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POLICY CENTER
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POLICY BRIEF

Update on administrative changes to the Affordable Care Act

By Dr. Roger Stark, Policy Analyst,
Center for Health Care

September 2018

Key Findings

1. *The sweeping Affordable Care Act (ACA) has not come close to reaching its supporters' promised goals of providing universal health insurance coverage and decreasing ever-rising health care costs.*
2. *Congress has been unable to act to reform and improve the U.S. health care system.*
3. *The Trump Administration has taken a number of actions outside of the ACA in an effort to hold down costs and increase access to health care:*
    - *Discontinued the unauthorized cost-sharing reduction payments.*
    - *Extended the use of short-term, limited-duration plans.*
    - *Eliminated cost-reduction subsidies.*
    - *Encouraged association health plans.*
    - *Reduced funding for navigators and advertising*
    - *Improved the economy, leading to more employers providing health benefits.*
4. *In addition to executive-order changes, the ACA contains two broad areas that are open to Administrative interpretation. These are Section 1332 state waivers and Section 1115A state Medicaid waivers.*
5. *States, either through legislation or the waiver process, have been active in attempting to decrease health care costs and improve health care access for their residents.*
6. *This policy trend has produced positive results for citizens, and is achieving one of the long-sought goals of national health care policy – making quality coverage more affordable for everyone.*

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Update on administrative changes to the Affordable Care Act

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Introduction

The controversial Affordable Care Act (ACA), also known as Obamacare, has helped some people gain health care coverage. The tragedy is that the sweeping federal law has not come close to reaching its supporters' promised goals of providing universal health insurance coverage and decreasing ever-rising health care costs.

The complex law has not improved health care quality and has not provided patients with more health care choices. It has, unfortunately, forced millions of people to lose health coverage that they liked, and be forced to seek new health insurance while imposing a huge financial and regulatory burden on the vast majority of Americans.[1]

This study describes and analyzes the federal and state administrative changes that have been made so far in the Obamacare program. This is an update to our major study released in January 2018.

Background: The Impact of the Affordable Care Act

To date, the ACA has only insured 20 million of the 50 million people who were without health insurance when it became law. Nationally, half of these newly insured people were forced into the substandard Medicaid entitlement program. In Washington state, 80 percent of the newly insured found themselves pushed into Medicaid.

Obamacare has raised insurance premiums for virtually everyone in the country outside of the free Medicaid entitlement. Health care spending was 17 percent of the economy when the ACA became law in March 2010. By 2021, with the ACA in place, government estimates show that the country will spend 21 percent of the annual economic production on health care. The ACA has limited patients' insurance options, has generated over 20,000 pages of new federal regulations, has not improved health quality, and has not decreased waste, fraud, and abuse in the medical system.

In 2016, in part due to the unpopularity of the ACA, voters gave Republicans control of the presidency and of both houses of Congress. The U.S. House of Representatives passed a partial repeal of the ACA and a health care reform bill in

1 "Update on the status of the Affordable Care Act," by Roger Stark, MD, Policy Brief, Washington Policy Center, December, 2016, at http://www.washingtonpolicy.org/library/doclib/PB-Affordable-Care-Act. pdf.

May 2017.[2] House leadership stated this legislative step was to be the first of three phases.[3]

Phase two is executive-order changes to the ACA that the Trump Administration can make without Congressional action. This phase uses the 1,400 "Secretary shall..." provisions that Democrats wrote into the original law giving the executive branch wide discretion in changing and implementing the law.

Phase three would hopefully be passage of bipartisan, long-term solutions for the country's health care system problems. Thus far, the U.S. Senate has been unable to pass health care reform legislation. Consequently, phase two takes on more importance, as the only present means the Trump Administration has to affect health care policy

In addition to executive-order changes, the ACA contains two broad areas that are open to Administrative interpretation. These are Section 1332 state waivers and Section 1115A Medicaid waivers. States must apply to the federal government for these waivers, which can then be used to implement state-based changes to the ACA.[4]

Federal executive actions to date

Waivers

The Trump Administration has been aggressive about encouraging states to apply for 1332 ACA waivers. As of July 2018, six states have had 1332 waivers approved, two states have waivers pending, and six states have incomplete applications.[5]

States have also taken advantage of Medicaid 1115A waivers.[6] To date, 43 states have had 1115A waivers approved and 22 have them pending. Washington state has had one 1115A waiver approved.

Cost-reduction subsidies

The Affordable Care Act has three revenue-neutral provisions for market stabilization in the Obamacare exchanges.[7] Reinsurance and risk corridors began in 2014, ran for three years, and, by law, ended in 2016. The federal reinsurance program covered high-cost people and was funded by an excise tax on all insurance premiums. Risk corridors limited losses and gains for insurance companies within the exchanges by having the federal government redistribute money from profitable insurance companies to insurance companies that lost money.

