Actions the Executive Branch Could Take to Impact the Affordable Care Act

This document identifies in Part I administrative actions that might be considered by the Trump Administration in its effort to repeal provisions of the Affordable Care Act (ACA) with respect to Marketplace (Exchange) coverage, Medicaid and the Center for Medicare and Medicaid Innovation (CMMI). Types of administrative actions that might be used, specifically rulemaking and Executive Orders, are described in Part II. The issues that identified here are not intended to be exhaustive. In addition, some items listed, such as those that would weaken the Marketplaces, may not be consistent with the new Administration's short-term goals, which at this point are unknown.

I. ACA Provisions That Might Be Subject to Administrative Action

A. Marketplace Coverage

1. Eliminate/weaken individual mandate

- Create additional exemptions to the individual mandate. The Obama Administration used regulatory authority to provide for exemptions to the individual mandate beyond those specified in statute. Additional exemptions (e.g., "hardship exemptions") might be created by the new Administration to limit the application of the mandate.

- Avoid IRS enforcement of penalties. Taxpayers declare on their Form 1040s whether they had minimum essential coverage for the tax year; they are subject to the individual mandate ("shared responsibility") penalty if they do not make this declaration and do not provide evidence that they qualify for an exemption. The ACA limits the ability of the IRS to enforce the mandate. No criminal penalties apply to a failure to pay the penalty, and the IRS is prohibited from putting a lien or levy on taxpayer property. As a result, the penalty may only be collected by reducing any refund owed to the taxpayer or by asking the taxpayer to pay any penalty amount owed.[1] The Trump Administration could further limit or eliminate enforcement of the penalty by using the IRS general administrative waiver authority (IRS Manual 20.1.1.3.3.2 (08-05-2014)) to provide relief from a penalty.[2]

2. Reduce employer burdens

- Fail to enforce the employer responsibility requirement (mandate)
    - Under the ACA, employers with at least 50 full time employees are subject to a monetary penalty if they fail to provide minimum essential coverage or one or more of their employees obtains subsidized coverage through a Marketplace. The law provided that this provision apply as of 2014. Through subregulatory guidance, the IRS provided for "transition relief" with respect to both the employer shared responsibility and associated reporting requirements, providing that they not apply until 2015. The Trump Administration may be able to establish criteria for new transition relief or, more likely, simply fail to collect the penalty assessments for non-compliance.

3. Reduce burden on health plans

- Reduce/eliminate special enrollment periods (SEPs). Individuals who enroll during SEPs have been higher-cost on average, so insurers would benefit from steps to limit enrollment outside the annual enrollment period. (Would also reduce enrollment totals.)
- Continue to delay enforcement of data disclosure requirements for insurers (including CMS' scheduled quality, provider network, and formulary data submission requirements for Qualified Health Plans). Reduces administrative burden on health plans. Also makes plan information and plan comparisons less transparent for consumers.
- Revise Medical Loss Ratio (MLR) reporting requirements to allow insurers more flexibility in accounting for anti-fraud and abuse, quality improvement, marketing and other functions.

4. Increase flexibility of plan benefits

- Extend availability of ACA-noncompliant health plans in accordance with state law; perhaps take new action to allow states to permit new enrollment in these plans which offer much less comprehensive benefits but are also less expensive. The current CMS transitional policy allows these plans to be sold (and enrollees exempt from the individual mandate penalties) through 2017. When CMS extended this policy in 2014, it indicated that it would consider the impact of its extension of the transitional policy through 2016 in assessing whether an additional one-year extension was appropriate.[3] The Trump Administration presumably could extend the application of this policy indefinitely.
- Stop Justice Department suits defending Obama administration actions requiring employers to include all FDA-approved contraception in their insurance plans.
- Relax various requirements imposed by regulation or guidance on Qualified Health Plans related to the adequacy of provider networks.
- Relax various consumer/employee protections such as non-discrimination protections that help to safeguard access for high-risk enrollees to the essential health benefits and seek to prevent discriminatory practices on the basis of gender identity. The non-discrimination rules related to employer wellness programs could also be weakened.

