Actions the Executive Branch Could Take to Adversely Affect the Affordable Care Act and Their Interaction With California Laws
March 29, 2017

This document identifies administrative actions that could be taken to weaken the coverage provisions of the Affordable Care Act (ACA) with respect to marketplace (Exchange) coverage and Medicaid (Medi-Cal in California). The issues identified here are not intended to be exhaustive. Pending the appeal of the ACA, President Trump's first Executive Order instructed departments and agencies responsible for implementing the ACA "to ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market."[i]

ACA Provisions That Might Be Subject to Administrative Action	Potential Implications for California Law
Marketplace Coverage	
Discontinue Funding of Cost-Sharing Subsidies	
If the Trump Administration decides to discontinue funding, insurers would not be expected to participate in the Exchanges in 2018 and could even attempt to terminate participation for the remainder of 2017.[ii]	There are no California-specific laws related to cost-sharing subsidies. Covered California enrollees benefit from an estimated $4.2 billion in advanced premium tax credits and over $700 million in cost-sharing reductions to reduce costs at the point of care.
Eliminate/Weaken Individual Mandate (Personal Responsibility Requirement)	
The Obama Administration used regulatory authority to provide for exemptions to the individual mandate beyond those specified in statute (e.g., a large number of different types of hardship exemptions from the requirement for minimum essential coverage). The Trump Administration could establish new hardship exemptions or other changes to the implementing rules related to the individual mandate to weaken its impact in motivating individuals to obtain and retain health insurance. The Trump Administration could further signal its intent to provide for lax enforcement of the tax penalties for not having minimum essential coverage 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.[iii,iv]	There are no state laws imposing an individual mandate that requires individuals to maintain minimum essential coverage. If federal law is changed to no longer require that individuals maintain minimum essential coverage, several individual market reforms will become inoperative 12 months later, including but not limited to guaranteed availability and the prohibition on pre-existing condition exclusion. [HSC §1357.51, §1399.825 et seq., §1399.855. §1399.836; CIC §10950 et seq., §10119.2, §10198.7, §10965, §10965.5] Individual market requirements implementing the ACA must only be implemented to the extent a requirement meets or exceeds an ACA provision. [HSC §1399.862; CIC §10965.16]

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Reduce Employer Burdens	
The Trump Administration could fail to enforce the employer responsibility mandate (employers with at least 50 full-time employees), by establishing criteria for new transition relief with respect to both the employer shared responsibility and associated reporting requirements — or, more likely, simply fail to collect the penalty assessments for non-compliance.	There are no state laws requiring employers to provide health coverage for their employees.
Reduce Burden on Health Plans	
The Trump Administration's February 2017 market stabilization proposed rule calls for a reduction in the Special Enrollment Periods (SEPs) beginning with 2018, and the SEP proposal is expected to be finalized.[v]	In California, issuers must allow an individual to enroll in or change health benefit plans for up to 60 days from specific triggering events defined in state law. Exchange issuers must also comply with all triggering events in federal exchange rules. [HSC §1373.96; CIC §10133.56]
The Trump Administration could continue to delay enforcement of network adequacy standards, data disclosure and other requirements for insurers (including CMS' scheduled quality, provider network and formulary data submission requirements for Qualified Health Plans).The Qualified Health Plan network adequacy requirements would be pared back under the Administration's market stabilization proposed rule.[vi]	Qualified Health Plan (QHP) requirements are outlined in the Covered California QHP issuer contract. AB 1602 (Pérez, Chapter 655, Statutes of 2010) requires Covered California to determine the minimum requirements health plans must meet for participation in Covered California, as well as the standards and criteria for selecting health plans to be offered in Covered California. It also requires Covered California to provide in each region of the state a choice of QHPs at each of the five levels of coverage contained in federal law.
The Trump Administration could revise medical loss ratio (MLR) reporting requirements to allow insurers more flexibility in treating anti-fraud and abuse, certain quality improvement, marketing and other activities as benefit or quality improvement rather than administrative activities, thus increasing their MLRs (which may, for some plans, lower or eliminate the need to provide premiums rebates to their customers).	Health plans are required to meet a minimum MLR of at least 85 percent for large group plans and 80 percent for small group and individual market plans. Otherwise, the plan must reimburse its enrollees any amount it retained in excess of the MLR for any coverage year. Further, a plan must comply with all regulations issued by the federal government relating to MLR, including regulations issued pursuant to 42 U.S.C. § 300-gg18, e.g., 45 C.F.R. Part 158. [HSC § 1367.003; CIC §10112.25]

