because states retain the authority to regulate the underlying insurance contract, they can retain the three-month limit on STLDI or use some other more restrictive definition.[30]

As of early January of this year, only the DOL has proposed its new rules, which the department believes will enable as many as 11 million Americans to find coverage,[31] although proposed rules on the STLDI definition can be expected soon. As anticipated, the DOL proposed amending the definition of "employer" under ERISA for purposes of determining whether association coverage can be sold as a large group policy, and thus avoid the more onerous ACA requirements for individual and small group coverage. Somewhat surprisingly, the DOL also redefined "employer" to include sole proprietors and working owners, effectively permitting certain individuals to join AHPs for purposes of purchasing coverage outside of the individual markets. While many issues remain uncertain, it is likely that, should some version of the AHP rule be finalized, the Trump administration will have significantly altered the manner in which many small employers and self-employed individuals purchase health insurance coverage.

Cost-Sharing Reductions

On the evening of that same executive order, the Trump administration announced that it would no longer make ACA CSR reimbursement payments to health insurance issuers. Under the ACA, HHS must reimburse health insurers for the CSRs those insurers provide to certain eligible individuals (i.e., those who enroll in silver-level plans and meet certain income requirements). The payment of these funds to health insurance issuers had long been challenged by the Republican-controlled House of Representatives and was until recently the subject of an appeal before the D.C. Circuit Court of Appeals.[32] In ending the payments, the administration changed its

position and agreed with the House that Congress has not appropriated funds for HHS to make those reimbursement payments; therefore, under federal appropriations law, continued payments were impermissible.

The next day, the Department of Justice filed a status report in the ongoing litigation over whether there is an appropriation for CSR reimbursements. In the status report, the department said that the administration would not make the CSR reimbursement payments due in October. It also said that: "The executive branch will confer with the other parties about this development and proposes that the parties make submissions to govern proceedings by the time of the status update presently scheduled for Oct. 30." In response, 18 states and the District of Columbia sued the administration, stating that this abrupt decision lacked explanation and disregarded mandatory spending.

Some states, anticipating that the administration may stop making the reimbursement payments, have allowed insurers to include the cost of providing the CSRs in premiums for the 2018 plan year. However, not all states have permitted insurers to include these costs, and the financial impact of this decision will be particularly significant for those insurers that remained in the exchanges for 2018. At the very least, losing CSR payments for the last few months of 2017 may have significantly impacted insurers because they likely did not account for this loss when setting 2017 premiums.[33]

Looking Ahead

After a full year of Republican control over both Congress and the White House, Republicans have sought to significantly alter the structure of the ACA, with further changes likely as the executive order's regulations are issued and finalized. But, notably, efforts to repeal the ACA legislatively have fallen short. The vast majority of the ACA's market reforms remain intact, Medicaid expansion in the states continues, and employers are subject to the employer-shared responsibility payments (i.e., the employer mandate). With congressional elections likely slowing legislative action, 2018 may be a make-or-break year for the ACA since health care remains a key issue in advance of November's all-important midterm elections.[34]

By far the most important development to monitor looking ahead to 2019 is the elimination of CSRs, the impact of the repeal of the individual mandate, and any ensuing effect on state and insurer exchange participation. As noted, many major insurers are already losing money on the exchanges, and an increasing number of counties have only one insurer on their exchanges in 2018. Without the CSR guarantees, many insurers will have to choose between raising rates significantly or leaving the exchanges altogether.[35] Sensing the importance of CSRs to the ACA's ultimate fate, Democrat attorneys general in 18 states mounted legal challenges to the administration's decision to eliminate payments.[36] The outcome of those suits could materially impact insurance premiums for the 2019 plan year, which will be finalized in the weeks leading up to the approaching mid-term elections. As a result, the outcome of the ongoing CSR litigation is likely to have significant political ramifications. Although the CSR case will likely receive significant attention, the proposed AHP rulemaking, as well as anticipated STLDI and HRA guidance, could result in alternative plans with less expensive coverage and fewer consumer protections. Because these plans will likely attract younger, healthier individuals, ACA plans may be left with a larger proportion of older, sicker people, thereby driving up prices further.

On the legislative front, Republicans have hinted that the effort to repeal and replace the ACA may have ended with Alabama's election of Democrat Doug Jones to the Senate in December 2017. With only a 51 to 49 majority in the Senate, and with a small number of moderate Republicans warning that repeal bills face an uphill battle, congressional Republicans likely will not waste valuable time trying for yet another full repeal. Still, if the individual mandate repeal and increased premiums due to lack of federal CSR payments do indeed bring about a "death spiral," Republican lawmakers likely will seize the opportunity to promote an alternative to the ACA like those considered throughout much of 2017.[37]

The primary area of potential change to the structure of the ACA is likely to occur in any regulatory changes adopted pursuant to the executive order. The degree of any changes will depend on (1) the scope of the rules at the federal level and (2) the extent to which states and employers exercise any newfound flexibility. Therefore, any impacts of these new rules will likely vary significantly from state to state and employer to employer. That said, these efforts should be watched by all stakeholders since they are intended to, and very likely could have, major impacts on the cost and delivery of health insurance coverage throughout the country. ⊙

Endnotes

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