THE CENTURY FOUNDATION

Appendix: A Pathway to Universal Health Care: Building on the Affordable Care Act

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Appendix A: Undoing the Trump Administration's Assault on the Affordable Care Act

The Trump Administration has taken a number of steps that have undermined the ACA. The first step in any program to improve the ACA will require nullifying the Trump administration's attempts to undermine the ACA by administrative action.

The attempt by the Trump administration and by congressional Republicans to repeal the Affordable Care Act failed in the U.S. Senate by one vote. Democratic control of the House, as well as the severe losses Republicans suffered in the 2018 congressional election—in large measure driven by the unpopularity the repeal attempt—makes a successful legislative assault on the program unlikely. But the Trump administration has used its regulatory authority to attempt to weaken the Act in a variety of ways. Indeed, the very first executive order that Trump issued after his inauguration declared that it was his goal to repeal the ACA, and directed all federal agencies to "exercise all authority and discretion available to them to waive, defer, grant exemptions for, or delay implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty or regulatory burden, families, health care providers, health insurers, patients, recipients or health care services . . . ," and so on.[1]

Some of the Trump administration's steps to undermine the law may fail as the result of court challenges, but others will likely survive, and even those that are ultimately struck down will act as a drag on the program. In addition, as part of their overall tax reform package, Republicans succeeded in including a repeal of the tax penalties used to enforce the ACA's individual mandate to purchase health insurance. The administration has also joined a number of Republican state attorneys-general in a suit that attempts to have the entire law struck down as unconstitutional.

The Trump program of sabotage has two broad prongs. One prong is a wide variety of measures designed to undermine the system of private insurance created by the ACA. That system was to ensure that everyone not eligible for public coverage or affordable employment-based insurance has access to affordable, comprehensive private insurance. The second prong is the assault on the Medicaid program—and especially the Medicaid expansion established by the ACA.

The steps taken by the Trump administration to undermine the system of private insurance created by the ACA form a veritable murderer's row of anti-patient regulations and

guidances. The administration slashed programs to help people navigate the exchanges and made other adjustments that made it more difficult to enroll.

It took a number of steps to raise premium, make the marketplace unsustainable, and water down the quality of coverage. These steps included allowing less-valuable silver plans to be offered, adjusting indexing in a way that would reduce the value of the premium subsidies provided by the ACA, suspending cost-sharing subsidy payments to insurance companies, and allowing "junk plans" not meeting the standards of the ACA to siphon off younger and healthier enrollees from the insurance exchanges, exposing these enrollees to substandard insurance. The administration broadened the definition of Association Health Plans (AHPs) in a way that would remove patients from ACA protections and open up greater opportunities for fraud and risk selection. It redefined section 1332 waivers, intended to allow states to experiment with ways to improve coverage, so that they could become an engine for making coverage worse rather than better. It relaxed the standards for the essential health benefits insurance was supposed to offer.

Beyond the attempts to undermine the private insurance program established by the ACA, the Trump administration also took aim at Medicaid. The Republican bill to repeal the Affordable Care Act not only proposed eliminating the provisions of the ACA to expand Medicaid, but it also took sought to weaken the underlying program by converting it to a block grant. Absent legislative action, the administration is using the demonstration authority under section 1115 of the Medicaid statute to encourage states to modify their programs, especially for the expansion population, in ways that would reduce rather than increase coverage and access to essential services.

Private Insurance

The key elements of the Trump administration's attempt to use its real or asserted regulatory authority to weaken the structure of comprehensive, affordable private insurance established by the ACA include:

- *Making it more difficult for potential beneficiaries to enroll in marketplace plans.* Immediately after taking office, the administration canceled ads informing potential beneficiaries about enrollment in the program. It actually used public funds to attack the ACA, with the U.S. Department of Health and Human Services (HHS) releasing videos featuring people who said they were harmed by the ACA, as well as using its Twitter account to disseminate anti-ACA messages. Later in the year, the administration ended contracts to provide information and assistance to people who might wish to enroll in exchange plans, and subsequently cut funding for marketplace outreach by 90 percent and funding for navigator assistance by 40 percent. HHS staff were forbidden to participate in marketplace enrollment events. A subsequent cut reduced navigator funding to just 20 percent of its 2016 level. HHS reduced email outreach for the marketplace open enrollment period by cutting all the names from the list of people who were not currently enrolled.[2]

