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# Did the Trump Administration Hurt or Help the ACA? It Helped.

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## Abstract

**What is the message?** The Trump Administration provided Republicans long-sought opportunities to repeal the ACA and revamp the U.S. health system. So did Trump era policy actions impact access to affordable health care? We posed that question to two leading policy analysts with contrasting perspectives (read the opposing view here).

**What is the evidence?** Analysis and interpretation of publicly available data from multiple sources.

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## Introduction

Critics of the Trump administration have focused on policy actions they believe constitute evidence of sabotage against the Affordable Care Act (ACA).[1] While it is true that the former administration and many Republicans in Congress considered the ACA to be an overreach of

federal regulation into the private health insurance market, it is important to distinguish between the overblown rhetoric (from both sides of the political aisle) during the Trump era and the net effect of that administration's policies on enrollment in private health plans.

The mantra "repeal and replace" was taken by some as a threat to reverse the ACA's insurance reforms and coverage expansion, resulting in a loss of coverage for millions of Americans. Although it was unclear what the replacement policy would be, most Republicans recognized that simply repealing the ACA would be inhumane and politically disastrous. The argument was not about whether people should have access to affordable health care, but rather how that should be accomplished.

Key themes—greater consumer choice, incentives rather than mandates, lower costs, greater responsibility for the states—were broadly accepted by the Trump administration without much clarity initially on how those ideas would be implemented.[2] The U.S. House or Representatives narrowly approved the American Health Care Act in May 2017, following intense debate among Republicans over the scope of the bill.[3] The Senate considered several proposals to repeal and replace the ACA, all of which failed to pass.

Controversy over substantial cuts in Medicaid spending, lack of consensus over changes in the ACA, and a one-vote majority in the Senate contributed to this defeat. Meanwhile, the Trump administration took actions to modify the operation of the insurance exchanges and expand coverage options outside the ACA framework. Despite criticism from advocates, none of these actions undermined coverage offered on the exchanges. Whether intentional or not, one of those policies made exchange coverage more attractive to low-income families.

## Failure of Repeal and Replace

The Republican victory in the 2016 election led to a concerted, but ultimately failed, effort to legislate a more market-oriented replacement for the ACA. Party leaders had argued for repealing the ACA since it was enacted in 2010, and now they had an opportunity to make major changes in the law. A narrow majority in the Senate meant that the proposal needed to go through the reconciliation process to avoid a filibuster.

President Trump's first executive order, signed on inauguration day, indicated he would seek a

prompt repeal of the ACA and directed federal agencies to scale back its provisions to the extent possible.[4] The order was primarily a messaging exercise as it included no specific policies, but it set the administration's tone helped initiate a nearly year-long effort by congressional Republicans to develop a replacement plan.

The American Health Care Act (AHCA) was narrowly approved by the House on May 4, 2017. The bill was criticized by the conservative House Freedom Caucus for failing to repeal major sections of the ACA, including the essential health benefits requirement and other insurance rules.[5] However, reconciliation rules in the Senate preclude provisions that do not change the level of federal spending or revenue, or where any such change is incidental to the provision's policy effects. Since changes to ACA insurance regulations were likely to be dropped in the Senate, they were not included by the House.

Despite that limitation, the American Health Care Act addressed many Republican policy concerns.[6] Mandate penalties were repealed. To reduce adverse selection, states could allow insurers to increase premiums for applicants following a lapse in coverage. The ACA's advance premium tax credit (APTC) was converted to fixed amounts that increase with the enrollee's age rather than being tied to the enrollee's income and the cost of the benchmark health plan. States were allowed to modify ACA insurance rules, including raising the limit on age rating and instituting their own set of benefit requirements. Other changes included repealing ACA tax increases, reducing federal support for state Medicaid programs, and promoting high-risk pools.

The Senate considered several proposals to reform or replace the ACA, none of which was passed.[7] The Better Care Reconciliation Act retained many of the provisions of the AHCA, including a premium surcharge for applicants with a lapse in coverage. The Obamacare Repeal Reconciliation Act repealed the coverage mandate as well as the APTC and cost-sharing subsidies. The Health Care Freedom Act was a stripped-down version whose main provision was to repeal the coverage mandate. The last attempt at a compromise was the Graham-Cassidy amendment to the AHCA, announced on September 13. It retained most of the AHCA's provisions but also repealed the APTC and cost-sharing subsidies. Graham-Cassidy was not voted on for lack of support.

