

**Promoting Healthcare Choice and Competition across the United States**

**Executive Order Issued on October 12, 2017**

**Summary**

Below is a summary of the provisions in the President’s Executive Order (EO) concerning health care coverage. The EO itself does not implement regulatory changes; it is a directive to the Departments of Labor, Treasury, and Health and Human Services to propose regulatory changes intended to expand access to health care coverage through: Association Health Plans (AHPs); short-term, limited-duration insurance (STLDI); and health reimbursement arrangements (HRAs). The EO also expresses the Administration’s focus on improving competition in the health care market by “lowering barriers to entry, limiting excessive consolidation, and preventing abuses of market power,” as well as improving access to information to help patients/consumers make informed health care decisions, including “data about healthcare prices and outcomes, while minimizing reporting burdens on affected plans, providers, or payers.”

**Association Health Plans**

The EO directs the Department of Labor to consider expanding access to Association Health Plans (AHPs) to potentially allow employers in the same line of business anywhere in the country to join together to offer group healthcare coverage to their employees. Thus, allowing the selling of insurance across state lines. The EO does not include allowing individuals to group together to form or join an AHP. It is unclear whether self-employed individuals would be able to group together.

In addition, if AHPs are considered ERISA plans and are self-insured, all state insurance law is preempted. Thus, no state patient or consumer protection, network adequacy or transparency, benefit mandates, or prompt payment laws would apply to the ERISA self-insured AHPs.

Policy D-165.971 supports any AHPs that safeguard state and federal patient protection laws, including those state regulations regarding fiscal soundness and prompt payment. Similarly, Policy H-180.946 supports the selling of insurance across state lines that ensure that patient and provide protection laws are consistent with and enforceable under the laws of the state in which the patient resides. With ERISA, Policy H-285.915 calls for the elimination of the ERISA preemption of self-insured health plans from state regulation.

Overall, the Department of Labor will redraft rules to allow small employers to join together to form AHPs with large group designation. Given that an EO generally provides directions for an agency to take action, we currently do not know how much impact the EO may have on the insurance markets. AHPs may split the current small group market into two markets based off of health status. If self-employed individuals are allowed to join AHPs, it may also segment the individual market.

**Short-Term, Limited Duration Insurance**

The EO directs the Departments of Treasury, Labor, and HHS, within 60 days, to consider proposing regulations or revising guidance to expand the availability of STLDI. The EO directs the Secretaries to consider allowing such insurance to cover longer periods and be renewed by the consumer. Under rules issued by the Obama Administration in October of 2016, the duration of STLDI plans was shortened from less than 12 months to less than 3 months. These plans tend to limit benefits or offer policies only to individuals who do not have expensive medical conditions, and do not meet the minimum essential coverage requirements of the ACA—individuals who buy them may be subject to tax penalties. ACA advocates and some policy experts have argued that expanding such plans could keep healthier consumers out of the ACA exchanges, thereby dividing the market and making it unstable. This could also result in rising premiums—in some cases, unaffordable premiums—for those individuals who want to buy more comprehensive coverage.

In terms of AMA policy, expanding the availability of STLDI would be inconsistent with Policy H-165.838, which supports the elimination of denials for pre-existing conditions, as well as Policy H-165.856, which supports health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. Policy H-165.856 also calls for greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan, and states that departures from national regulations should not drive up the number of uninsured or create adverse selection – a threshold that expanding coverage through STLDI does not meet. This would also be inconsistent with a multitude of policies in support of meaningful coverage; provisions to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations; and coverage of preventive services, maternity care, and mental health and substance use services. In addition, such policies would be inconsistent with Policy H-185.952 supporting the elimination of lifetime maximums of health insurance benefits, and inconsistent with Policies H-155.959, D-155.993, D-330.923 and H-320.968 addressing medical loss ratios.

**Health Reimbursement Accounts**

The EO also directs the Departments of Treasury, Labor, and HHS to, within 120 days, consider changes to Health Reimbursement Arrangements (e.g., employer-funded accounts that reimburse employees for healthcare expenses) so that employers can expand their use of them. Policy H-165.854 supports HRAs as one mechanism for empowering patients to have greater control over their health care decision-making. Policy D-165.954 states that our AMA will educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with HRAs and other forms of consumer-driven health care, and monitor and support rigorous research on the impact of HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

**Comments**

In general, the AMA supports patient choice, reducing physician reporting burdens, and promoting market competition, and supports the concept of association health plans. The EO must be viewed, however, in the context in which it is being offered. It includes pejorative comments on the Affordable Care Act (ACA), which the AMA supports and is advocating to improve—including stabilizing the individual insurance markets in the ACA Exchanges. Also, in a separate announcement on October 12, the Trump Administration announced it will no longer reimburse insurers for the ACA’s cost-sharing reductions for low-income individuals, which will further destabilize the individual markets in the ACA Exchanges. Until further details are released, it would be difficult to determine the extent of the impact the EO will have on access to meaningful and affordable health insurance coverage. We are concerned, however, that the EO’s proposal to expand access to association health plans and allow short-term plans to cover longer time periods may weaken important patient protections and lead to instability in the individual and small group health insurance markets.