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WHITE PAPER

November 2016

The Future of the Affordable Care Act

President-elect Trump and Congressional Republican leadership have indicated that they intend to take decisive action on health care and that significant changes to the ACA are inevitable.

Legislation from 2015 that sought to repeal core provisions of the ACA but was not ultimately enacted is a starting point for considering the future of the ACA. The legislation would have repealed multiple parts of the statute, including the individual mandate, the premium tax credit, the Medicaid expansion, the employer mandate, and various taxes enacted under the ACA. The 2015 legislation did not seek to repeal or amend insurance reforms that were enacted with the ACA, including the ban on exclusions for preexisting conditions and the requirement to offer coverage to children of enrollees up to age 26.

This *White Paper* looks to the 2015 legislation to identify elements likely to be part of the coming restructuring or replacement of the ACA, discusses likely changes to regulations, policies, and enforcement, and concludes with a Q&A section addressing some immediate stakeholder concerns.

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President-elect Trump has made revamping our health care system a top priority for his new administration. He has been clear that action needs to be taken because health care remains unaffordable, and he believes the structure of the Affordable Care Act ("ACA") for delivering coverage is not working. Whether the mechanism is cast as a repeal and replacement of the ACA or as a radical amendment to the law, all signs from the President-elect and the Republican Congressional leadership indicate that action will be swift, and that the changes will be significant.

At the same time, there appears to be the possibility of retaining some elements of the ACA, such as the ACA's ban on exclusions for preexisting conditions and required coverage under the parent's plan for children up to age 26. Indications of this possibility include post-election comments by Mr. Trump, and Speaker Ryan's health care proposal, released last summer.

A huge array of stakeholders are keen to know what is going to be the future of the ACA, starting with the individuals and families who want affordable health coverage and expanding to the hundreds of thousands of employers that continue to provide health coverage to half the country. Health care absorbs nearly 20 percent of the American economy, and the future of the ACA will have a profound effect on the physicians, nurses, hospitals, laboratories, medical device manufacturers, pharmaceutical companies, and many others who operate in this sector.

While we wait for a specific proposal, this *White Paper* seeks to identify many elements that are likely to be included in legislation to change the ACA, as well as statutory provisions that are likely to remain unchanged. It also identifies significant changes in policy that the incoming administration may well make, using the authority they will have to change regulations and other guidance and their enforcement discretion. Finally, we list questions individuals, employers, and health care providers are likely to have immediately as they try to plan and budget for the future, and we provide answers to the extent available.

ANTICIPATED ELEMENTS FOR LEGISLATION

Congressional rules may well have a significant impact on what can be included in legislation to change the ACA. Senate rules have long required 60 votes to pass legislation other than legislation that is specifically created as part of budget reconciliation. Budget reconciliation legislation is drafted in response to instructions in a Congressional budget resolution, which must first be adopted by both the House and the Senate. Budget reconciliation may include only provisions that affect the revenues or outlays of the federal government. The Senate Parliamentarian has final authority to determine whether a bill satisfies the requirements for budget reconciliation or contains "extraneous material." While Senate Republicans will continue to control the chamber in the 115th Congress, they will not have a supermajority of 60 votes. Assuming the Republican majority retains the longstanding Senate rules, any repeal or significant amendment of the ACA may have to move through budget reconciliation unless it could attract Democratic votes (which at the moment seems unlikely but could change depending on the specifics of the legislation).

In 2015, Congressional Republicans passed budget reconciliation legislation to repeal the core provisions of the ACA. As expected, President Obama vetoed the bill. While the 2015 legislation was not effective in repealing the law, it did confirm that the package of provisions it contained could pass muster under the strict rules for budget reconciliation. The 2015 legislation sought to repeal the ACA provisions that provoked the strongest objections all the way to the United States Supreme Court: the individual mandate, the premium tax credit, and the Medicaid expansion. The 2015 legislation also sought to repeal the taxes that were enacted under the ACA.

What follows is a list of core ACA provisions that were included for repeal in the 2015 legislation, all of which seem likely candidates to be included in legislation the Trump Administration and Congressional Republicans move forward in early 2017. In the "Possible Effective Date" column, we provide some commentary on when the change may be effective based on the 2015 legislation and the current status of the provision; however, effective dates may also be affected by attempts to maintain budget neutrality in the reconciliation process.