## Expanding Options Through Regulation

By the fall of 2017 it was clear that Congress would be unable to enact a repeal and replace bill. On October 12, President Trump signed executive order 13813 directing federal agencies to develop federal regulations that could allow less expensive health insurance alternatives to exchange plans.[8] Three changes were envisioned.

- **Short-term, limited duration plans (STLD).** Short-term health insurance policies provide coverage over a limited time period. They do not have to cover the ACA's essential health benefits, they do not cover pre-existing conditions, and they are not required to cover people in poor health. Short-term plans offer lower premiums for more limited coverage.[9] To forestall possible erosion of the exchange market, the Obama administration limited short-term plans to no more than 90 days duration (instead of the prior limit of a year) and prohibited renewals (not previously banned).[10] The Trump administration reversed those restrictions, allowing short-term plans up to 364 days and allowing plans to extend coverage up to three years, subject to the approval of state insurance regulators.[11]
- **Association health plans (AHPs).** AHPs allow small firms to jointly purchase health insurance, in essence operating as one large employer plan. This could give those firms scale economies and greater market power than they have purchasing insurance as separate companies. The Trump administration relaxed the requirement limiting AHPs to firms with a "commonality of interests" beyond simply offering a health plan to employees and allowed sole proprietors to purchase coverage through an AHP.[12]
- **Health Reimbursement Arrangements (HRAs).** HRAs allow employers to give tax-free funds to workers for their families' medical expenses, including deductibles and other cost-sharing payments and health items not covered by insurance. The Trump administration expanded the use of HRAs to allow those funds to pay premiums for individual health insurance and gave employers flexibility to offer either the employer's plan or an HRA to broad classes of workers (salaried versus hourly workers, full- or part-time status, or geographic location).[13]

These initiatives offered the possibility of lower-cost insurance compared with exchange plans, which could expand the number of people with coverage but could increase premiums in the exchange market. The ACA already had a problem with adverse selection. Providing new plan

options that would attract younger, healthier people away from exchange plans would worsen that situation to some extent.

Not surprisingly, interest groups that could be affected by the new regulations had an opinion about their impact backed up by dozens of consultant reports designed to confirm the group's financial and political position. Less biased analyses came from the Congressional Budget Office (CBO) and the Centers for Medicare & Medicaid Services (CMS) chief actuary, but all projections of the effect of new policies are subject to considerable error.

CBO, in conjunction with the Joint Committee on Taxation, estimated that premiums for STLD plans could be as much as 60 or 90 percent below the lowest cost bronze plan in the exchange market, depending on the type of insurance product offered.[14] Such plans do not have to cover all of the ACA's essential health benefits, premiums would be based on the individual's expected health spending rather than spending in the local market, and the plans would be able to exclude coverage of pre-existing conditions or refuse coverage for a person likely to have high health costs. Association health plans would be about 30 percent less expensive than in the exchange market, primarily because premiums would be set based on spending in the AHP rather than in the broader community.

Enrollment patterns would change modestly as a result. About 5 million more people would newly enroll in an AHP or a short-term plan.[15] Of that amount, about 3 million would otherwise have been covered in the small group market, 1 million would have been covered in the nongroup market, and 1 million would have been uninsured.

The CMS Chief Actuary estimated that STLD plan enrollment would increase by about 1.9 million people in 2022 because of the new regulations.[16] Enrollment in exchange plans would decline by about 800,000. Because STLD plans are expected to enroll healthier individuals, those remaining in the exchanges would be relatively less healthy, causing average exchange premiums to rise by about 6 percent. Overall, the number of people covered by a STLD plan or in the individual market is expected to increase by roughly 0.2 million in 2022.