In addition to reducing information and assistance for enrollment in exchange plans, the Trump administration also cut the open enrollment period in half, from twelve weeks to six weeks, and shut down the system for enrolling except for one Sunday morning during the enrollment period, Sundays being a popular time for enrollment events sponsored by outside groups.[3] It also made it more difficult for people to sign up during special enrollment periods.[4]

In its most recent proposed rule, issued in January 2019, the administration suggested it might eliminate automatic re-enrollment for beneficiaries who fail to choose a plan during the open enrollment period. This rule would not only reduce total enrollment, it would also be most likely to disproportionately disenroll people in good health who likely have less commitment to ensuring that they have insurance coverage. This, in turn, would raise premiums for those who remained. While this proposal was not included in the final rule, the administration noted that it had not ruled out implementing it in the future.

- *Raising premiums, making the marketplace unsustainable, and watering down the quality of coverage.* As noted above, the administration included repeal of the enforcement provisions of the individual mandate in their omnibus tax bill. The key regulatory steps they initiated in order to raise premiums and make the marketplace unsustainable included:

    - o allowing less valuable silver plans to be offered;
    - o adjusting indexing in a way that would reduce the value of the premium subsidies;
    - o suspending cost-sharing subsidy (CSR) payments;
    - o allowing "junk plans" not meeting the standards of the ACA to siphon younger and healthier enrollees from the health exchanges, potentially raising premiums for those remaining in the exchanges (as well as creating a group of individuals who have insurance that does not provide them adequate protection);
    - o allowing association health plans;
    - o opening up section 1332 waivers; and
    - o relaxing essential health benefit standards

- Repealing the enforcement provisions of the individual mandate. The provision was included in the Republican omnibus tax bill passed in December of 2017. The repeal went into effect in 2019, but the Trump administration had already stopped requiring evidence of insurance to be submitted to the IRS, suggesting that the penalty would not be enforced even without legislation.[5] The Congressional Budget Office (CBO) estimated in November 2017 that repeal of the individual mandate would increase the number of the uninsured by 13 million by 2025 and raise average premiums in the nongroup market by 10 percent, because those people most likely not to enroll if there were no financial penalty for failing to do so would be disproportionately younger and healthier.[6]

- *Allowing less-valuable silver plans to be offered.* In a proposed rule finalized in April 2017, the Trump administration granted silver plans additional flexibility to lower the average value of their offerings. Silver plans are required under the statute to pay at least 70 percent of the cost of the services they cover. This 70 percent is referred to as their actuarial value. Under the regulations established by the Obama administration, plans were allowed a so-called *de minimus* variation from the 70 percent, presumably to allow for some uncertainties in calculation. This *de minimus* variation was set at a maximum of 2 percent. The Trump administration rule expanded this to 4 percent. The cost of premiums for the second-least-expensive silver plans in a region are, under the ACA, used to set the premium subsidies for all plans. This change would allow the lower cost benchmark plan used to determine subsidies to offer less valuable coverage and have the effect of increasing the unsubsidized share of the premium or reducing the value of the benefits for all enrollees, regardless of whether they enrolled in the specific low-cost plan. A calculation by Aviva Aron-Dine and Edwin Park at the Center for Budget and Policy Priorities found an example family of four with an income of $65,000 would see a reduction in its tax credit subsidy for coverage of $327, or more than 4 percent. Alternatively, the family could buy a plan with a lower premium, but be subject to an increase in its per person deductible of $550.[7]

- *Adjusting indexing.* In its 2019 proposed rule, the Trump administration proposed to adjust the indexing of premium subsidies provided in the

ACA in a way that would reduce the value of the subsidies. In order to hold down the twenty-year cost of the ACA and help achieve its passage, the ACA legislation provided that annual subsidy increases would be set at a level that was likely to be somewhat less than actual premium growth. Specifically, the law set a cap on the percent of income that individuals would have to pay for coverage (the cap varied by income level and phased out 400 percent of the FPL for premium subsidies). Under the limit, if premiums grew faster than GDP, the maximum percent of income individuals would have to pay would rise at a rate equal to the average premium increase divided by the GDP increase.

