Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

November 29, 2017

Health Care Executive Order Would Destabilize Insurance Markets, Weaken Coverage

By Sarah Lueck

President Trump portrayed his October 12 executive order on health care as expanding the health coverage options available to individuals and small businesses. In reality, the policies envisioned by the order, if implemented as described, would have severe, damaging effects. They would destabilize insurance markets that cover millions of individuals and small businesses, undermine protections for people with pre-existing health conditions, and make health coverage far less comprehensive and less affordable than it is today.

The order itself doesn't have any practical effect. But it directs relevant agencies to consider making changes to regulations and guidance in order to:

- Roll back an existing time limit on short-term health insurance plans, which don't comply with Affordable Care Act (ACA) standards, so that more individuals can enroll in them for much longer;
- Allow more small businesses to offer coverage through association health plans (AHPs), which would let them bypass ACA rules that otherwise apply to small-group coverage and also purchase coverage "across state lines"; and
- Expand health reimbursement arrangements (HRAs), a type of tax-favored, employer-funded account, to allow more mid-sized and large employers to offer HRAs for employees to purchase coverage on their own (rather than offering an HRA paired with a standard employer health insurance plan).

It remains to be seen what specific changes to regulations and guidance or other administrative actions will result from the executive order; such changes are expected to unfold over a number of months and are in some cases also likely to face serious legal challenges. But if these ideas are allowed to take effect as described in the executive order and its accompanying documents, they would inflict significant harm to the existing individual and small-group insurance markets and the millions of people who rely on them.

Expanding Short-Term Health Plans Would Undermine the Individual Market and Harm Consumers

The executive order directs federal agencies to consider changes to regulations and guidance that would "expand the availability" of short-term plans and allow such plans "to cover longer periods and be renewed by the consumer."[1] Such changes pose serious risks for the ACA-compliant individual market and the people enrolled in it, many of whom are likely to face premium hikes or reduced coverage options. The spread of such plans also puts consumers who enroll in them at risk, as they could be exposed to expensive medical bills if they get sick.

Short-Term Plans Fail to Provide the ACA's Major Consumer Protections

Before the ACA, the individual health insurance market was a highly flawed, much less accessible market for many people, particularly those who had pre-existing medical conditions or modest incomes. Insurers denied coverage to some applicants or quoted them very high premiums based on their health conditions and on characteristics such as their gender, occupation, and other factors. Many plans lacked key benefits, such as prescription drugs and maternity services, or tacked on a large additional premium cost for people who needed these services. The individual market often wasn't a viable option for someone who faced a gap in coverage when they were between jobs that offered health benefits or for other reasons.

Starting in 2014, the ACA required insurers in the individual market to issue coverage to any applicant, both during an annual open enrollment period available to anyone and during "special" enrollment periods during which certain individuals and their families are eligible because they lose other health insurance or experience certain other life events. The ACA also bars insurers from charging someone a higher premium rate because they have a pre-existing health condition, and it requires plans to cover a comprehensive set of "essential health benefits" that includes maternity services and prescription drugs, as well as mental health care and treatment for substance-use disorders — benefits that were often lacking prior to the ACA. Subsidies are also available to help people with low and moderate incomes afford their premiums and their deductibles if they buy an ACA-compliant plan through a health insurance marketplace.

Some insurers, however, tried to bypass these ACA standards by offering short-term individual-market insurance plans of less than a year in duration.[2] Because short-term plans are not considered individual market coverage that must meet ACA standards, they can, and typically do, exclude coverage of pre-existing medical conditions, limit the amount of benefits that a person can receive from the plan in a year, and fail to include many of the essential health benefits, such as maternity care, mental health and substance-use disorder services, and prescription drugs.[3] (Short-term plans

---

[1] "Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States," White House Office of the Press Secretary, October 12, 2017. https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition.

[2] Sabrina Corlette, "Health Plans Get Creative at Skirting the ACA, and That Means Buyer Beware," Center on Health Insurance Reforms, September 4, 2013.

[3] One 2016 analysis found that the best-selling short-term plans on eHealth's website exclude these four categories of essential health benefits. See Dania Palanker, "As Administration Reviews Comments on Short-Term Insurance Plans, Analysis Finds Gaps in Coverage," Center on Health Insurance Reforms, Georgetown University Health Policy Institute, August 22, 2016, http://chirblog.org/as-administration-reviews-comments-on-short-term-insurance-plans-analysis-finds-gaps-in-coverage/.

are not considered minimum essential coverage, and people who have only that type of coverage would generally owe a penalty under the ACA's individual mandate.)