Such estimates are highly uncertain and depend on how the federal government implements its rules as well as the responses by state regulators, employers, and consumers. People with low health costs are more likely to shift from exchange plans to AHPs or short-term plans, which

would adversely affect the exchange market. The impact depends on how many people actually switch plans, not the number who could benefit.  As we have seen in other contexts, consumers often continue with their current health plan even when far superior options are available.[17]

Early on, some observers argued that the Trump administration's executive order would trigger risk segmentation that would drive up premiums and could eventually lead to dismantling the ACA exchanges.[18] Plausible estimates suggest that the new regulations would have a small but noticeable impact on the exchange market—if those regulations had not been stopped by court decisions and the Biden administration.[19] [20] [21]

## Stopping Payment on Cost-Sharing Subsidies

On October 12, 2017—the same day that he signed the executive order to expand low-cost insurance options—President Trump took the more consequential step of halting federal payments to insurers for ACA-required cost-sharing reduction subsidies (CSRs). That action did not change the requirement that insurers lower cost-sharing requirements to eligible families, but insurers were now faced with billions in uncompensated costs.

This was the result of a long-standing dispute over whether Congress had formally appropriated funds for CSR payments. House Republicans took the Obama administration to court in 2014 over this issue, and in 2016 the District Court for the District of Columbia ruled that the government did not have authority to make the payments.[22] Legal action was delayed to give the parties a chance to resolve the matter, but no action was forthcoming. President Trump acted to halt what he called "bailouts" for insurers, undoubtedly expecting that this would change the course of the ACA.[23]

Halting CSR payments did change the course of the ACA, but perhaps not the way that was intended. Although the President's decision came less than a month before the start of the ACA annual open enrollment period, insurers and state regulators quickly re-evaluated their positions and devised a workaround.  To make up for lost CSR funds, insurers substantially increased premiums for their silver plans with lower increases for plans at other metal tiers.

This "silver loading" strategy took advantage of ACA premium subsidies tied to the second lowest-cost silver plan in each market. The APTC increases dollar-for-dollar with the premium of

the benchmark plan in each market area. Enrollees who receive the APTC are guaranteed that their premiums will not increase if they select the benchmark plan. This ensures a stable enrollment base even when silver premiums are rising sharply. It also increases federal payments—those dreaded bailouts—to insurers.

In addition, premiums for other metal tiers did not increase as rapidly as they would otherwise. With dramatically higher premium subsidies, many families could enroll in a lower-level bronze plan without having to pay a premium.[24] They could also purchase more generous coverage in the gold tier at a lower net premium than if they selected a silver plan.

While that was good news for families eligible for a premium subsidy, silver loading substantially increased silver plan premiums that had been affordable to unsubsidized families before the policy change. The U.S. Government Accountability Office (GAO) documented the shift in premium costs from subsidized to unsubsidized families between 2017 and 2018 for the 39 states using Healthcare.gov.[25] Average silver premiums increased by 44 percent, but net of subsidies silver premiums declined by 13 percent. Unsubsidized gold plan premiums increased by 24 percent, but subsidized gold premiums declined by an average 39 percent.

Overall enrollment declined modestly, from 9.2 million to 8.7 million, most likely because of a loss of families not eligible for the APTC. Plan choices shifted away from silver plans. About 74 percent of enrollment in 2017 was in silver plans, compared with 65 percent in 2018. The share of enrollment in gold and bronze plans both increased as families sought either better benefits or zero premiums.

Other estimates using data from all 50 states plus the District of Columbia indicate that silver loading caused a one-time bump up in average exchange premiums rather than a series of annual increases. Premiums weighted by plan enrollment increased about 30 percent between 2017 and 2018, followed by a nearly 3 percent increase in 2019 and a 0.2 percent decline in 2020.[26]

Other policy changes—a reduced advertising budget, less funding for navigators (who help people with enrollment), and a shorter open enrollment period—also had an impact on enrollment, but these had minor effects. The ACA had been in full operation starting with the 2014 plan year, and plan participation and enrollment had largely stabilized by 2017. Costs and

benefits of plan offerings, not promotional activities, had become the key factors in determining whether a family would choose to enroll.

## The Trump Legacy

Arguably, Donald Trump came too late to the presidency to make much of an impact on the ACA. Exchange plans had been in operation for three years before he was inaugurated, plan offerings had been approved in the fall of 2016, and the open enrollment period for 2017 was nearly completed. Any policy change would not take effect until 2018 or later.

Congressional Republicans had campaigned since 2010 on repeal and replace, but even the most ambitious proposal would have left the core of the ACA intact. Although public opinion was split along partisan lines on the ACA, most people had employer coverage and felt that they would not be directly affected by the new law.[27] The Republican argument over *how* to expand health coverage had been eclipsed in the public's mind by a sense that a social wrong was being righted and the rest was just details.