Provision	Description	Possible Effective Date
Individual Mandate	Repeal the requirement that individuals either obtain health insurance, qualify for an exemption, or pay a tax penalty. (26 USC § 5000A)	The 2015 legislation made this change retroactive to the first day of the calendar year in which it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2017.
Premium Tax Credit	Repeal the subsidy available to pay part or all of the premium for a health plan purchased on a state or federally operated health insurance exchange. Modify the tax rules that require repayment of any excess advanced to the insurer over the amount of credit allowed when the tax return is filed. (26 USC § 36B)	The 2015 legislation retained the premium tax credit for two years after the year in which it was passed. The 2017 legislation, likewise, may make this change effective after a transition period.
Cost-Sharing Reductions	Repeal the additional subsidies paid to insurers to reduce cost-sharing for individuals who purchase coverage on a state or federally operated health insurance exchange and have household income at or below 250% of the Federal Poverty Level. (42 USC § 18071)	The 2015 legislation retained the cost-sharing reduction for two years after the year in which it was passed. The 2017 legislation may, likewise, make this change effective 1/1/2019. Note that cost-sharing reductions are the subject of litigation pending before the D.C. Circuit that challenges HHS's authority to pay the subsidies to health insurers. *See House v. Burwell, U.S. House of Representatives v. Burwell*, No. 14-1967 (D.D.C. May 12, 2016), appeal docketed, No. 16-5202 (D.C. Cir. July 14, 2016).
Medicaid Expansion	Repeal the expansion of Medicaid that provides additional federal funds to states that expand eligibility to all individuals with a household income at or below 133% of the Federal Poverty Level	The 2015 legislation phased out the Medicaid expansion over two years after the year in which it was passed. The 2017 legislation, likewise, may make this change effective after a transition period.
Employer Mandate	Repeal the penalty that applies to "large" employers that fail to offer adequate health coverage to at least 95% of their full-time employees or that offer coverage that is not affordable. (26 USC § 4980H)	The 2015 legislation made this change retroactive to the first day of the calendar year in which it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2017.
Transitional Reinsurance Program	Eliminate the transitional reinsurance program designed to provide reinsurance to insurers in the individual market who experience adverse risk selection that is funded by certain insurers and self-insured employers. (42 USC § 18061)	The transitional reinsurance program runs for three years. Only payments for the third year remain to be paid, and they are due to HHS by 1/17/2017, though payees can elect to defer a small part of the payment to 11/15/2017. The 2015 legislation made this change effective the first day of the calendar year after it was passed. It remains to be seen whether the 2017 legislation will provide any relief with respect to the fee.
Small Business Tax Credit	Repeal the tax credit available to employers with 25 or fewer full-time equivalent employees that pay $50,000 or less on average in wages, and that offer employees health insurance through the state or federally operated exchanges. (26 USC § 45R)	The 2015 legislation retained the small business tax credit for two years after the year in which it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2019.

Provision	Description	Possible Effective Date
Cadillac Tax	Repeal the excise tax on the cost of health coverage that exceeds certain dollar thresholds. (26 USC § 4980I)	The Cadillac Tax has not yet gone into effect and, under current law, would not go into effect until 1/1/2020. The 2015 legislation eliminated the Cadillac Tax effective as of 1/1/18. The 2017 legislation, likewise, may prevent the Cadillac Tax from ever going into effect.
Limit on use of HSAs, FSAs, HRAs, and MSAs to purchase over-the-counter medicines	Repeal the prohibition on using Health Savings Accounts ("HSAs"), Flexible Spending Accounts ("FSAs"), Health Reimbursement Arrangements ("HRAs"), and Medical Savings Accounts ("MSAs") to purchase over-the-counter medicines without a prescription. (26 USC §§ 106, 220, 223)	The 2015 legislation made this change effective for expenses incurred on or after the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Limit on annual contributions to FSAs	Repeal the limit on annual contributions to FSAs, which, as adjusted for inflation, is $2,600 for 2017. (26 USC § 125)	The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Threshold for medical expense deduction	Reduce the threshold on medical expense deduction from 10% of adjusted gross income (level post-ACA) to 7.5% of adjusted gross income (level pre-ACA). (26 USC § 213)	The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Fee paid by manufacturers of brand-name pharmaceuticals	Repeal the fee paid annually by manufacturers of brand-name pharmaceuticals. (PPACA § 9008)	The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Medical Device Excise Tax	Repeal the medical device excise tax. (26 USC § 4191)	Under current law, the medical device excise tax is suspended for 2016 and 2017. The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Health Insurers Fee	Repeal the fee paid annually by health insurers. (PPACA § 9010)	Under current law, the health insurer fee is suspended for 2017. The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Net Investment Income Tax	Repeal the 3.8% tax on net investment income for individuals with annual modified adjusted gross income over $200,000 (or for married couples, $250,000). (26 USC § 1411)	The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.