Expanding Access to Short-Term Plans Would Undermine ACA-Compliant Market

When health plans subject to weak market rules and consumer protections are sold as an alternative to health plans that meet more stringent standards, the insurance market separates into healthy and unhealthy enrollee groups, or risk pools. This dynamic is known as "adverse selection."

As short-term plans grew in popularity, concern increased that they were becoming an alternative form of primary coverage, which they were never intended to be, and that their spread would introduce significant adverse selection that could destabilize the ACA-compliant individual market.[4]

Responding to these concerns, the Obama Administration adopted regulations in 2016 defining short-term plans as those lasting less than three months. The regulations took effect early in 2017. The Trump Administration's executive order now calls on federal agencies to consider changes to rules and guidance in order to expand short-term insurance and "consider allowing such insurance to cover longer periods and be renewed by the consumer."[5]

If the Trump Administration allows short-term plans to once again last for nearly a full year, such "short-term" coverage could constitute a full-blown alternative to the ACA-compliant market for individual coverage and thus could lead to severe adverse selection. Short-term plans would be most likely to attract healthier people, leading to premium increases for ACA-compliant plans and destabilizing individual insurance markets across the nation.

Even if the federal government were to relax its limit on short-term plans, states would presumably still have the ability to impose their own limits and to establish other restrictions and consumer protections that could help shore up the ACA market. However, few states have such rules in place at this time,[6] and depending on timing of changes to the existing regulations, states may not have sufficient time to act to protect their markets before they face harm. Many states would thus likely default to the weakened federal framework, placing their ACA plans, and the consumers that enroll in them, at substantial risk.

Notably, the Obama Administration's limit on short-term plans was supported by a wide range of stakeholders, including the two major health insurer trade groups as well as consumer advocacy organizations. "Short-term policies usually exclude coverage for pre-existing conditions and do not provide affordable care in the long term for consumers," America's Health Insurance Plans wrote the Trump Administration in support of maintaining the three-month limit. Extending the length of

---

[4] Anna Wilde Mathews, "Sales of short-term policies surge," *Wall Street Journal*, April 10, 2016; Beth Pinsker, "Despite Obamacare, gap health insurance market explodes," Reuters, June 3, 2015, http://www.reuters.com/article/us-usa-health-gapinsurance/despite-obamacare-gap-health-insurance-market-explodes-idUSKBN0OJ1G220150603.

[5] "Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States," White House, October 12, 2017.

[6] Tim Jost, "Trump Executive Order Expands Opportunities for Healthier People to Exit ACA," *Health Affairs* blog, October 12, 2017.

short-term plans "will draw lower risk people out of the individual market single risk pool and drive up premium costs for consumers."[7]

The resulting premium increase could be felt as early as 2019. If the Trump Administration changes rules to remove the limit on short-term plans sometime during 2018, then premium increases for ACA individual-market plans in 2019 (which would become public during the spring and summer of 2018 and be finalized in the fall of that year) are likely to be significantly higher than they otherwise would be, as ACA-compliant insurers price in the greater risk of adverse selection due to short-term plans.

In addition to undermining the ACA-compliant market, broader access to short-term plans would put the consumers who buy them at risk. Prior to the ACA, short-term health plans arguably were justified as an option for people who could not get health coverage on the individual market or other sources for a very limited period of time. Now, the rationale for these plans is far less clear, particularly if they are issued for lengthy periods of time. While a healthier consumer may be able to get a short-term plan for a relatively low premium and may not be concerned about the plan's exclusions and limitations, if a person with a short-term plan ends up needing medical services, they will likely find that the gaps and limitations inherent in such coverage leave them with expensive medical bills even though they thought they were protected. In some instances, companies selling short-term plans have used aggressive marketing practices that are likely to confuse or mislead consumers about what, exactly, they are buying and what protections the plans may provide.[8] (See text box, "Short-Term Plans: Buyer, Beware.") Senator Ron Johnson, a vocal supporter of expanding short-term plans, recently recounted the story of a constituent who enrolled in short-term coverage instead of an ACA-compliant plan and was left with a $45,000 hospital bill the short-term plan wouldn't cover.[9]

Even before any Trump Administration change, it's important to recognize that companies that sell short-term plans are already finding ways around the existing time limit and are marketing short-term coverage as a lower-cost alternative to ACA plans. At eHealthinsurance.com, people can sign up to automatically extend short-term coverage past the three-month limit that is still in place, under eHealth's offer to take one application and "automatically activate to ensure no lapse in coverage for up to 360 days."[10] Insurers and brokers offering short-term plans would take full advantage of any regulatory change made by the Trump Administration, which would dramatically increase the risk of adverse selection and higher, unaffordable premiums for ACA-compliant plans.