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Increase Flexibility of Plan Benefits	
The Trump Administration could relax the regulations and guidance that define the scope and nature of essential health benefits (EHBs). The administration could allow issuers of individual and small group plans more flexibility in meeting the required metal levels of EHBs. In addition, members of the Trump Administration have indicated a willingness to ease other rules related to EHBs.	Issuers of non-grandfathered individual and small group coverage inside and outside of the exchange must provide coverage for EHBs, as outlined in state law. The state requirement to cover EHBs must only be implemented to the extent EHBs are required pursuant to the ACA. *Same rules apply to exchange and outside market.* [HSC §1367.005(k); CIC §10112.27(k)] Any EHB must only be covered to the extent federal law does not require the state to defray the costs of the benefit. *Same rules apply to exchange and outside market.* [HSC §1367.005(l); CIC §10112.27(l)]
The Trump Administration could extend the availability of ACA-noncompliant ("grandmothered") health plans that generally offer less comprehensive benefits but are also less expensive and perhaps also allow states to permit new enrollment. Less likely, but seemingly possible through an amendment to current regulations, are changes that make it easier for grandfathered plans — those that were in place on or before March 23, 2010, the date of the ACA's enactment and that are subject to very few ACA requirements — to retain that status.	State law required all non-grandfathered health plans to be ACA-compliant by 2014. SB 1446 (DeSaulnier, Chapter 84, Statutes of 2014) authorizes a small employer health plan or health benefit plan in effect on Oct. 1, 2013, and renewed by Dec. 31, 2013, that does not qualify as a grandfathered health plan or health benefit plan, to 1) avoid compliance with specified provisions of the ACA and related state law and 2) be renewed until October 2016, at which time compliance with the ACA and state law is required.
Under current law, health plans offered in the group and individual insurance markets are required to cover preventive health care services without cost sharing if recommended in guidelines issued by the Health Resources and Services Administration, including all FDA-approved contraception services for women.[vii] The Trump Administration could do any of the following: discontinue the Justice Department's defense of these contraceptive coverage requirements, provide more exceptions for additional employers to be exempt from these rules because of religious or for other reasons, and revisit its definition of required preventive services to no longer require coverage of contraception or encompass a more limited definition of those services.	In California, issuers must comply with the requirements in federal law (by specific reference to 42 USC 300gg-13) related to coverage and cost sharing for preventive services. *California adopts federal standard; same rules apply to exchange and outside market.* [HSC §1367.002; CIC §10112.2]

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The Trump Administration could relax various consumer/employee protections such as non-discrimination protections that help to safeguard access for high-risk enrollees to the EHBs 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. The Trump Administration could relax prohibitions against discrimination on the basis of gender orientation, identity and stereotyping. The administration could discontinue defending against a lawsuit charging that HHS regulations require providers to perform and provide insurance coverage for gender transitions and abortions regardless of their religious beliefs or medical judgment. The administration could also revise non-discrimination rules to be less restrictive, allowing for discrimination based on sexual orientation, gender stereotyping or gender identity, and allowing health insurance issuers and providers to deny treatment for gender reassignment, deny coverage for gender reassignment surgery and other related services, and to refuse to perform abortions.	Pre-existing provisions of California law that prohibit discrimination for specific individuals and health conditions continued to apply under the ACA. In addition, ACA reforms to the individual market rules in California prohibit marketing practices or benefit designs that will have the effect of discriminating against or discouraging the enrollment of individuals with significant health needs. *California exceeds federal standard and/or preserves California pre-existing law; same rules apply to exchange and outside market.* [HSC §1399.851; CIC §10965.5] Prohibited factors for determining eligibility or continued eligibility mirror federal law and apply to all issuers. *California adopts federal standard; same rules apply to exchange and outside market.* [HSC §1399.849; CIC §10965.3]
Take steps to Weaken Marketplaces	
The Trump Administration could shorten the annual Exchange open enrollment period for the 2018 plan year, as proposed in the market stabilization proposed rule. Under existing rules, open enrollment for the 2018 Exchange plan year begins on Nov. 1, 2017, and extends through Jan. 31, 2018. Critics, including consumer and patient groups, say that the shortened open enrollment period could undermine rather than reinforce the stability of the risk pool. This is because it would reduce the time to test the education, outreach and administrative limits of the state exchanges and, more critically, dampen enrollment, especially for young and healthy people who tend to wait until the last minute to sign up for coverage.	Coverage effective dates adopted in state law are generally based on federal rules for exchanges. Issuers must make coverage effective consistent with specified and detailed timelines in state law. Issuers *must* limit guaranteed availability to initial and annual open enrollment and specified special enrollment periods during which individuals can enroll in or change coverage. *California exceeds federal standards and/or preserves California pre-existing law; same rules apply to exchange and outside market.* [HSC §1399.849; CIC §10965.1] Issuers of non-grandfathered plans both inside and outside of the California exchange must offer enrollment periods as outlined in federal exchange rules. California *exceeds federal standards and/or preserves California pre-existing law; same rules apply to exchange and outside market.* [HSC §1399.849(c); CIC §10965.3(c)]