The existing rules based this calculation on the increase on premiums for employment-based plans, on the grounds that premiums in the individual market would be much more unstable, based on uncertainties from implementation of the ACA and the associated expansion of individual coverage to a much wider population. As described, the actions of the Trump administration have increased uncertainties in this market. But the Trump proposal would adjust the percent of income individuals would have to pay before subsidies kicked in based on increases in premiums in the entire market, including both individual and employer increases, effectively reducing the subsidies individuals would receive.[8]

- *Suspending CSR subsidy payments.* Following a lower court ruling (currently stayed, and pending appeal), Trump threatened to suspend the payments under the ACA that subsidized cost-sharing for individuals and families with incomes under 400 percent of the FPL. Even the threat of this action had the effect of creating uncertainties for insurers and prompting some to leave the exchange market.[9] The policy was made final on October 12, 2017.

Because insurers are still required to provide the cost-sharing reductions mandated under the ACA, even without the federal payments, the effect of removing the federal payments is to require premium increases to cover the cost of the subsidies. The Congressional Budget Office (CBO) and the Joint Tax Committee (JCT) jointly estimated that the effect of this change would raise silver plan premiums (the most popular offering in the exchanges) by 10 percent in 2018, and 20 percent in subsequent years.[10] In fact, average premiums for all plans jumped significantly between the 2017 and 2018 plan years—from $341 per month in 2017 to $621 per month in 2018.[11]

This jump in premiums had little effect on people eligible to receive subsidies under the ACA. Premium subsidies are tied to a cap on the percentage of income spent for premiums, so for people who are eligible, premium costs do not go up as actual premiums rise. Cost-sharing subsidies, which are available only to individuals with incomes below 250 percent of the FPL, are based on raising the actuarial value of the plan—the amount paid by the insurance company for covered services—from the 70 percent required for silver plans generally to a higher level. Since the actuarial value of the plan is based on the proportion of covered costs paid by the insurer and has nothing to do with premiums, the increase in premiums does not affect cost-sharing subsidies, either. Ironically, because the premium subsidies were pegged to the cost of silver plans, the jump in silver plan premiums allowed some subsidy-eligible individuals to buy more valuable gold plans more cheaply than the silver plans to which the subsidies were pegged. But people not eligible for premium subsidies faced substantially higher costs for silver plan coverage as the result of the new policy.[12]

- *Allowing junk plans.* Among the most blatant attempts of the Trump administration to undermine the ACA are the steps they have taken to permit the marketing of lower cost substandard plans that would not meet the minimum requirements of the ACA and are designed to siphon healthy consumers out of the ACA risk pool. The ACA did indeed allow short-term health plans, primarily as a vehicle for consumers in transition between insurance plans—perhaps because they were changing jobs—but who did not necessarily qualify for a special enrollment period under an exchange plan to purchase low-cost short-term health plans. These plans were not required to meet ACA requirements.

But the original regulations limited the duration of such plans to no more than three months. On February 20, 2018, the Trump administration proposed to allow such plans to be offered for one year and to be renewed for up to three years, essentially treating them as regular insurance plans not subject to such central ACA requirements as provision of essential benefits, open enrollment, prohibition on pre-existing condition limitations, and lifetime and annual limits.[13] The proposal was finalized August 3, 2018. The Urban Institute estimated the change would increase the number of people without minimum essential coverage by 2.6 million in 2019 and raise premiums for ACA plans by 18 percent in states that do not limit such plans (only six had such limitations).[14]

- *Relaxing rules on association health plans.* Association health plans (AHPs) are arrangements allowing a group of employers to either offer or purchase a single insurance plan for themselves and their employees. They are a subset of multiemployer welfare arrangements (MEWAs). The rules for such arrangements are quite complicated. In general, the rules have been designed to prevent selection of health risks out of a broader risk pool, fraud, and avoidance of appropriate state regulation. Because these arrangements are treated like a large employer plan, they are exempt from many of the ACA requirements that would be applicable if the members purchased coverage as individuals or as small businesses. Despite the existing rules, MEWAs have had a long history of fraudulent arrangements in which the organization is set up as an insurance plan that avoids state regulation, collects premiums, but defaults without paying the promised benefits.