---

[7] "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients," AHIP Comments, July 12, 2017.

[8] Sabrina Corlette and JoAnn Volk, "You Don't Know Who You are Dealing With: Unscrupulous Broker Tries to Sell Us Short-Term Insurance," Center on Health Insurance Reforms, June 13, 2016.

[9] Susannah Luthi, "Executive Order on Short-Term Plans Opens Door to Sale of Supplemental Plans," Inside Health Policy, November 3, 2017.

[10] "Need More Than 90 Days of Temporary Coverage?" web page at https://www.ehealthinsurance.com/ehi/st/best-sellers?multiPeriodFlow=true&clearFilters=true, accessed November 14, 2017. Under current rules, one short-term policy cannot extend past 90 days. However, eHealth is combining plans to, in effect, convert short-term coverage into long-term coverage.

Short-Term Plans: Buyer, Beware

Short-term plans may seem like a good deal for a healthier person, who would likely find they can pay a relatively low premium. But if a healthier person ends up needing medical services, they can't expect the same protections from a short-term plan as they would have if they had coverage that meets all ACA standards. Data compiled by the National Association of Insurance Commissioners (NAIC) show that in 2016, the short-term insurers with the greatest enrollment reported spending just half of the premiums they collect on enrollees' medical claims. Several real-life examples show how these plans can be harmful to consumers and use aggressive, and sometimes misleading, marketing tactics.

- The Pennsylvania Insurance Department has received several recent complaints from enrollees in short-term health plans. Consumers reported their medical claims are not being paid, even though they paid months of premiums. In some cases, consumers say they were duped by agents who assured them — before they bought a plan — that their families' health needs would be covered. One woman in rural Pennsylvania was hospitalized after suffering a stroke and was left with more than $250,000 in medical bills after finding that core benefits, such as medications, were not covered. A Pennsylvania man was diagnosed with an abnormal heartbeat, but his plan denied his claims. The company deemed the condition pre-existing after noting the enrollee had previously seen a doctor for high blood pressure.
- An Atlanta woman who bought a short-term plan in 2014 when she was between jobs was then diagnosed with breast cancer. She was left with $400,000 in medical bills when the insurer, Golden Rule, a subsidiary of UnitedHealthcare, determined it would not cover the treatment. Even though the patient was unaware of the cancer when she bought the policy, the insurer was allowed to treat the disease as a pre-existing condition excluded from coverage.
- A California man bought a short-term plan in 2015 and then experienced three separate health incidents that sent him to the doctor. The company, Tokio Marine HCC, denied his claims and demanded years of detailed medical records. The man paid his medical bills himself and then sued the company, which led to an unspecified settlement.
- In 2009, reporter Karen Tumulty wrote for *Time* about the challenges her brother Pat faced when he was diagnosed with kidney disease while covered by a short-term health plan. The company that sold him the coverage issued a succession of six-month policies to Pat, for a total of six years of supposedly short-term coverage. After Pat became ill, the company looked back over his medical records and found prior test results, and then deemed the kidney disease a pre-existing condition that was not covered. The insurer's rationale: When Pat got the tests, he was covered by a different short-term policy, so the kidney disease was technically a pre-existing condition even though Pat's doctors didn't diagnose him until much later and even though he was continuously covered by the same company. The insurer said Pat should never have relied on short-term coverage for a long period. "I wish the company had told my brother that when it sold him the policy the first place," Tumulty wrote. The company eventually agreed to pay Pat's medical claims from the last year his policy was in force, citing "extraordinary circumstances."

Sources: Pennsylvania Insurance Department; Erik Larson and Zachary Tracer, "The Health Plans Trump Backs Have a Long History of Disputes," Bloomberg Politics, October 16, 2017, https://www.bloomberg.com/news/articles/2017-10-16/trump-s-insurance-directive-renews-preexisting-conditions-fight; Karen Tumulty, "The Health-Care Crisis Hits Home," *Time*, March 5, 2009; "Accident and Health Policy Experience Exhibit," National Association of Insurance Commissioners, 2016, http://www.naic.org/prod_serv/AHP-LR-17.pdf.