Moreover, the health sector had moved on. Insurers had invested a great deal of energy and money over the prior six years to meet the ACA's requirements and take full advantage of the new entitlement program. Providers had anticipated an opportunity to provide better care for more people—and get paid for it. Now that the ACA was in operation, there was little desire to make changes.

Republicans were able to reduce the ACA's mandate penalty to zero as part of the tax reform bill passed in December 2017. Given the modest amount of the penalty, lax enforcement, and ample opportunities to be exempted from paying the tax, zeroing out the penalty was a symbolic victory. Even advocates for the mandate recognize that it had little effect on people's decisions to purchase insurance.[28]

The Trump administration's most significant policy change—halting CSR payments—increased federal costs and made exchange coverage more attractive to people eligible for the ACA's premium subsidy. It also increased premiums for unsubsidized lower-middle income families—families no longer able to buy coverage they had before the ACA and who can't afford more expensive exchange plans. Initiatives to expand lower-cost alternatives to exchange plans

could have provided a path to coverage for these people, but those efforts were slow to develop and have since been discarded with the change in administrations.

The American Rescue Plan Act, signed into law on March 11, 2021, increases premium tax credits and makes them available to all families who purchase exchange coverage, regardless of income.[29] That expansion is limited to 2021 and 2022, although it is widely expected that the provision will be made permanent. The Congressional Budget Office and Joint Committee on Taxation estimate that 1.7 million people would gain exchange coverage in 2022, 1.3 million of whom were previously uninsured.[30] New enrollees are projected to account for $13.0 billion in federal costs, with most of that spending occurring in 2021 and 2022.[31]

Although more generous subsidies resolve a major inequity of the ACA, more spending exacerbates the problem of rapidly rising health costs that makes all forms of health insurance increasingly unaffordable. Creating a more efficient and effective health system that promotes competition and rewards innovation is necessary to sustainably improve access to affordable private health coverage. That should be the challenge going forward.

**References**

[1] Center on Budget and Policy Priorities. Sabotage Watch: Tracking Efforts to Undermine the ACA. https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.

[2] Sarlin B. What is 'Repeal and Replace?' A Guide to Trump's Health Care Buzzwords. NBC News. January 28, 2017. https://www.nbcnews.com/news/us-news/what-repeal-replace-guide-trump-s-health-care-buzzwords-n713366.

[3] Antos, J, Capretta, J. The Road Not Taken. In:  Emanuel E, Gluck A, editors. The Trillion Dollar Revolution: How the Affordable Care Act Transformed Politics, Law, and Health Care in America. New York:  Public Affairs, March 2020. P. 66-80. https://www.aei.org/wp-content/uploads/2020/04/Chapter-3-Trillion-Dollar-Revolution.pdf?x9120

8.

[4] Executive Office of the President. Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal. Executive Order 13765. January 20, 2017. https://www.federalregister.gov/documents/2017/01/24/2017-01799/minimizing-the-economic-burden-of-the-patient-protection-and-affordable-care-act-pending-repeal.

[5] Bade R, Dawsey J, and Haberkorn J. How a secret Freedom Caucus pact brought down Obamacare repeal. Politico. March 26, 2017. https://www.politico.com/story/2017/03/trump-freedom-caucus-obamacare-repeal-replace-secret-pact-236507.

[6] Jost T. "House Passes AHCA: How It Happened, What It Would Do, And Its Uncertain Senate Future." Health Affairs. May 4, 2017. https://www.healthaffairs.org/do/10.1377/forefront.20170504.059967. Kaiser Family Foundation, "Summary of the American Health Care Act." May 2017. http://files.kff.org.attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act.

[7] Kaiser Family Foundation. Compare Proposals to Replace the Affordable Care Act. September 8, 2017. https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/.

[8] Executive Office of the President. Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States. Executive Order 13813. October 12. 2017. https://trumpwhitehouse.archives.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/.

[9] AgileHealthInsurance. Study Shows Major Premium Savings for Short Term Health Insurance as Compared to Entry-Level Obamacare Plans. February 18, 2015. https://www.agilehealthinsurance.com/health-insurance-learning-center/obamacare-vs-term-health-insurance-premiums.