Provision	Description	Possible Effective Date
Additional Medicare Tax	Repeal the additional 0.9% Medicare Tax on excess wages and self-employment income for individuals with annual wages or self-employment income over $200,000 (or for married couples, $250,000). (26 USC §§ 1401, 3101)	The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.
Tanning Tax	Repeal the excise tax on indoor tanning services. (26 USC § 5000B)	The 2015 legislation made this change effective for the first day of the calendar year after it was passed. The 2017 legislation, likewise, may make this change effective 1/1/2018.

The 2015 repeal legislation assumes that the state and federally operated health insurance marketplaces, including www.healthcare.gov, will continue to sell qualified health insurance plans for two years after the repeal legislation is enacted. The marketplaces are necessary because the 2015 repeal legislation uses the ACA's premium tax credit and cost-sharing reductions as transition tools to allow time to implement a replacement approach. The premium tax credit and cost-sharing reductions are available only for plans purchased through the marketplaces. To make the premium tax credit available outside of the marketplaces would require not only legislative changes but also substantial new administrative infrastructure to deliver the tax credit dollars to the insurers.

The 2015 legislation did not seek to repeal any of the ACA's insurance reforms. All of the following requirements that were enacted with the ACA would have been left in effect by the 2015 repeal legislation:

- Ban on preexisting condition exclusions
- Requirement to offer coverage to dependents of enrollees up to age 26
- Requirement for community rating (which allows premiums in the individual and small-group market to vary based only on age, geography, and tobacco use)
- Requirement for guaranteed issue of health insurance
- Ban on waiting periods in excess of 90 days
- Requirement that plans in the individual and small-group market offer essential health benefits in 10 prescribed categories
- Prohibition on annual and lifetime dollar limits on coverage for essential health benefits
- Prohibition on certain retroactive terminations (rescissions) of health coverage
- Requirement regarding access to primary care physician and ob/gyn professional
- Requirement to cover out-of-network emergency room services on par with in-network coverage
- Requirement to distribute standard summary of benefits and coverage
- Requirements for review of claims denials, including external review
- Prohibition on discriminating in favor of highly compensated individuals in fully insured plans
- Expanded requirements for wellness programs, as well as increase in maximum permissible reward
- Requirement to cover certain preventive services without cost-sharing
- Requirement to cover expenses for participation in clinical trials
- Ban on discriminating against licensed providers in nontraditional practices, such as acupuncture and chiropractic
- Statutory maximum on annual deductibles for plans in the individual and small-group market
- Statutory maximum out-of-pocket limitation for in-network services
- Reporting on quality of care and transparency in coverage, proposed to be included in Form 5500 reporting
- Required rebates of premiums if insurers do not meet or exceed required medical loss ratio

These provisions do not generate federal government revenue or spending, so it is unclear whether they could be repealed or amended in budget reconciliation legislation. Thus, repeal of these mandates may require legislation that would need to attract bipartisan support in the Senate in order to garner 60 votes for passage. Further, as noted above, there is some indication from both President-elect Trump and Speaker Ryan

that they would support retaining the ban on preexisting condition exclusions and the requirement that health coverage be offered to an enrollee's dependents up to age 26.

Although we cannot yet predict what the alternative approach will be, the statement on health policy published on the website for President-elect Trump's transition team and Speaker Ryan's "A Better Way" proposal from last summer provide some insight into potential components of replacement legislation. These components may include expanded use of HSAs, allowing people to purchase health insurance across state lines, reestablishing state high-risk pools, providing an advanceable refundable tax credit to subsidize the cost of health insurance for individuals and families who do not have access to coverage through their employers, and converting federal Medicaid payments to state block grants or per capita allotments.

It is possible that budget reconciliation legislation to repeal the core provisions of the ACA will move forward in advance of legislation establishing a replacement approach to bolster the insurance markets and address affordability, although President-elect Trump has expressed an intent to enact the replacement at the same time provisions of the ACA are repealed. If there are two phases to the legislative process, the first bill could follow the model of the 2015 repeal legislation, leaving the ACA's premium subsidies in place for a short period to give additional time to draft the alternative. That said, there are long lead times to design insurance products, secure approval from state regulators, sell them to consumers, and initiate coverage. Indeed, insurers will need to submit the products they intend to sell in 2018 to their state insurance regulators this spring. Accordingly, the new administration may seek to act quickly if one of its goals is to minimize the length of time in which the country uses remnants of the ACA as a bridge to a replacement.