5. Take steps to weaken marketplaces

- Limit risk corridor payments to amounts Congress appropriates each year and continue to fight lawsuits by insurers to obtain these payments.[4]
- Increase administrative barriers to enrolling in Marketplace plans, for example by requiring additional verification of individuals seeking eligibility for premium and cost-sharing subsidies and reconciling advance payments of premium assistance with income information.
- "Disable/defund" the CMS Center for Consumer Information and Insurance Oversight, for example, by stopping funds for outreach and enrollment assistance funds or eliminating staff.

- Discontinue defending payment of cost-sharing subsidies to insurers without an appropriation. (These payments cover the cost-sharing amounts that are reduced for eligible low-income enrollees in the Exchange silver level plans.) The Obama Administration is appealing an adverse lower federal court decision in the *House v. Burwell* ruling that the cost sharing subsidies were paid without a specific Congressional appropriation for those payments.[5] The Trump Administration could withdraw its appeal and stop paying cost-sharing reduction payments to insurers (this may take a rule change).

6. Other Issues

- Allow employers to eliminate coverage for abortions without an alternative arrangement for coverage. Under current rules, employers must either submit a self-certification form to their insurer or health plan administrator or notify HHS of their religious objection to providing such coverage. The coverage is then provided separately by the health plan insurer or third-party administrator.

B. ACA Medicaid Expansion/State models

Before "replacement" legislation or repeal of the Medicaid expansion takes effect, the Trump Administration could take steps to increase state flexibility by allowing ACA expansion states to seek or amend Section 1115 federal waivers to allow for features the Obama Administration was unwilling to accept. This may result in Medicaid waivers that increase cost sharing requirements imposed on the expansion population, tie eligibility for Medicaid to meeting certain work requirements, or put time limits on Medicaid eligibility. Currently, Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire have approved Section 1115 waivers for implementing the Medicaid expansion; another 25 states have adopted the ACA expansion for the adult population without use of any federal waivers. Depending on the time horizon for repeal/replace legislation, additional expansion states may consider shifting to a waiver approach. As of November 2016, a total of 19 states have not expanded Medicaid to include the ACA adult population.

While a block grant approach to financing the federal share of Medicaid requires legislation, the Administration might also seek to use Section 1115 waiver authority to provide states with greater flexibility regarding other aspects of the Medicaid program. During the George W. Bush Administration, for example, CMS created a fast-track waiver review process for Health Insurance Flexibility and Accountability waivers. While that effort was targeted at considering a range of state approaches to coverage expansions, a waiver program targeting other types of state flexibility (e.g., use of health savings accounts) might be developed.

C. Centers for Medicare and Medicaid Innovation (CMMI):

The CMMI enjoys direct appropriations to carry out demonstrations to test innovative health care delivery models. CMS interpreted the statute broadly, including giving itself the authority to mandate provider and supplier participation in models. Because repeal of the CMMI would be costly (CMMI is estimated to save $27 billion over 10 years), a new administration may make a number of changes to how CMMI operates as follows:

1. It may change the way CMMI demonstrations are conducted; for example it could clarify that provider participation in demonstrations is always voluntary.
2. It may increase provider involvement in demonstration model design or seek provider approval of proposed models.
3. It may decline to finalize demonstration models that have not yet been implemented (e.g., the Part B drug demo and Cardiac Care demonstrations).
4. It may terminate a demonstration model that has been implemented.
5. It may decline to expand a demonstration model that is being tested.
6. It may change its interpretation of waiver authority to conduct or expand demonstration models. (Current interpretation of the waiver authority is considered very broad, vesting enormous discretion in the agency.)

II. Types of Administrative Actions

A. Rulemaking Authority

A President may repeal a regulation that has gone in effect. To repeal a final rule that has gone into effect, the regulation carrying out the repeal must go through the same notice and comment rulemaking that was used to promulgate the regulation it seeks to repeal.

Where a lame duck President in the final weeks of his/her final term pushes through a great quantity of final regulations (sometimes referred to as "Midnight Rules"), the next President who disagrees with those final rules may instruct the relevant agency as follows:

(1) If the final rule has <u>not yet been published</u> in the *Federal Register*, to rescind or withdraw the final rule. There is no notice and comment period required for rescinding or withdrawing a final rule that has not been published in the *Federal Register*.
(2) If the final rule is published in the *Federal Register* <u>but</u> has not yet become effective, delay the effective date of the final rule.