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2 "H.R. 1628, – the American Health Care Act of 2017," 115th Congress, CONGRESS.GOV, at https://www. congress.gov/bill/115th-congress/house-bill/1628.

3 "The three phases of repeal and replace," Speaker of the House Paul Ryan press release, March 7, 2017, at https:// www.speaker.gov/general/three-phases-repeal-and-replace.

4 "Administrative improvements to the Affordable Care Act and state options for health care reform," by Roger Stark, MD, Policy Brief, Washington Policy Center, January, 2018, at https://www.washingtonpolicy.org/library/doclib/Stark-Administrative-improvements-to-the-Affordable-Care-Act-and-state-options-for-health-care-reform.pdf.

5 "Tracking Section 1332 State Innovation Waivers," Henry J. Kaiser Family Foundation, July 16, 2018, at https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/.

6 "Medicaid waiver tracking: which states have approved and pending Section 1115 Medicaid Waivers?," Henry J. Kaiser Family Foundation, July 26, 2018, at https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/.

7 "Explaining health care reform: risk adjustment, reinsurance, and risk corridors," by C. Cox, A. Semanskee, G. Claxton, and L. Levitt, The Kaiser Family Foundation, August 17, 2016, at http://www. kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-andrisk-corridors/.

Risk adjustment began in 2014 and is set to continue indefinitely. Risk adjustment redistributes funds from insurance plans that have low-risk patients to plans with high-risk patients based on actuarial data. It is designed to be cost neutral.

The ACA also provides subsidies for low-income individuals above and beyond the standard exchange subsidies. These so called cost-sharing reduction subsidies were never funded by Congress, specifically due to inaction in the U.S. House of Representatives. The Obama Administration then unilaterally instructed the Treasury Department to pay out these funds, which were renewed on a monthly basis.

The U.S. House of Representatives, led by its Republican leadership, sued the Obama Administration for allowing unconstitutional spending out the Treasury and won. Congressional leaders successfully argued that it was illegal for the Obama Administration to pay out money from the U.S. Treasury without authorization from Congress. The Obama Administration appealed. The Trump Administration essentially dropped the lawsuit and discontinued the unauthorized cost-sharing reduction payments.

Regardless of whether the cost-sharing reduction subsidies are in place, the exchanges continue to attract a greater number of older and sicker people and comparatively fewer young and healthy individuals. The exchanges are on a downward path to financial collapse, regardless of whether or not the federal subsidies are paid out.

The individual mandate

A fundamental part of the ACA was the individual mandate that forced all adult Americans to own a health insurance policy or pay a penalty. The U.S. Supreme Court ruled in 2012 that the penalty for not owning insurance was actually a "tax."

As part of the major tax reform law passed in 2017, Congress repealed the tax on not owning health insurance. Without the penalty as enforcement, this 2017 law effectively repealed the individual mandate beginning in 2019.

Essential health benefits

The ACA states that every health insurance plan must contain ten well-defined essential health benefits (EHB). These benefits were determined by bureaucrats who do not necessarily understand the needs of any specific patient. For example, an unmarried man does not need an obstetrical coverage "essential benefit," yet he is forced to pay a higher premium for it.

Through the 1332 waiver process, the Administration has been open to changes from the states in the EHB requirement to expand coverage choices and to make health insurance more affordable.[8]

Short-term, limited-duration health insurance

In December 2016 the Obama Administration issued what was thought to be the final definition and regulations regarding short-term, limited-duration health

8 "Trump Administration encourages states to ask for Obamacare waivers," by Tom Howell, Jr., *The Washington Times*, May 16, 2017, at https://www.washingtontimes.com/news/2017/may/16/trump-administration-encourages-states-to-ask-for-/.

insurance. These policies are designed for people between jobs or for individuals transitioning from one health insurance plan to another.

The plans are affordable because they are not required to contain all of the costly essential health benefits required in the ACA, but could potentially offer affordable major medical or catastrophic coverage. The Obama Administration set the limit for use of a short-term plan at three months.

The Trump Administration has extended the three-month coverage limit to one year, renewable for the next two years. The Administration could extend the time duration of short-term plans indefinitely, and thereby give people more choices in the health insurance marketplace.

Even if a short-term plan did not satisfy the EHB mandates requirement, in all likelihood, it would be more cost effective and provide satisfactory coverage for young and healthy people.

Navigators, certified application counselors, and advertising

The ACA provides millions of dollars in grant money to hire government employees who help enrollees find the most appropriate, government-approved health insurance plan within the exchanges. There are several categories of helpers, including navigators and certified application counselors. These new government employees essentially duplicate the function of private insurance brokers and compete with them for clients. Insurance brokers and online services have a long-standing relationship with the American public and offer real benefits to customers.