POLICY CHANGES, REGULATIONS, AND ENFORCEMENT DISCRETION

The incoming Trump Administration can also be expected to reverse ACA requirements through use of its authority to change regulations, withdraw sub-regulatory guidance, and exercise enforcement discretion. While the new administration will have some discretion over whether and how to enforce whatever provisions may remain in effect following enactment of legislation, states and private entities do have independent authority to enforce at least some provisions of the ACA. For example, state governments have concurrent authority to require health insurers in the individual market to satisfy the Act's requirements. 42 U.S.C. § 300gg-61(a)(1). Similarly, some provisions of the ACA are enforceable in private lawsuits. *See, e.g.*, 29 U.S.C. § 218c (whistleblower protections). The following is a list of policies that are likely to be changed.

Requirement for Health Plans to Cover Contraceptive Services

The ACA requires all nongrandfathered health plans, including most employer-sponsored health plans, to cover certain preventive services without cost-sharing for the enrollee. The preventive services that must be covered for women according to the statute are a combination of services identified by the United States Preventive Services Task Force, the Centers for Disease Control, and the Health Resources and Services Administration ("HRSA") of the U.S. Department of Health and Human Services. Under the Obama Administration, HRSA issued guidelines making contraceptive services among the preventive services that employer-sponsored health plans must cover without cost-sharing. The new Trump Administration could expand the religious exemption that relieves certain employers from this contraceptive-coverage mandate to encompass a broader range of religious organizations than are currently covered. Alternatively, the Trump Administration will have the authority to take services off the HRSA list, including contraceptive services, and because the HRSA guidelines are not formal regulations, they can make the change summarily without going through a notice and comment process. If contraceptive services were removed from the HRSA guidelines, employers—regardless of whether they have a religious objection—would no longer be at risk of a significant tax penalty if they elected not to cover contraceptive services in the health plans they sponsor. Employers who chose to continue covering these services would have the option of imposing cost-sharing on the coverage.

Ability to Reimburse Employees for Premiums They Pay to Purchase Individual Health Coverage

The Obama Administration, in sub-regulatory guidance under the ACA, has taken the position that an employer is offering a group health plan when it offers to reimburse two or more employees for part or all of the premiums they pay to buy health insurance in the individual market. Further, this guidance provides that a group health plan of this type violates the ACA's prohibition on annual limits on essential health benefits

because there is a dollar limit on what the group health plan will pay. The current administration has refused to view the employer's reimbursement arrangement as an integrated part of the individual health coverage the employee has purchased, even though the coverage itself complies with the prohibition on annual limits. The Trump Administration is likely to reverse this position, which has been unpopular with employers of all sizes and has been targeted by legislation with bipartisan support. The Obama Administration's position also made it more difficult for employers to allow their employees to pursue greater choice and possible administrative convenience through private health insurance exchanges. Because this requirement has been announced only through sub-regulatory guidance, it can be changed summarily without going through a notice and comment process.

Nondiscrimination Rule for Fully Insured Group Health Plans

The ACA prohibits fully insured group health plans from discriminating in favor of highly compensated employees. Although nondiscrimination rules for self-insured health plans were in place years before the ACA was enacted, there was no parallel restriction for fully insured plans. The IRS announced in late 2010 that it would not enforce the nondiscrimination requirement for fully insured employer group health plans until final regulations have been promulgated. In the intervening six years, it has yet to propose regulations, let alone finalize them. If the nondiscrimination rule for fully insured group health plans cannot be removed rapidly by legislation, the Trump Administration is likely to preserve the existing nonenforcement position until the provision can be repealed.

EEOC Wellness Regulations

Although regulations issued under the ACA give employers broad latitude to offer wellness plans that provide rewards or penalties for employees who participate in various health screenings or assessments, the U.S. Equal Employment Opportunity Commission ("EEOC") has issued regulations under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act that prohibit employers from requiring employees to participate in medical tests or medical inquiries as a condition of participating in an employer-sponsored health plan. (For a detailed discussion of the regulations, *see* "EEOC Issues Final Wellness Plan Regulations and Immediately Asserts Retroactive Effect.") The EEOC's regulations are being challenged in pending litigation in the 7th Circuit (*see Equal Employment Opportunity Commission v. Flambeau, Inc*., 131 F. Supp. 3d 849 (W.D. Wisc. 2015), appeal docketed, No. 16-1402 (7th Cir. Feb. 25, 2016)). The Trump Administration will be able to appoint commissioners who could propose regulations that reverse the EEOC's current position.