If a final rule is published in the Federal Register but has not yet become effective pursuant to the effective date established under the final rule, it does have the force of law but it is not yet effective. The rationale for this is that the public impacted by the rule may need time to comply with the new requirements under the rule. Effective dates are generally 30 or 60 days after publication of the final rule. So, a newly inaugurated President may direct the agencies to delay the effective date of the Midnight Rules of his/her predecessor. President Reagan ordered a widespread delay of rules so his administration could "review" them; this "review" went on for quite some time.

B. Use of Executive Orders

A President may exercise authority through an executive order (EO). An EO is generally directed to and governs actions by Government officials and agencies. The President's authority for an EO must be granted by an Act of Congress (e.g., a statute or a resolution) or must be discerned from the Constitution. Thus if the EO is consistent with an express or implied delegation of authority to the Executive branch under a statute, or even is compatible with the will of Congress, it will have the force and effect of law, including any requirements or prohibitions imposed by the EO. The concern with executive orders is that they may constitute legislative activity where there is no authority from a congressional action or the Constitution, which is a violation of the constitutional separation of powers doctrine. An executive order can be, and has been, overturned in court where it can be shown that the order is effectively an unconstitutional legislative act because there is no statute or provision of the Constitution that authorizes it.

The President may revoke, modify or supersede any executive order, including ones he or she issued. While an EO is published in the *Federal Register*, it does not require a public notice and comment period to become effective. Executive orders may also instruct the agencies to rescind orders, rules, guidelines and policies from earlier executive orders. Congress may also revoke all or part of an EO by directly repealing the order, removing the underlying authority of the EO (i.e., amending the authorizing statute or resolution), or by precluding the use of appropriations to carry out the EO.

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[1] It is unclear whether the IRS to date has taken any steps to systematically verify the accuracy of information from individuals who declare on their 1040 that they have met the requirements for minimum essential coverage. Resource constraints would make this seem unlikely, although this may occur during an audit.

[2] These Administrative waivers may be addressed in either a policy statement, news release, or other formal communication stating that the policy of the IRS is to provide relief from a penalty under specific conditions. Another option is to issue an Executive Order directing the IRS to stop imposing the penalty but the high visibility of that step might result in legal challenges by insurers.

[3] On November 14, 2013, CMS issued a letter to the state insurance commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets stating that, if permitted by applicable state authorities, health insurance issuers could choose to continue certain coverage that would otherwise be cancelled because it was not compliant with the ACA, and affected individuals and small businesses could choose to re-enroll in such coverage. CMS further stated that, under the transitional policy, non-grandfathered health insurance coverage in the individual or small group market that was renewed for a policy year starting between January 1, 2014 and October 1, 2014 would not be considered to be out of compliance with certain market reforms if certain specific conditions were met. On March 5, 2014, CMS issued subregulatory guidance extending the transition policy. About 40 states adopted the transitional policy for at least some part of the time. Individuals and small groups who have remained in or newly enrolled in these plans are likely to be younger and healthier since these plans do not provide the full array of Essential Health Benefits or comply with other ACA insurance requirements. The existence of transitional plans has contributed to the lower-than-anticipated enrollment and higher concentration of older and sicker enrollees in the individual and SHOP Marketplaces, driving up their plan premiums. (See, for example, www.commonwealthfund.org/publications/blog/2014/jun/adoption-of-the-presidents-extended-fix.)

[4] These payments, authorized by the ACA for 2014, 2015 and 2016, were intended to reduce the risk assumed by insurers offering QHPs in the marketplaces during a time when estimating premiums would be challenging given uncertainty about plan claims experience. The program applies a statutory formula to collect funds from QHP insurers that enjoy excessively large profits and to make payments to QHP insurers that suffer exceptionally large losses. The ACA does not clearly require the risk corridor program to be revenue neutral. For 2014 and 2015,

however, Congress adopted appropriations riders limiting risk corridor payments to the amount collected. For 2014, HHS was only able to pay 12.6% under the constraint imposed by the appropriations riders. HHS has indicated that 2015 payments will be devoted to paying out 2014 obligations and that there may not be funds to pay the 2015 amounts owed. A number of issuers are suing HHS and HHS has indicated its interest in reaching a settlement. The Department of Justice, however, says that the government is not obligated to make risk corridor payments. At least one federal court has in effect sided with the Department of Justice saying that the government does not have a contractual obligation to make the risk corridor payments.

[5] *United States House of Representatives v. Burwell*, 1:14-cv-01967 (D.D.C., 2014).