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CLIENT ALERT

Assessing President Trump's "Executive Order Promoting Health Care Choice and Competition"

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Executive Summary

On October 12, 2017, President Donald Trump signed an executive order (the "Order") designed to "promote healthcare choice and competition across the United States," which in effect will allow many Americans to sidestep protections under the Affordable Care Act ("ACA").[1] The Order instructs various departments to consider regulations relating to three main areas: (1) association health plans ("AHPs"); (2) short-term, limited duration insurance products ("STLDI"); and (3) health reimbursement arrangements ("HRAs"). Each area threatens to destabilize the ACA exchanges in different ways, and each proposal may be subject to legal challenges. While the effective date of final regulations may be relatively distant, the administration may act quickly to develop proposed regulations that will invite public comment. Therefore, interested parties should prepare for regulations relating to AHPs, STLDI, and HRAs and understand the effect that regulations regarding each may have on healthcare providers and insurers, as well as the general population.

The Order

The Order requires the Secretaries of Health and Human Services ("HHS"), Labor, and Treasury ("Secretaries") to "consider proposing regulations or revising guidance" as directed in the Order within 60 days (i.e., January 4, 2018), or 120 days for regulations relating to HRAs. While the Secretaries could revise departmental guidance with little administrative burden, many of the proposed changes will need to be made through regulation. As a result, there will be little immediate impact from the Order. In order for each Secretary to change or create new regulations that implement the intent of the Order, each will have to go through the rulemaking process under the Administrative Procedure Act. This procedure requires a department that intends to create new regulations to (barring extraordinary circumstances) (1) draft the regulations, (2) publish

[1] Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017).

the draft regulations in the Federal Register and invite public comment on them, (3) consider the public comment and revise the draft regulations accordingly, and (4) publish the final rule in the Federal Register no less than 30 days prior to the effective date of the regulation.[2] The process is not quick. If the rulemaking process commenced pursuant to the Order moves smoothly, regulations that would have a practical effect would not become effective for months. If one considers that the Order does not compel the Secretaries to publish proposed regulations within 60 (or 120) days (but rather to "consider proposing regulations" within 60 or 120 days), the potential for voluminous public comment and subsequent revisions, and potential litigation, the timeline for the implementation of final effective regulations may be over a year away.

Association Health Plans

AHPs afford the opportunity for groups of small employers to join together and be treated like large employers for purposes of the ACA, the Employment Retirement Income Security Act of 1974 ("ERISA") and state insurance law.

Under current regulations, an AHP that is organized amongst small groups that have a "commonality of interest" are treated like a single large employer, thus avoiding (i) many ACA requirements such as essential health benefits, cost-sharing limits and pre-existing condition requirements and (ii) if self-funded, many state insurance laws per the ERISA preemption clause (multiple employer benefit plans, or multiple employer welfare arrangements ("MEWAs"), being the main exception). The "commonality of interest" exception has been interpreted very narrowly by the Department of Labor, with most state insurance departments, Congress and others repeatedly opposing expanding this definition.

The Order recognizes this and instructs the Secretary of Labor to propose regulations or revise guidance "to expand access to health coverage by allowing more employers to form AHPs." Specifically, it calls on the Secretary of Labor to expand the commonality-of-interest requirement, and consider permitting the formation of AHPs based on "common geography or industry".

By not having to comply with many ACA mandates and most state insurance laws, AHPs would likely be able to offer health plans at a lower cost, albeit with less coverage, thus attracting a healthier population. AHPs would likely pull such members from current small group plans including small group exchange products, leaving them with a less healthy population with higher premiums, i.e. segmenting the small group market.

There are many uncertainties, however. It is unclear how the administration would address AHPs composed of individuals (as opposed to small groups) since ERISA only

[2] There are numerous exceptions to the procedure summarized here, including expedited "interim final rules," "good cause" to expedite the effective date of a proposed rule, or extended delays prior to the effective date of "significant" or "major" final rules. The procedure outlined in this article is, however, the most common route for the drafting of regulations, and the Order does explicitly call for the Secretaries to consider public comment in their rulemaking.

applies to employees, not individuals who are not employees. Nor is it clear how the administration would address selling AHPs across state lines although it states that it is a goal of the administration to "facilitate the purchase of insurance across state lines". One common concern with selling across state lines is forum shopping and the "race to the bottom" to find the least regulated state law. Lastly, the Order did not address any plans to change states' authority to regulate MEWAs.

Short Term, Limited Duration Insurance

STLDI policies are designed for use over a limited period to cover short-term gaps between a person's access to more comprehensive coverage, and are not intended to provide primary coverage. These products do not meet the requirements of individual health insurance coverage under the ACA (due in part to the fact that they do not provide "Minimum Essential Coverage" and permit exclusions for pre-existing conditions); therefore, holding these policies does not relieve an individual from tax penalties for failure to be insured under the ACA. Instead, STLDI plans are designed to cover basic, medically necessary services and services to treat acute conditions. Deductibles and out-of-pocket maximums are extraordinarily high in comparison to individual market products (out-of-pocket maximums can range from in excess of $5,000 to $20,000). Historically low utilization by a healthier population for periods longer than 90 days has resulted in these plans yielding an average medical loss ratio of less than 70 percent. Health plans on the individual market are required to have a minimum medical loss ratio of at least 80 percent.

STLDIs, like other high-deductible plans, are attractive to healthier individuals who have relatively low medical utilization rates, and therefore prefer the cheaper premiums STLDIs offer in exchange for high out-of-pocket costs. Because of this, the HHS, Treasury, and Labor Departments issued new regulations in October of 2016, effective for all STLDI policies issued on or after January 1, 2017. The regulations limited coverage terms to less than three months (including renewals), which aligns with the maximum period for qualifying coverage under the ACA before individuals are subject to a penalty.[3]

Section III of the Order directs the Departments of HHS, Treasury, and Labor to expand the availability of STLDI, allow STDLI policies to cover terms in excess of the current 3-month limit, and be renewable for additional terms.

