Policy Alert

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Affordable Care Act: Executive Actions and Legislative Outlook

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On January 28, 2021, President Biden issued an Executive Order on Strengthening Medicaid and the Affordable Care Act, responsive to Democrats' longstanding commitment to "roll back Trump's health care sabotage [of the Affordable care Act (ACA)] and expand coverage." The Executive Order (EO) is simply the first step; the Biden-Harris administration will now turn to implementing the EO while pursuing its immediate priority of responding to the COVID-19 pandemic. Stakeholders may see delays with implementation. The Department of Health and Human Services (HHS) and its operating division, the Centers for Medicare & Medicaid Services (CMS), are, at the date of publishing, significantly understaffed with few political appointees who typically play critical roles in policy development and implementation. When they are appointed, they will be working to implement a sweeping range of executive actions, including ongoing initiatives in response to the COVID-19 pandemic.

Congress, by contrast, may move more swiftly. With opportunities to utilize the budget reconciliation process, the annual appropriations process and other pending health care measures as potential vehicles, it is likely Democrats will seek to pass legislative provisions bolstering the ACA. Navigating slim majorities in both chambers, Democrats will turn to enhancing the ACA after working to advance a shared legislative agenda for economic and COVID-19 relief. This alert provides an overview of both the ACA EO and its implications, as well the legislative outlook for ACA-related legislation in Congress.

Special Enrollment Period and ACA Marketing

The ACA EO requires the Secretary of HHS to "consider establishing a Special Enrollment Period…through the Federally Facilitated Marketplace…." On the day the EO was signed, HHS announced a Special Enrollment Period (SEP) in response to the COVID-19 emergency, to begin February 15, 2021, and end May 15, 2021. Currently, 30 states have Federally Facilitated Marketplaces where HHS performs all marketplace functions. Six states (AK, KY, ME, NM, OR and VA) have State-Based Marketplaces that rely on federal platforms. It is not clear whether these states are covered by the EO, though some have indicated they will comply. The remaining 14 states (CA, CO, CT, DC, ID, MD, MA, MN, NV, NJ, NY, PA, RI, VT and WA) and the District of Columbia are responsible for all marketplace functions and therefore are not

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covered by the EO. At least two states, California and Washington, have announced they will conduct SEPs, and other states are expected to follow suit.

The Biden-Harris administration is seeking to bolster ACA-related marketing efforts that had been significantly curtailed in recent years, and it will have additional monetary resources to do so. A recent estimate from the Kaiser Family Foundation indicated the Trump administration refrained from spending the full amount of available funding from marketplace user fee revenue on the order of approximately $400 million annually between Fiscal Years 2018 to 2020. Because this funding carries over, the current administration reportedly has at its disposal $1.2 billion to "support marketplace enrollment, including navigator consumer assistance, marketing and outreach, the HealthCare.gov marketplace website, and the federal marketplace call center."

ACA Executive Order Implementation: Review of Regulations and Potential Rulemaking

The ACA EO directs the Secretaries of HHS, the Treasury and Labor and "all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA" to conduct an "immediate review" of agency actions to determine whether they are inconsistent with the administration's stated policy of support for the ACA. The EO directs agencies to examine policies or practices that might undermine protections for people with preexisting conditions, including COVID-19 complications; demonstrations and waivers that may reduce coverage or undermine ACA or Medicaid; policies or practices that could undermine health insurance markets; policies or practices that could present unnecessary barriers to access for Medicaid or ACA coverage; and policies or practices that may make coverage more expensive.

The EO further directs that, upon identifying these policies, the agencies shall consider whether to suspend, revise or rescind them and consider whether to take further action to "more fully" enforce the Administration's policy of support for the ACA.

However, while the Biden-Harris administration has self-styled its flurry of executive actions as reminiscent of President Franklin Delano Roosevelt, it faces significant challenges in the execution of the orders. The first obstacle is prioritization. Some of President Biden's earliest executive actions were focused on fighting the COVID-19 pandemic, emphasizing the importance of the pandemic response to the administration. While the President's pandemic orders have redesigned the response's decision-making structure, the operational details will likely still fall to HHS and its operating divisions, consuming limited staff time and potentially leading to bottlenecks with key decision-makers.

The administration's ACA agenda also may be delayed as a result of a "skeleton" staff. Compliance with the ACA EO will require a thorough analysis of existing rules and extensive policy and technical decision-making. It falls to political appointees within HHS to make those decisions. These staff members are not Senate-confirmed, yet they are critical in monitoring the rulemaking process on a daily basis and driving the policy-level decisions to guide the agency's career technical experts as they draft regulatory language. To date, few political appointees have taken positions in HHS, including CMS, where the bulk of the ACA EO's implementation will occur.