The ACA modified the rules for AHPs. In general, AHPs did not get special treatment under the ACA. Instead, if an individual or small business obtains coverage through an AHP, they are treated as any other small business or individual insurance plan and subjected to the same rules and regulations. The exception is when an AHP qualifies as a single multiemployer plan under ERISA (The Employment Retirement Income Security Act), which would allow it to be treated as a large group health plan for ACA purposes. Historically, ERISA multiemployer plans were plans set up by employers all working in the same industry, such as trucking or construction, pursuant to a collective bargaining agreement.

In January 2018, the Trump administration's Department of Labor issued a proposed rule that made it much easier for a health plan issued or purchased by an association to be considered a MEWA treated as a group health plan. With some modifications, the rule was finalized on June 19, 2018, but blocked by court action (which is under appeal by the administration). The rule would have relaxed the commonality of interest rules that restricted MEWAs to employer associations that have a strong relationship, not those that were set up largely to sell insurance to members or are a general business group like a Chamber of Commerce. Under the new rules, an AHP's principal purpose can be the provision of benefits, although it must have at least one "substantial business purpose." This can be as limited as holding conferences or promoting common economic interests.

The new rule would undermine the ACA in two ways. First, employees of small businesses that join an AHP could lose benefits that would otherwise be guaranteed by the ACA, including provision of essential benefits. Second, AHPs could be designed to attract healthier groups of small employers, raising the costs for those who remained in the broader risk pool. Three separate estimates of the proposed rule found the result would be substantial increases in premiums in both the individual and small group market.[15]

- Section 1332 waivers. On October 22, 2018, the Trump administration also issued guidance designed to further undermine the ACA marketplace. This guidance encouraged states to use the so-called section 1332 waivers for this purpose. Section 1332

of the ACA allows states to implement a system of guaranteed coverage different from that specified in statute if it is as least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number or residents of the state as would be provided coverage absent the waiver, and does not increase the federal deficit. Prior to the guidance, a number of states used 1332 waivers to set up reinsurance programs designed to reduce premiums in the marketplace.[16]

The Trump administration's modifications to the Obama administration guidance undermines section 1332 in several ways. First, the modified guidance now states that the Trump administration would look favorably on plans that provide increased access to "affordable private market coverage," which is defined to include short-term health plans and association health plans. The Trump administration states that it will also look favorably on plans that promote "consumer driven health care," which is shorthand for high deductible plans. The guidance does not require states to show that as many people would actually be covered under the waiver as under the regular program; rather the plan is evaluated on whether it provides access to such coverage, so the waiver standard could be met if more people enroll in less comprehensive coverage. The previous standard also evaluated the coverage provided to vulnerable subgroups of the population under the waiver; this requirement is now dropped. The requirement that a waiver plan be adopted by state statute has also been weakened, giving a state governor authority to move ahead with a plan that might not be approved by a state legislature.

One expert summarizes the changes to the guidance as showing the Trump administration's willingness to approve proposals that would lead to:

- "An increase in the number of people with less comprehensive coverage relative to the ACA;
- An increase in the number or consumers exposed to higher cost-sharing and out-of-pocket costs relative to the ACA;
- Coverage losses or higher out-of-pocket costs among vulnerable populations, such as older adults or low-income people; and
- Expanded coverage options, such as short-term health plans, that exclude coverage for preexisting conditions and other key benefits using health status underwriting."[17]

- *Watering-down essential health benefits.* The ACA requires coverage of ten categories of essential health benefits in individual and small group plans: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. While these categories cover a broad range, they are also general, and thus do not by themselves indicate the scope of coverage within each category. Moreover, plans are generally allowed to put limits on days of treatment or number of visits for these services, although not dollar limits.