Like any business, health insurance companies allocate money for advertising. The ACA supplies additional money for enhanced advertising. It is always problematic when the government requires citizens to pay taxes, and then uses that money to promote itself over private-sector alternatives.

The Trump Administration has cut the navigator and advertising budgets by millions of taxpayer dollars.[9]

Expand and promote the use of association health plans

Association health plans (AHP) allow small groups and individuals to join together to purchase health insurance in the same way large groups do. Large group plans are regulated by the federal ERISA law and therefore avoid many of the most restrictive and cost-adding features of the ACA.

AHPs also have the potential to reduce health care costs by increasing the number of people in the risk pool and by offering insurance with fewer mandated essential health benefits.

The Trump Administration has encouraged AHPs and has issued rulings on their implementation.[10] Multiple research groups estimate that four million people

9 "Trump slashing Obamacare funding by 90%," by Tami Luhby, CNN Money, August 31, 2017, at https://money.cnn.com/2017/08/31/news/economy/obamacare-trump-advertising/index.html

10 "Trump administration finalizes rule to expand association health plan access," by Virgil Dickson, *Modern Healthcare*, June 19, 2018, at http://www.modernhealthcare.com/article/20180619/NEWS/180619904/.

will potentially take advantage of AHPs over the next five years, gaining access to affordable coverage options that were not available before.

The economy

Half of all Americans receive their health insurance from their employers or their spouse's employer.

The Trump Administration has decreased the regulatory burden on employers and at the same time has supported passage of tax reform in Congress. These measures have resulted in the lowest unemployment rate the country has experienced in decades.

This new hiring has resulted in the first increase in employer-paid health benefits seen in six years. In 2017, 69 percent of employers offered health insurance, up from 67 percent in 2016.[11] The higher the number of employers offering health benefits, the greater the number of Americans who have access to affordable health insurance.

State legislative and regulatory actions

Approved 1332 waivers for states

Federal officials have approved 1332 waivers for Alaska, Minnesota, Wisconsin, Maine, and Oregon to establish state-based reinsurance programs. Hawaii used a 1332 waiver to align its previously-established employer mandate with the requirements of the Small Business Health Options Program (SHOP) provisions of the ACA.

Pending 1332 waiver requests

Officials in New Jersey and Maryland have applied for federal waivers to establish reinsurance programs in their states.

1332 waivers deemed incomplete

Vermont wants its small employers to be able to enroll employees in the individual market without the use of SHOP. Ohio wants an official ruling to repeal the individual mandate, not just the tax for not owning health insurance. Since the cost reduction subsidies (CRS) program has been repealed, Massachusetts wants to place a premium surcharge on health insurance plans that would offset the loss of its CRSs.

These requests are under consideration and Federal officials have not yet issued a final decision on waiver applications from these states.

Withdrawn 1332 waivers

Several states applied for a 1332 waiver, but subsequently withdrew their application. California sought to allow illegal immigrants to purchase health insurance through the ACA exchange, without taxpayer subsidies. Iowa wanted to offer a single health insurance plan and establish a reinsurance plan. Oklahoma wanted to set up a reinsurance program.

11 "Trumpcare beats Obamacare; An encouraging expansion in private insurance coverage," by James Freeman, *The Wall Street Journal*, July 23, 2018, at https://www.wsj.com/articles/trumpcare-beats-obamacare-1532370778?mod=searchresults&page=1&pos=3.

1115A Medicaid waivers

The waivers have differences, but they fall into five broad categories:

- Requests for delivery system changes (most of these go from a fee-for-service model to a managed-care or health maintenance organization model.)
- Requests for modifications of a state's long-term care system.
- Creative ways of expanding Medicaid or reallocating funds.
- Changes in behavioral and mental health funding.
- Changes specific to individual aspects of the Medicaid program, such as a work requirement, a lifetime cap on eligibility, and means testing based on total asset ownership.

Arkansas, Indiana, and Kentucky[12] have had waivers approved to institute a work requirement. Seven other states have a work requirement waiver pending. Legal challenges are expected against these work requirements.

Officials in Washington state submitted a 1115A waiver application to the federal government in 2015. It was approved by the Department of Health and Human Services in 2016. The waiver has allowed the state to transform the state-managed Medicaid program from a fee-for-service plan to a managed care program using regional accountable care organizations.

Individual mandate

Massachusetts had a state-based individual mandate as a part of its Romneycare program, which pre-dated the ACA.[13] Consequently, the federal tax repeal in 2017 does not effect Massachusetts residents. The New Jersey legislature passed its own state individual mandate which will take effect in 2019.[14]

Several other states and the District of Columbia are considering enactment of individual mandate laws to apply to their residents.