Association Health Plans Would Destabilize the Small-Group Market

The executive order directs the agencies to make association health plans (AHPs) broadly available to small businesses on a nationwide basis. This is likely to result in policy changes that would harm affordability in the small-group insurance market, as healthier firms drift toward lightly regulated AHP options. It also raises the risk that states' ability to protect their residents from bad actor AHPs will be badly weakened.

Currently, health insurance plans sold to individuals through associations must meet all rules and standards that otherwise apply in the individual insurance market. The same goes for small groups: plans sold through associations to small businesses are subject to small-group market rules. That includes requirements to cover the essential health benefits, cap consumers' out-of-pocket costs each year, and charge every firm the same premium regardless of the health status or gender of their employees.

A common misconception is that AHPs improve "pooling" for smaller businesses, letting them band together to increase their bargaining power and get a better deal on the cost of insurance coverage. In reality, *the ACA* has improved pooling for small businesses. It requires each insurer in the small-group market to treat all their small-group business as part of one single risk pool when setting premiums, meaning that the price a business must pay for coverage is not set based on the cost of covering its workers alone. This is a major improvement compared to before the ACA, when small firms especially had their premiums based on their workers' health status, age, and claims history. Back then, one sick employee could mean premium spikes the following year for the entire business.

One way the Administration may attempt to broaden AHP enrollment would be to allow small businesses that purchase coverage through an association to be subject to the rules for large employer self-insured plans, not those for small employer plans, effectively exempting small employer plans from many of the standards and consumer protections that they currently must meet, such as the requirement to cover essential health benefits and the community-rating provisions. This could also allow AHPs to be sold "across state lines," because if the AHP is treated as a large employer plan, then it is not generally subject to state insurance regulations.

Kentucky's Experience With Adverse Selection

In 1994, Kentucky passed a set of health insurance reforms (for the individual and small-group markets) that were very similar to the ACA's market reforms. These included a requirement for insurers to accept all applicants regardless of their health status, restrictions on exclusions of pre-existing health conditions, and a requirement that premiums be set without regard to health status, claims experience, or gender. Premium variations for age, family size, and geographic factors were limited, and plan benefits were standardized. Insurers in the state resisted the reforms and lobbied to repeal parts of it.

In 1996, Kentucky's legislature passed legislation that repealed many of the market reforms. Crucially, the law exempted associations of employers or individuals from the premium-rating and benefits requirements, a loophole that allowed associations to sell coverage under a much weaker regulatory scheme. In part because healthy individuals could buy association plans, the risk of adverse selection against the reformed individual market increased. Nearly all insurers left Kentucky's individual market or declined to sell new policies that were subject to the stronger rating and benefits standards. In 1998, the Kentucky legislature passed a bill that repealed many of the state's remaining health insurance reforms.

Kentucky Senator Rand Paul is now a leading advocate of broadening the availability of association health plans at the national level to more small employers and individuals. But the lesson from his own state is that allowing more weakly regulated association health plans to operate alongside a market where insurers must issue coverage and set premiums regardless of people's health status, and where plans must include certain core benefits such as maternity care and mental health services, endangers the market where consumers can access better coverage and pre-existing condition protections, making it unsustainable over time.

Source: Adele M. Kirk, "Riding the Bull," *Journal of Health Politics, Policy, and Law*, Vol. 25, No. 1, February 2000, pp. 133-173.

Here, too, the result could be adverse selection, as AHPs serve as a full-scale alternative market subject to weaker standards than ACA-compliant small-group plans, putting small business employees at significant risk. Past experience with AHPs in states such as Kentucky bears this out. (See text box, "Kentucky's Experience With Adverse Selection.")

The extent of the damage to ACA-compliant small-group markets, and the workers and their families enrolled in them, would depend on the specifics of the AHP regulations the Administration may ultimately propose. Nevertheless, it's likely that AHPs would raise severe adverse selection risks for the ACA small-group market. Associations could "pick off healthy groups," by limiting benefits needed by high-cost people, increasing rates for older groups, and marketing to groups that are likely to be healthier.[11]

AHPs also raise concerns because they have a history of fraud and financial problems. If they are no longer subject to state oversight, then the federal government would be in charge of watching out for insurance scams involving AHPs. This would undermine state regulators' ability to protect their residents. In addition, if the Trump Administration moves to make AHPs available "across state lines," then this could mean the associations may also be exempt from state licensing and financial requirements that help ensure that companies are able to fulfill their obligations to pay enrollees' medical claims.[12]

For all these reasons, AHPs, and the related idea of allowing sales of insurance "across state lines," have both been long opposed on a strongly bipartisan basis by groups such as the National Governors Association and the National Association of Insurance Commissioners.[13]

The Administration could attempt to allow AHPs to be sold to individuals as well, without abiding by the ACA's individual market consumer protections. That would likely result in severe adverse selection in the ACA-compliant individual market, with similar or even worse results than the short-term plan changes discussed above.