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The Trump Administration could limit risk corridor payments to amounts Congress appropriates each year and continue to fight lawsuits by insurers to obtain these payments.[viii] The administration could also fail to implement various changes that the Obama Administration announced for 2018 and subsequent years to the risk adjustment methodology that would improve the federal risk adjustment program, including reducing its over-prediction of risks for certain lower-cost enrollees and under-prediction of costs for higher-cost enrollees. Some insurers are likely to exit the individual and small group insurance markets if they anticipate continued "losses" as a result of the risk adjustment methodology.	There are no state-specific laws related to the risk adjustment, reinsurance and risk corridor programs provided under the ACA. Covered California did not elect to establish its own risk adjustment, reinsurance or risk corridor programs; therefore, the programs are federally administered.
The Trump Administration could 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. Pre-enrollment verification of all individuals seeking premium and cost sharing subsidies is included in the Trump Administration's market stabilization proposed rule for 2018.	There are no California-specific laws related to eligibility for premium and cost-sharing subsidies.
The Trump Administration could "disable/defund" the CMS Center for Consumer Information and Insurance Oversight (CCIIO) — for example, by stopping funds for outreach and enrollment assistance, or by eliminating staff.	There is no interaction between CCIIO and state law.

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The Trump Administration could do nothing to promote Exchange coverage for 2018. One of the first acts of the Trump Administration was to cancel the TV and radio advertising scheduled for the final week of the open enrollment period for 2017. Coupled with the likely reduction in the 2018 open enrollment period by six weeks, limited or nonexistent HHS outreach to promote enrollment would likely reduce enrollment by hundreds of thousands and could produce an older and sicker risk pool than currently exists.	There is no interaction between Exchange marketing at the federal level and state law.
Other Issues	
The Department of Justice could drop its anti-trust lawsuits blocking Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana, enabling their merger plans to move forward, at least to the extent that state lawsuits do not impede them. The federal courts have so far ruled against the mergers. However, recent reporting related to the Anthem/Cigna merger suggests that the Department of Justice may yet reverse its position that the merger would not be anti-competitive, reviving the possibility of a successful merger.[ix]	California law provides that the Insurance Commissioner does not have direct approval authority over the Anthem and Cigna merger unless the company being acquired is domiciled in California. Cigna is domiciled in Connecticut.
The Trump Administration could 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.	In 1981, a court ruled that, under the California Constitution, the state must treat abortion and maternal care neutrally. Any plan offered or regulated by the state that offers pregnancy coverage must also cover abortions. California Constitution, article 1, section 1; HSC §1340, et seq. and HSC§ 123460 et seq., and implementing regulations.

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State Innovation Through Waivers	
The Trump Administration is encouraging states to apply for federal waivers, through which they could be afforded greater flexibility to adopt innovations in individual and small group markets through Section 1332 state innovation waivers (which enable states to use innovative strategies to improve their individual and small group markets) and through Medicaid Section 1115 Medicaid Research and Demonstration waivers, under which states would have greater freedom to design their Medicaid programs.	Prior to the Trump Administration's guidance, SB 10 (Lara, Chapter 22, Statutes of 2016) required the Exchange to apply to HHS for a waiver to allow individuals who are not eligible to obtain health coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. California applied for, then later rescinded, that waiver request. California currently operates a Section 1115 demonstration waiver entitled "California Medi-Cal 2020 Demonstration," effective through Dec. 31, 2020, which primarily provides foundational funding for the public hospitals.