Short-term, limited-duration health insurance

Because of state laws, residents of New York, New Jersey, Massachusetts, Vermont, and Rhode Island do not have the option of purchasing short-term, limit-duration health insurance plans.[15]

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12 Although the Kentucky waiver was approved by the federal administration, a Kentucky court invalidated the work requirement.

13 https://www.bostonglobe.com/business/2017/12/20/despite-action-congress-mass-individual-mandate-remains/7LuXPvjpQ1VeZMjHCjx5GP/story.html

14 http://www.governing.com/topics/health-human-services/gov-new-Jersey-passes-individual-mandate-law.html

15 https://www.healthinsurance.org/short-term-health-insurance/

Policy analysis

In spite of the 20 million "newly" insured, Obamacare has been a clear policy failure. Except for the enrollees in the Medicaid entitlement program, virtually every person with health insurance in the United States has experienced a loss of choice and a significant increase in insurance premiums.

Millions have lost insurance plans they liked, lost access to their doctors, and have seen the cost of their deductibles go up. Access to health care is a growing problem, especially in the Medicaid and Medicare entitlement programs. Just having health insurance on paper is no longer a guarantee of getting necessary health care services in a timely fashion.

There is wide agreement that the health care system was dysfunctional before the ACA became law. Going back to the situation as it existed before 2010 is not a solution. Going forward, the country has two choices at this point: 1) impose more government control at an ever-increasing cost to taxpayers, or; 2) move toward more decentralized patient control, affordability, and choice.

Policymakers could increase government control by further expanding Medicaid, allowing non-seniors to buy into Medicare, offering a public, socialized option in the individual market and placing more regulations on the employer-paid market. With these maneuvers, a mandatory single-payer, government-run health care system, like that in Canada, could soon become a reality in the United States.

Alternatively, policymakers could move toward giving patients more control and re-establishing the private relationship between patients and doctors, while reducing government-directed interference.[16]

Former President Obama bypassed Congress and used administrative fiat liberally to expand government control over people's access to health care. In contrast, the Trump Administration has been using administrative action to move policy in the direction of empowering patients, rather than government regulators. States, either through legislation or the waiver process, have also been active in attempting to decrease health care costs and improve health care access for their residents.[17]

Conclusion

The goal of any reform should be to give patients the greatest control of their own health care, just as citizens control other essential aspects of their lives. Patients, acting as health care consumers, would demand more transparency in pricing and, just as happens in other areas of life, would promote competition, and improve quality and service. As a result, natural competition in a normally-functioning health care market would drive costs down and increase access to quality health care for all Americans.

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16 "Health care reform; lowering costs by putting patients in charge," by Roger Stark, MD, Policy Brief, Washington Policy Center, June, 2015, at https://www.washingtonpolicy.org/library/docLib/Stark-_Health_care_reform_and_alternatives_to_the_Affordable_Care_Act.pdf.

17 For a complete list of reform possibilities, see "Administrative improvements to the Affordable Care Act and state options for health care reform," by Roger Stark, MD, Policy Brief, Washington Policy Center, January 2018, at https://www.washingtonpolicy.org/library/doclib/Stark-Administrative-improvements-to-the-Affordable-Care-Act-and-state-options-for-health-care-reform.pdf.

Congress seems unable to act to reform and improve the U.S. health care system. The executive branch has acted and is using the legal administrative authority given to it by Congress to work toward meaningful reform. Similarly, policymakers in certain states are pursuing practical measures that are allowed outside of the ACA to increase access and health care choices for patients. This policy trend has produced positive results for citizens, and is achieving one of the long-sought goals of national health care policy – making quality coverage more affordable for everyone.

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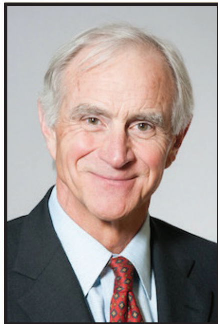

About the Author

Dr. Roger Stark is the health care policy analyst at Washington Policy Center and a retired physician. He is the author of two books including *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He has also authored numerous in-depth studies on health care policy for WPC, including *The Impact of the Affordable Care Act in Washington State, A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States, What Works and What Doesn't: A Review of Health Care Reform in the States,* and *Health Care Reform that Works: An Update on Health Savings Accounts*. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees in Washington DC regarding the Affordable Care Act. Dr. Stark graduated from the University of Nebraska's College of Medicine and he completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He has served on the hospital's governing board. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. He currently serves on the Board of the Washington Liability Reform Coalition and is an active member of the Woodinville Rotary. He and his wife live on the Eastside and have children and grandchildren in the area.