While the lack of lower- and mid-level political staff presents an obstacle to the quick implementation of the Biden-Harris administration's health care agenda, the total lack of Senate-confirmed leadership may increase the risk of delay. The Senate is not expected to begin formal confirmation hearings for HHS Secretary-designate Xavier Becerra until after the impeachment trial of former President Donald Trump. President Biden's nominee for Deputy Secretary, Andrea Palm, has yet to receive a Senate hearing.

President Biden also has not nominated a CMS Administrator, nor has he announced the leadership of any of the agency's centers and offices—in particular, the Director of the Center for Consumer Information and Insurance Oversight (CCIIO), which manages many aspects of the ACA. With positions in the Immediate Office of the HHS Secretary, the Office of the CMS Administrator and the Office of the CCIIO Director all empty, and given policy-makers' immediate focus on the broader pandemic response, it seems likely that the administration will be hard-pressed to deliver quickly on its ACA policy goals.

Legislative Outlook

With two opportunities to utilize the budget reconciliation process (for Fiscal Years 2021 and 2022)—allowing them to bypass Republican opposition—congressional Democrats are likely to act both to shore up the existing ACA and to enhance the health law.[1] On February 1, 2021, House Budget Committee Chairman John Yarmuth (D-KY) released the text of the House budget resolution, the first step in the budget reconciliation process. The budget resolution contains instructions to committees, allowing the committees to consider legislation pursuant to those instructions. Among the goals of the resolution, according to Chairman Yarmuth is to "expand access to … affordable health care…." Likewise, on February 2, 2021, Senate Budget Committee Chairman Bernard Sanders (D-VT) released the text of the Senate budget resolution for Fiscal Year 2021. According to Chairman Sanders, the resolution will "enable the Senate to expand Medicaid."

Details remain sketchy regarding the nature and extent of the ACA-related policies that will be included in the first round of budget reconciliation. To help understand the universe of policies that could be considered, and are likely to be considered in the future, stakeholders might look to the House-passed Patient Protection and Affordable Care Act Enhancement Act (H.R. 1425, 116th Congress), sponsored by Rep. Angie Craig (D-MN). The bill is the latest iteration of congressional Democrats' years-long effort to bolster the ACA. Similar legislation has been introduced in the Senate in the 117th Congress by Sen. Mark Warner (D-VA).

The bill is comprehensive and builds upon the ACA in several ways. It rescinds Trump administration rules viewed as inconsistent with the ACA, including the expansion of short-term, limited-duration health insurance plans and changes to the premium adjustment percentage. Importantly, it expands premium tax credits beyond 400 percent of the federal poverty level (FPL) and reduces the amount of income required to be paid toward health insurance premiums, effectively increasing the subsidy amount.

The bill addresses the so-called "family glitch" by providing that an offer of employer-sponsored coverage does not preclude eligibility for premium subsidies. The bill

establishes a $10 billion annual Health Insurance Affordability Fund, beginning in 2022, which states may use to lower costs through reinsurance and other means. The legislation defers to CMS to develop an application process and allocation methodology for the fund. It provides $200 million to state-based marketplaces in the form of two-year grants; $200 million to promote innovation among states to increase coverage; $100 million annually for ACA-related marketing; and $100 million for ACA navigators (drawn from health insurance user fees).

The bill further promotes Medicaid expansion through a carrot-and-stick approach. Like the original ACA, the bill provides for the federal government to offset 100 percent of the cost of Medicaid expansion, reduced to 90 percent after three years (beginning the year the state began the expansion). The bill also would penalize non-expansion states by reducing their federal medical assistance percentage (FMAP) by one-half percent each quarter, up to ten percent, and requiring reporting to the federal government related to the number of uninsured individuals in those states.

Finally, the legislation contains several provisions unrelated to the ACA. It permanently authorizes the Children's Health Insurance Program, increases postpartum Medicaid eligibility, increases Medicaid reimbursement for primary care physicians who treat Medicaid patients, and extends Medicaid to U.S. territories. The final title of the bill is taken from Title I of the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3, 116th Congress), which the Democratic-led House passed in 2019. Specifically, these provisions would eliminate the Medicare Part D noninterference clause, allowing the federal government to negotiate drug prices and set an average international market price for some drugs.

[1] Under the Congressional Budget Act of 1974, the budget reconciliation process may only be used to consider policies with a direct effect on federal spending, and the determination as to whether a policy can be considered under the process is made by the President of the Senate, in consultation with the Senate Parliamentarian.

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