The statute addresses this issue by directing the U.S. secretary of health and human services to "ensure that the scope of essential health benefits is equal to the benefits provided under a typical employer plan." There are also some other directives to the secretary—for example, that the benefits take into account health needs of diverse populations—that suggest that the requirement that the scope equal that of a typical employer plan is not absolute. In any event, the Obama administration chose to not specify the scope of benefits in detail. Rather, it allowed each state to select its own benchmark plan from four options: one of the three largest small group plans in the state; the state employee health benefit plan, any of the three largest national Federal Employee Benefits Program plan options, or the largest commercial HMO in the state. Where the benchmark plan did not include one or more of the essential health benefits, the regulations prescribed alternative benchmarks for those benefits. Plans were allowed to change the scope and specifics of benchmark plan benefits within the ten essential benefit categories, but only if the resulting benefit was at least actuarially equivalent to the benchmark plan for that category.

The Trump administration proposed to weaken the ten essential benefit requirements in several ways. First, it allowed states to select a benchmark for any state, essentially reducing the benchmark requirement to those of the least generous state benchmark. The proposal also allowed the state to pick and choose among benchmark categories from other states. Finally, states could choose a benchmark that is a "typical employer plan," defined in a way that would allow states to choose a benchmark from any plan with more than 5,000 enrollees, substantially expanding the permissible choices for a benchmark plan. An analysis by New York Medical College professor Adam Block and colleagues looked at four states and found that this change would allow these states, if they chose to, to drop anywhere from six to ten currently covered benefits.[18]

Medicaid

On January 11, 2018, the Trump administration issued new guidance for section 1115 of the Social Security Act, which allows demonstration projects that may waive some of the normal federal Medicaid rules. The guidance would encourage states to establish demonstration projects that have the goal of creating incentives for Medicaid beneficiaries to participate in work and community engagement activities.[19] For the first time, the new guidance would allow states to impose this work or community activity requirement on individuals as a condition of their gaining and maintaining Medicaid eligibility.

To date, fifteen states have waivers approved or pending.[20] Work or community activity requirements under the waivers generally apply only to working-age adults and have various exceptions, including such exceptions as young children at home, disability, or medical frailty. Virtually all of the waiver applications project that there will be substantial coverage loss as a result of the new work requirements, further undercutting the goal of universal coverage.

The Kaiser Family Foundation estimates that if work requirements were imposed in all Medicaid programs, between 1.4 million and 4 million of the 23.5 million working age, non-disabled adults currently on Medicaid would lose coverage—between 6 percent and 17 percent of all enrollees in this category. In both cases, large majorities of those who lose coverage would be kicked off the rolls because of reporting or other administrative requirements, rather than because they actually failed to fulfill the work requirement or qualified for an exemption.

The Kaiser Family Foundation survey of adults on Medicaid potentially subject to work requirements found that 62 percent were already working. Among those not working, most (32 percent) were not working because they were caregiving for other family members, not working due to school attendance, or in fair or poor health due to illness or disability. All of these would be potential reasons for exclusions from the requirements under most state waivers, although under the terms of specific waivers a "medical frailty" exclusion might not apply to all those self-reporting not working for health reasons and caregiving might not be allowed for those with older children. Only 6 percent were not working for other reasons, which could include problems beyond the individual's control, such as lack of transportation or lack of available jobs or training.[21]

The Kaiser analysis appears to be borne out by the experience under the Arkansas work and community participation requirements. Over 18,000 individuals lost coverage—more than 25 percent of all beneficiaries subject to the policy. An analysis by the Center for Budget and Policy Priorities suggests that most of those who lost coverage did so because of failure to fulfill reporting or other bureaucratic requirements rather than actual ineligibility.[22]

As with other attempts to undermine the ACA, the 1115 waivers are being challenged in court, and so far the courts have agreed that work requirements are not consistent with the legislative goals of the Medicaid program.

Regardless of the reasons why individuals might not qualify for coverage under a work and community participation requirement or the legal arguments regarding use of 1115 waivers, the existence of such a requirement undercuts a basic premise of universal coverage: that health care is a matter of right, not a privilege.

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Notes

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