Standalone HRAs Would Undermine Job-Based Coverage and Could Weaken the Individual Market

The executive order also calls for expanding health reimbursement arrangements (HRAs), a type of tax-favored account, funded solely by employers, that workers can use to pay for health insurance premiums and/or out-of-pocket costs.[14] Depending on the specific proposals, and what employers

---

[11] Jost, *op cit.*

[12] Kevin Lucia and Sabrina Corlette, "President Trump's Executive Order: Can Association Health Plans Accomplish What Congress Could Not?" Commonwealth Fund, October 10, 2017, http://www.commonwealthfund.org/publications/blog/2017/oct/association-health-plans-executive-order.

[13] "NGA Opposes Association Health Plans," National Governors Association, March 31, 2004, https://www.nga.org/cms/home/news-room/news-releases/page_2004/col2-content/main-content-list/nga-opposes-association-health-p.html; "Consumer Alert: Association Health Plans are Bad for Consumers," NAIC, http://www.naic.org/documents/consumer_alert_ahps.pdf.

[14] HRAs are distinct from tax-favored health savings accounts (HSAs), which must be paired with a high-deductible health insurance plan, can be funded by both employers and employees, cannot be used to pay health insurance

do in response, HRAs could negatively affect the individual market by moving more high-cost people into that risk pool, raising overall premiums, and leaving other individual-market consumers and the federal government (through the premium tax credit) paying more.

Employers decide the specifics of HRAs, including what types of health expenses they may be used for and the maximum amount that workers can receive in the HRA each year. Typically employers have paired a contribution to an HRA with the offer of a standard employer health insurance plan. Workers can then use HRA funds to help pay deductibles and other out-of-pocket costs under their employer plans. A far less common strategy before the ACA was to offer a "standalone" HRA, meaning that an employer would offer only funds in an HRA, but not pair the HRA with a health insurance plan. Then, the worker could use the HRA to help pay premiums for a plan purchased in the individual insurance market.

Under the ACA, however, an HRA generally must be paired with a standard employer (or group) health insurance plan. This is because the account itself has long been considered a group health plan, under the law. And the ACA requires group health plans to meet certain standards that HRAs can't meet, specifically the ban on annual and lifetime limits and the requirement to cover certain preventive services at no cost to plan enrollees. (HRAs by definition contain an annual limit on the amount of the employer's contribution, and they are just accounts that do not cover any benefits.) In 2013, the Internal Revenue Service issued a notice explaining that an HRA could only meet these standards if it was paired with a regular health plan that met those requirements.[15]

In 2016, Congress passed legislation specifically allowing small employers that meet certain criteria to offer "standalone" HRAs under which workers can use HRA funds that their employers contribute to buy a plan in the individual market.[16] Congress chose to limit these "standalone" HRAs to employers that generally: have fewer than 50 workers, do not also offer a standard employer health insurance plan, limit yearly HRA contributions to no more than about $5,000 per person, offer the HRA on the same terms to all full-time workers, and provide notifications to workers so that the HRA amount can be coordinated with any ACA marketplace subsidies they may also receive.

If the Administration attempts to broaden the availability of such "standalone" HRAs, that would likely prompt fewer businesses to offer health coverage to their employees. Workers who now have good coverage and substantial contributions from an employer could see those benefits dropped and replaced with an HRA that leaves them paying higher premiums for less comprehensive coverage than what they have today.

The ability to once again offer "standalone" HRAs could also open new avenues for employers to shift workers with high health costs into the individual market, thereby reducing and capping the employer's cost for group health coverage. Large employers with sicker workforces may be more

---

premiums, have balances that roll over year to year, and are under the control of the employee (and thus may be retained by the employee after leaving employment). In contrast, HRAs can be paired with any health plan, are funded solely by employers, maybe be used for premiums and may or may not roll over (both at the discretion of employers), and always remain under the employer's control.

[15] Notice 2013-54, Internal Revenue Service, https://www.irs.gov/irb/2013-40_IRB#NOT-2013-54.

[16] 21st Century Cures Act P.L. 114-255

likely to make such a shift than employers with healthier employees because such employers are likely facing higher costs for group health insurance premiums than employers with a healthier overall workforce. That could move significant numbers of relatively costly people to the individual market.