[i] Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, Jan. 20, 2017. https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and

[ii] In 2017 agreements with issuers offering plans through federal Marketplaces, CMS included a cause for termination if cost sharing subsidies are not provided to plan enrollees. The contract acknowledges that issuers developed their products based on the assumption that premium tax credits and cost-sharing reductions will be available to enrollees, and that if those subsidies do not become available it states "that Issuer could have cause to terminate this Agreement subject to applicable state and federal law." While this appears to open the door for plans to exit the federal Marketplaces mid-year, plans would also be subject to other state and federal laws. Therefore, the practical effect of this provision is unclear.

[iii] 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. The ACA's financial penalties for not having minimum essential coverage have been criticized by numerous experts as being weak since many people find that they are less costly than paying for coverage. Moreover, the ACA prohibits the IRS from collecting on the health coverage penalty the same way it collects other tax debts. It cannot garnish the taxpayer's wages for failure to pay the penalty or put a lien on or seize other property. It can, however, deduct the penalties owed from future tax refunds.

[iv] About 80 percent of taxpayers (approximately 117 million tax returns processed through mid-December) checked the box to indicate they had qualifying coverage all year. Another approximately 6.9 million dependents (about 5 percent of tax returns), who do not have to report on their coverage, filed a return, for a total of 85 percent. This was an increase from 81 percent reported in the Commissioner's January 2016 letter in this category for tax year 2014. About 12.7 million taxpayers claimed one or more health care coverage exemptions. About 4.3 million returns in 2015 did not include information on whether the taxpayer had minimum essential coverage. The IRS is checking their returns to determine coverage status. Approximately 6.5 million taxpayers reported a total of $3 billion in individual shared responsibility payments (with the average being around $470; the median around $330). The 6.5 million taxpayers who reported a payment is about 20 percent lower than the approximately 8 million taxpayers who reported a payment for tax year 2014. IRS Commissioner John

Koskinen letter to Members of Congress to update them on 2016 tax filings related to ACA provisions, Jan. 9, 2017, www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf

[v] HHS/CMS Proposed Rule, Patient Protection and Affordable Care Act; Market Stabilization CMS-9929-P, *Federal Register,* Feb. 17, 2017, beginning at p. 10980.

[vi] HHS/CMS Proposed Rule, Patient Protection and Affordable Care Act; Market Stabilization CMS-9929-P, *Federal Register,* Feb. 17, 2017, beginning at p. 10980. Beginning with the 2018 plan year, HHS would rely on state reviews for network adequacy in states in which a federally facilitated Exchange was operating and where the state had a sufficient network adequacy review process (i.e., states with a sufficient review process as those having authority that is at least equal to the "reasonable access standard" defined in §156.230). The reasonable access standard in §156.230 requires that issuers maintain a network sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services and to assure that all services are accessible without unreasonable delay. In states that do not have the authority and means to conduct network adequacy reviews, HHS proposes to apply a standard similar to the one used in 2014. It would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity.

[vii] U.S. Department of Health & Human Services, Health Research and Services Administration, Women's Preventive Services: Required Health Plan Coverage Guidelines, http://www.hrsa.gov/womensguidelines.

[viii] 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 percent 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.

[ix] Barber, Ryan, Anthem, in DC Circuit, Fights to Save $54B Cigna Merger, *Law.Com,* March 24, 2017, www.law.com, www.law.com/sites/almstaff/2017/03/24/anthem-in-dc-circuit-fights-to-save-54b-cigna-merger/?slreturn=20170229100847; Carolyn Johnson, Watchdog group wants to know if White House is interfering in decision to block Anthem-Cigna merger, *Washington Post Wonkblog,* March 24, 2017, www.washingtonpost.com/news/wonk/wp/2017/03/24/watchdog-group-wats-to-know-if-white-house-is-interfering-in-decision-to-block-anthem-cigna-merger/?utm_term=.294ebd02cea6