Proposed Changes to Form 5500

The ACA requires health plans to be transparent and provide reporting on quality. The IRS and the Department of Labor periodically update the Form 5500 that employers must use to report annually on certain of their ERISA plans. The proposed version of the form issued earlier this year included substantial new reporting on quality measures and, once effective, would dramatically expand the group health plans subject to reporting. If the incoming Trump Administration elects not to enforce the ACA reporting requirements in light of the burden they place on employers and insurers, it could pull the current proposed Form 5500 and replace it with one that does not include the new quality reporting elements or the expansion of impacted plans.

Requirements for the Summary of Benefits and Coverage

The ACA requires all health plans to provide a summary of benefits and coverage ("SBC") in a specific format with specific contents. The standardized approach is intended to allow individuals and families to compare health plans more easily. Employers have objected to the rigidity of the rules and have asked for greater flexibility in how they describe their plans to their employees. Employers have been producing summaries of benefits and coverage for several years now and may have acclimated to the requirements. The requirement for a standardized SBC is unlikely to be included in budget reconciliation legislation. To the extent the Trump Administration believes the SBC rules place unnecessary burdens on employers, they may provide greater flexibility either by amending the regulations or announcing a policy of relaxed enforcement.

Nondiscrimination Rules for Participants in Federally Funded Health Care Programs

Section 1557 of the ACA prohibits discrimination based on race, color, national origin, sex, age, or disability in any health program or activity that receives federal funding. Regulations implementing this provision apply to health programs (including health plans) offered by health care providers that participate in Medicare (i.e., virtually all hospitals, health systems, and drug and medical device manufacturers). The regulations may

also apply to health plans sponsored by employers who offer employer group waiver program plans under Medicare Part D, although it is not entirely clear. Compliance with the regulations requires covered entities to eliminate all prohibited discrimination and specifically provides that discrimination based on sex includes failure to provide certain services related to gender transition. Compliance also requires a variety of administrative changes, such as inclusion of specific taglines in various notices and documents and translations of notices and documents into various languages. If section 1557 of the ACA is not repealed, the Trump Administration may seek to amend and clarify the regulations. If it is concerned about providing relief during the time it will take to go through the notice and comment process, it could announce a nonenforcement policy.

STAKEHOLDER QUESTIONS

All of this change will prompt countless questions from all the stakeholders who are affected. Set forth below are a few questions stakeholders are likely to have and answers to the extent they are available prior to the introduction of specific legislative and regulatory proposals.

Employers

Q: If the employer mandate is repealed early in 2017, may an employer who offers a health plan on a calendar-year basis immediately change the terms of its employer-sponsored health plan?

A: Yes, an employer may change the terms of its health plan in the middle of the plan year. For example, if an employer wants to offer coverage only to full-time employees, and the employer has been defining "full-time employee" as someone who works 30 hours per week or more in order to comply with the employer mandate, the employer could change the plan mid-year to raise the number of hours needed for full-time. Employees who ceased to meet the eligibility rules would no longer have coverage, and payroll reductions should be adjusted accordingly. These individuals would have to find alternate coverage but should have a special enrollment right due to the loss of coverage; federal COBRA would not apply. An employer could also make a mid-year change to the amount that employees must pay for health coverage. Such a change is a change-in-status event, meaning that pre-tax payroll reductions could be adjusted, and if the change is a significant increase, employees could be afforded an opportunity to make a different coverage election (including no coverage). If the employer's plan is fully insured, the ability to implement a mid-year change will also depend on the insurer's willingness to amend and reprice a policy mid-year.

Q: If the employer mandate is repealed early in 2017, may an employer stop tracking hours to determine who is a full-time or part-time employee using the ACA's complex counting methods?