[10] Internal Revenue Service et al. Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance. Federal Register. October 31, 2016.

https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance.

[11] Internal Revenue Service et al. Short-Term, Limited-Duration Insurance. Federal Register. August 3, 2018. https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance.

[12] Employee Benefits Security Administration, Department of Labor. Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans. Federal Register. June 21, 2018. https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans.

[13] Internal Revenue Service et al. Health Reimbursement Arrangements and Other Account-Based Group Health Plans. Federal Register. June 20, 2019. https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

[14] Congressional Budget Office. How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans. January 2019. https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

[15] Congressional Budget Office. How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans. January 2019. https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

[16] Spitalnic P. Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule. Centers for Medicare & Medicaid Services. April 6, 2018. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf.

[17] Sanger-Katz M. Why Most People Won't Shop Again for Health Insurance. New York Times. December 11, 2014. https://www.nytimes.com/2014/12/12/upshot/why-most-people-wont-shop-again-for-health-insur

ance.html.

[18] Diamond D. Trump's order could unwind Obamacare market. Politico. October 12, 2017. https://www.politico.com/tipsheets/politico-pulse/2017/10/12/trumps-order-could-unwind-obamacare-market-222765.

[19] Keith K. ACA Litigation Round-Up: Part II. Health Affairs Forefront. July 21, 2020. https://www.healthaffairs.org/do/10.1377/forefront.20200721.330502/full/.

[20] Keith K. ACA Litigation Round-Up: A Status Check. Health Affairs Forefront. February 1, 2021. https://www.healthaffairs.org/do/10.1377/forefront.20210201.561637/full/.

[21] Executive Office of the President. Executive Order on Strengthening Medicaid and the Affordable Care Act. Executive Order 14009. January 28, 2021. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/.

[22] Small L. House, states, Trump administration reach settlement in ACA subsidies case. Fierce Healthcare. December 18, 2017. https://www.fiercehealthcare.com/aca/house-states-trump-administration-reach-settlement-aca-subsidies-case.

[23] Kodjak A. Trump Warns Against 'Bailouts' For Insurance Companies In Bipartisan Health Care Deal. NPR. October 17, 2017. https://www.npr.org/sections/health-shots/2017/10/17/558370338/senators-reach-deal-to-stabilize-aca-insurance-markets-for-two-years.

[24] Pearson C., Sloan C, Carpenter E. Most Counties Will Have Free 2018 Exchange Plans for Low-Income Enrollees. Avalere. November 2, 2017. https://avalere.com/press-releases/most-counties-will-have-free-2018-exchange-plans-for-low-income-enrollees.

[25] U.S. Government Accountability Office. Health Insurance Exchanges:  HHS Should Enhance Its Management of Open Enrollment Performance. GAO-18-565. July 24,2018.

https://www.gao.gov/assets/gao-18-565.pdf.

[26] Author's calculation based on Gaba C. 2018-20 Rate Hikes. ACASignups.net. https://acasignups.net/rate-hikes/2018 (Total Avg. Increase CSR "AND" MANDATE SABOTAGE); https://acasignups.net/rate-hikes/2019 (Requested Avg. % Rate Change WITH 2018 sabotage); https://acasignups.net/rate-changes/2020 (Avg. 2020 Final Rates).

[27] Hamel L., Kirzinger A. et al. 5 Charts About Public Opinion on the Affordable Care Act and the Supreme Court. Kaiser Family Foundation. December 18, 2020. https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court/.

[28] Kliff S. Republicans Killed the Obamacare Mandate. New Data Shows It Didn't Really Matter. New York Times. September 18, 2020. https://www.nytimes.com/2020/09/18/upshot/obamacare-mandate-republicans.html.

[29] Park E and Corlette S. American Rescue Plan Act:  Health Coverage Provisions Explained. Georgetown University Health Policy Institute. March 11, 2021. https://ccf.georgetown.edu/wp-content/uploads/2021/03/American-Rescue-Plan-signed-fix-2.pdf.

[30] Congressional Budget Office. Reconciliation Recommendations of the House Committee on

Ways and Means (As ordered reported on February 10 and 11, 2021). February 17, 2021. https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

[31] Rae M, Cox C, Claxton G, McDermott D, and Damico A. How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured. Kaiser Family Foundation. March 25, 2021. https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/.