The reversal of the 2016 regulations is intended to foster more options for individuals in the individual market. It could in effect, however, cause healthier individuals to leave plans that offer Minimum Essential Coverage, leaving such plans with a riskier population more likely to prefer comprehensive coverage to low premiums. The potential regulations are somewhat unlikely to have a substantial effect on the marketplace, because the availability of an STLDI policy for an extended period of time has only recently been limited, meaning the proposed regulatory change would essentially revert the individual marketplace to its pre-2017 norm.

[3] The regulations also require plans to include mandatory disclaimers informing potential applicants that the plan does not qualify as Minimum Essential Coverage under the ACA.

Health Reimbursement Arrangements

Under current regulations and interpretive guidance, an HRA is an employer-sponsored fund that may be used to reimburse employees, tax free, for certain qualified medical expenses up to a maximum dollar amount.[4]

Although HRAs are not explicitly mentioned in the Tax Code or the ACA, the Internal Revenue Service ("IRS") has determined that, as tax-exempt group health plans, they must comply with ACA group health plan requirements.[5] Thus, under current interpretive guidance, an employer cannot use an HRA simply to pay premiums for coverage of employees and their dependents in the individual market.

Due to employer's unhappiness with the guidance that limited the use of HRAs for premium coverage, Congress included in the 21st Century Cures Act a limited exception that allowed a subset of employers to use HRAs for that purpose. Through the law, eligible small businesses (those exempt from the ACA employer mandate) can use a type of HRA called "Qualified Small Employer Health Reimbursement Arrangements" ("QSEHRAs") to allow employees to use HRA funds to pay for premiums and cost-sharing for individual insurance coverage. Over half of QSEHRA-eligible employers already sponsor health coverage for employees, however, and if an employee whose employer funds an HRA for them is also eligible for premium tax credits under the ACA, the HRA funds are clawed-back.[6] As a result, the impact of the QSEHRAs is limited both practically and legally.

The Order provides that the Secretaries of the Treasury, Labor, and HHS shall consider regulations to achieve three goals relating to HRAs: (1) increase the number of permitted uses for HRAs; (2) expand employers' ability to offer HRAs to their employees; and (3) allow HRAs to be used in conjunction with non-group coverage.

Based on the regulatory and political history of HRAs, some possible steps the agencies may take pursuant to the Order include: (1) re-issuing the HRA guidance to allow employers that are too large to qualify as a QSEHRA to use HRAs for the cost of premiums for individual insurance plans while maintaining the tax-exempt treatment; (2) allowing the use of HRAs for employer financing of premiums for STLDIs and AHPs to support the development of those markets; (3) allowing for greater variation in HRA offerings by state to allow employers to target the HRAs to specific insurance markets (HRAs currently must be offered on the same terms to all employees with limited exceptions); and (4) reducing the notification and reporting requirements. Although it

[4] Qualified medical expenses are those specified in the plan that generally would qualify for the medical and dental expenses deduction.

[5] HRAs are not formally recognized in the Tax Code, but were rather created by IRS interpretive guidance allowing for HRA plans to receive the group health plan tax exemption. IRS Notice 2002-45; *available at*: https://www.irs.gov/pub/irs-drop/n-02-45.pdf.

6 Specifically, the amount of the premium tax credit will be reduced dollar-for-dollar by the monthly HRA amount. For example, if an employee qualifies for a $500 premium tax credit but receives $400 in monthly HRA contributions from his or her employer, he or she will receive a $100 premium tax credit.

seems as if the administration would like to allow for the use of HRAs or QSEHRAs for individual insurance premiums for employees who are eligible for the premium tax credits without the claw-back of the tax credit, it is unclear how that would be possible under current law because the IRS prohibits double-dipping on tax benefits.

If the administration revises the HRA regulations and guidance to allow large-group employers to use HRAs for the cost of premiums for non-group insurance plans, it may contribute to the erosion of group insurance markets and will likely put additional pressure on the individual market, including the exchanges/marketplaces. If employers can push unhealthy employees into the individual market through the marketplaces, this will further undermine the individual risk pool.

Similarly, if the administration revises the HRA regulations and guidance to allow for the use of HRAs and QSEHRAs for association and short-term plans, it may contribute to an increase in demand for those types of plans and contribute to the further erosion of the individual market subject to ACA market regulations.

The Order is likely to face litigation to prevent its implementation, and such litigation will likely highlight an issue with HRAs that has previously been disputed. In adopting the QSEHRA program through the 21st Century Cures Act, Congress essentially accepted the Obama administration's assessment of the risks posed by broad HRA adoption to the markets and created a strictly limited exception. The reason Congress addressed the issue was due in part to the fact that the IRS did not believe the ACA permitted it to create the exception to HRAs that Congress eventually legislated. Attempts by the administration to unilaterally expand the scope of HRAs would seemingly run counter to the IRS's previous stance on the expansion of HRAs, and may well be prohibited by Congress's legislative authority.

Stakeholder Takeaway

Once issued the regulations are issued pursuant to the Order, stakeholders should be prepared to comment on the regulations, and study them for the impacts they may have to employers, insurers, providers, and many others in the health care space.

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This Client Alert was authored by **Karen L. Cavalli; Helaine I. Fingold; Kevin J. Malone; Gregory R. Mitchell;** *and* **Jackie Selby.** *For additional information about the Order and how it may impact you, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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