Managed Healthcare ExecutiveACA

Opinion: Trump's executive order will have limited impact on insurance market

October 25, 2017
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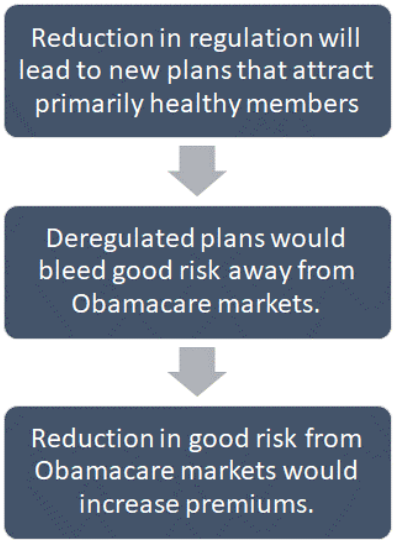
On October 12, President Trump signed an executive order to improve competition in Obamacare markets. Section 1a of the Executive Order seeks to "to facilitate the purchase of insurance across State lines."

While many analyses of Section 1a of the executive order cite doom and gloom for health plans, four tenuous contingencies *all* must take place in order for the executive order to have more than a limited impact on the individual health insurance market during the current presidential term.

Here are the four scenarios that must occur for the theoretical case in Figure 1 to take place:

Figure 1: Theoretical Impact of Executive Order on Insurance Markets



1. Regulations must be coordinated, well-crafted, and timely

An executive order itself has no regulatory power, therefore, there will be no immediate changes in any market right away. Changes will commence as a result of the formal regulatory process and will require a combination of the Department of Labor, Department of Health and Human Service and the Department of Treasury regulation.

Why this could be problematic:

Based on personal experience in the development of cross-departmental regulations, this type of regulation requires far more coordination than a regulation from a single department and therefore is frequently more time consuming than the six-month minimum regulatory process through a single agency. Generally, the development process for single-department proposed rules can take months or years, but optimistically, it could occur in 60 days. The NPRM must be available for comment for another 60 days. The administration must then finalize the rule after the end of the comment period which can take as little as an additional 30 days, but can also take months or years. Once the rule is finalized its effective date must be at least 30 days in the future. Overall, it will take a minimum of 180 days or six months for rulemaking to occur, making the requirements eligible for the 2019 plan year. However, any slippage from this deadline and health plans will have already made 2019 decisions, making the rulemaking first applicable to Plan Year 2020.

The Trump Administration may not be optimally positioned for success in shepherding a multi-department rule because of leadership vacancies:

- The Department of Health and Human Services has a confirmed appointment in seven of 18 key positions including the Secretary position.
- The Department of Labor has only one confirmed position out of 14, and
- The Department of Treasury has a confirmed appointment in nine of 28 positions.

Lastly, due in part to the Trump Federal hiring freeze in place from January 23, 2017 through April 12, 2017, the civil servants that actually develop new regulations are primarily career staff holdovers from the Obama and previous administrations, many of whom developed the original Obamacare regulations and may not be motivated to develop regulations that attempt to undermine markets they helped create.

2. States must participate

If regulations facilitating the purchase of health insurance across state lines are implemented, states are the primary regulators of insurance markets. All fifty states and the U.S. Territories license insurers and then license each specific product for sale after evaluating whether the product meets benefit requirements, rate setting rules, data reporting standards, marketing requirements, in addition to general oversight through each state's regulatory authority.

Why this could be problematic:

States value this regulatory authority; only four states elected for Federal enforcement of ACA market requirements in lieu of state enforcement, while 19 states rejected Medicaid expansion.

It is unlikely that states voluntarily cede regulatory authority to insurers based in other states meaning generally, states would need to be forced to permit unlicensed issuers into insurance markets.

Next: The final two scenarios

3. Insurers must overcome barriers to market entry

Even if regulations are successful and states participate, any change in the current market depends on health plans making a business decision to enter the market of a new state.

Why this could be problematic:

Georgia, Maine, and Wyoming already permit sale of insurance across state lines, however, this availability has not resulted in new insurance options in those states, according to a 2012 report from the Robert Wood Johnson Foundation.

Business requirements for market entry are a high barrier and adherence to regulatory requirements are only a small portion of that hurdle. The primary barrier to entry is the insurer would need to develop a provider network with competitive contracts to offer a competitive premium. Many new market entrants to the 2014 exchanges have failed including most co-ops, indicating the challenge of starting a brand new health plan.

In addition, in most markets, Blue Cross Blue Shield plans, the dominant commercial insurers in many markets, cannot compete using the Blue Cross Blue Shield brand in the same geographic region as other Blue Cross Blue Shield plans, excluding them as a source of new competition. Overall, the barriers to market entry are high, making the likelihood of a major and successful entrance of out of state health plans small.

4. Pricing differentials from "regulatory arbitrage" must lure current market enrollees to switch plans to new market entrants

If effective regulations are put forth, states comply, and plans expand to new states, there will still only be a market impact if individuals currently enrolled in plans select the newly available coverage options.

Why this could be problematic:

First, the coverage options will not be available through the exchange and therefore, tax credits which are utilized by 84% of the exchange market will not be available for these plans. Second, market reforms that are part of the ACA reduced much of the state-to-state insurance rule variation by compressing age bands and creating relatively comparable essential health benefits packages, thus leaving such a small window for "regulatory arbitrage" it is unlikely to move the market.

Adam E. Block, PhD, is a health economist with nearly 20 years of experience working on all sides of healthcare including research, government, managed care, and hospital administration. His work included developing regulations for CMS implementing the essential health benefits, actuarial value, and some rate setting regulations. He is currently an assistant professor of health policy and management at New York Medical College where his research focuses on provider selection and network development.