A: Yes, an employer could stop tracking hours to determine who is a full-time or part-time employee for purposes of complying with the employer mandate. However, to the extent the employer's group health plan stakes eligibility for health coverage on full-time or part-time status determined by the ACA's counting methods, the employer may need to make changes to the group health plan as well. One relatively easy way to eliminate this burden would be to amend the health plan to grandfather in all enrollees who are eligible for health benefits for the current plan year and set new eligibility rules for future years (and new hires) that do not rely on the ACA's counting methods. The employer may still need to count employee hours for purposes of compliance with other laws, like wage and hour laws.

Q: May an employer ignore the information reporting requirements and not file Forms 1095-C with the IRS in January of 2017?

A: It is unclear whether the information reporting requirements of the ACA can be repealed through budget reconciliation. Even if they could be repealed in future legislation, the information returns for 2016 are due on January 31, 2017, and it is unclear whether budget reconciliation legislation can move quickly enough to be enacted before the due date. Failure to file timely and accurate returns will trigger penalties under the Internal Revenue Code unless the employer has reasonable cause for failing to comply with the reporting requirement. The incoming Trump Administration may consider publicly announcing penalty relief to provide certainty and ease burdens on employers. The information returns that are due on January 31, 2017, report information for calendar year 2016. They are useful only for enforcing the individual mandate and employer mandate for 2016. An announcement that would release employers from the obligation to file the information returns may be attractive if the incoming administration anticipates that legislation may repeal those mandates retroactively for 2016, or it is not going to enforce those mandates for 2016.

Individuals

Q: Have the incoming Trump Administration or Republican Congressional leadership given any indication of their views on the potential effects of repeal legislation on individuals who have gained coverage through the ACA?

A: Both the incoming Trump Administration and Republican Congressional leadership have indicated an interest in avoiding disruption and continuing to give individuals choices for coverage.

Q: If individuals enroll in a plan through a public health insurance marketplace during the current open enrollment period and qualify for a premium tax credit, can they rely on receiving that credit to help pay their premiums for all of 2017? Is it possible they will have to repay all of the premium assistance when they file their taxes in 2018?

A: If the legislation advanced in 2017 follows the model of the 2015 repeal legislation, individuals will keep the benefit of premium tax credits for all of 2017 and will not need to repay amounts paid in advance to their insurance companies when they file their taxes in 2018, assuming they meet the eligibility criteria for the credit. However, until actual legislation is enacted, it is impossible to be sure whether the premium tax credit will continue to be available to help pay for coverage in 2017.

Q: Will individuals have to pay the net investment income tax and additional Medicare tax when they file their taxes in 2017? Should they wait to file to see whether legislation repeals these taxes?

A: The answer to this question will need to wait for the enactment of legislation. If the legislation advanced in 2017 follows the model of the 2015 repeal legislation, individuals would still owe the net investment income tax and the additional Medicare tax for 2016 and would have to pay it when they file their 2016 taxes during the 2017 filing season.

Health Insurers

Q: Can health insurers who receive payment for premiums through advance payments of the premium tax credit for 2017 rely on being able to keep that money, or might they have to pay it back?

A: If the legislation advanced in 2017 follows the model of the 2015 repeal legislation, insurers will not need to repay amounts paid in advance for coverage in effect during 2017. However, until actual legislation is enacted, it is impossible to be sure whether the premium tax credit will continue to be available to help pay for coverage in 2017.

Hospitals and Health Care Providers

Q: Will ACA repeal legislation include changes to the many ACA programs that affect health care providers directly, like accountable care organizations, bundled payments, and the Physician Payment Sunshine Act?

A: The answer to this question will have to await the introduction of specific legislation. Changes can be made to Medicare spending through budget reconciliation, but whether any of these or other specific ACA programs could be modified or eliminated by budget reconciliation legislation remains to be seen.

Q: Will tax-exempt hospitals still have to comply with the requirements of section 501(r)—the provision that requires adoption of a widely available financial assistance policy, completion of a community health needs assessment at least once every three years, and specific policies on billing and collection—which was enacted with the ACA?

A: It seems likely that tax-exempt hospitals will continue to have to comply with the requirements of section 501(r), including the requirement to have a financial assistance policy and make it widely available, perform a community health needs assessment at least once every three years, and refrain from extraordinary collection actions without first making reasonable efforts to determine whether a patient is eligible for financial assistance. Repeal of section 501(r) was not included in the 2015 repeal legislation, so there is no indication of whether it could be included in budget reconciliation legislation. Even if it could be repealed as part of budget reconciliation, the original champion of section 501(r) was Republican Senator Grassley of Iowa, who has been reelected to another term. He has been active in following the implementation of section 501(r) and may advocate to retain it.

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