In addition, as the American Academy of Actuaries noted, when provided with a standalone HRA, "less healthy individuals might prefer to use the HRAs to obtain ACA-compliant individual market coverage, whereas healthy individuals might prefer to use the HRAs to cover out-of-pocket spending or for non-compliant coverage." In other words, sicker people would be more likely to join the individual market risk pool in order to get good coverage, while healthier people would be less likely to do so and instead choose to be uninsured or enroll in non-ACA-compliant plans. Or, employers might find ways to shift mainly those workers with higher health costs out of group coverage and into the individual market. "Adverse selection could also be a problem," the actuaries wrote, "if employers could target their less healthy workers for individual market coverage, while offering group coverage to their healthy workers."[17]

Like the Cruz Amendment, Executive Order Proposals Would Endanger ACA-Compliant Plans That Provide Comprehensive Coverage

As explained above, the Administration's executive order could lead to adverse selection that would have severe consequences for the market for more comprehensive plans.

If weakly regulated plans are available to individuals and small businesses as an alternative to ACA-compliant plans, sicker people who have higher health costs would be more likely to enroll in the plans that meet ACA standards. Healthier people would gravitate toward the short-term plans and AHPs that cost less because they cover fewer benefits, can deny coverage or charge higher premiums to sicker people, or exclude coverage of pre-existing medical conditions. As enrollees separate into different risk pools, it would drive up premiums for the ACA-compliant plans to levels that would likely be unaffordable for many people with pre-existing conditions. This would destabilize the ACA-compliant market and make it less likely that insurers would offer more comprehensive coverage.

This exact dynamic would have occurred under the "Consumer Freedom" plans that Senator Ted Cruz proposed as part of Senate Republican efforts earlier this year to repeal the ACA. The Cruz amendment would have allowed insurers in the individual market that offer ACA-compliant plans to also offer Consumer Freedom plans that would be exempt from most ACA protections. As with short-term plans and AHPs, Consumer Freedom plans would not have to cover essential health benefits and could set premiums based on people's health status or past medical claims.

Consumer and patient groups, health policy experts, and others widely panned the Cruz amendment because of the danger of adverse selection and its detrimental impact on market stability and the availability of more comprehensive ACA plans. For example, the American Academy of Actuaries said the Cruz amendment would lead insurers to structure plans subject to looser rules in

[17] Letter to the Honorable Alexander Acosta, Eric D. Hargan, and Steven Mnuchin from the Health Practice Council of the American Academy of Actuaries, November 7, 2017, http://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf.

ways that would attract healthier people to them, using premium rates based on health status, fewer benefits, and higher cost-sharing charges. Premiums for ACA coverage "would far exceed those of noncompliant coverage, thereby destabilizing the market for compliant coverage," the actuaries wrote.[18] The Blue Cross and Blue Shield Association and America's Health Insurance Plans called the amendment "unworkable in any form."[19] And the American Cancer Society said the amendment would "essentially return cancer patients, survivors, and anyone with a serious illness to an underfunded high-risk pool."[20]

Experts are rendering a similar verdict on the executive order's proposals to broaden availability of short-term plans and AHPs, and potentially HRAs as well. A statement from 18 health groups, including the American Cancer Society and the American Heart Association, said the executive order "has the potential to price millions of people with pre-existing conditions and serious illnesses out of the individual insurance market and put millions more at risk through the sale of insurance plans that won't cover all the services patients want to stay healthy or the critical care they need when they get sick."[21] The American Academy of Actuaries wrote that, taken as a whole, the actions outlined in the executive order could lead to market segmentation, because, "(i)ndividuals and groups will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to less healthy individuals or groups will suffer from adverse selection. . . . [U]pward premium spirals could result, threatening the viability of the plans more advantageous to less healthy individuals or groups."[22]

[18] "Risk Pooling: How Health Insurance in the Individual Market Works," American Academy of Actuaries, July 2017, https://www.actuary.org/files/publications/RiskPoolingFAQ071417.pdf.

[19] Letter to the Honorable Mitch McConnell and Charles Schumer from America's Health Insurance Plans and the Blue Cross and Blue Shield Association, July 14, 2017, https://www.ahip.org/wp-content/uploads/2017/07/Joint-AHIP-BCBSA-Consumer-Freedom-Option-Letter-FINAL-071417.pdf.

[20] "Latest Senate Health Bill is Worse for Patients," American Cancer Society Cancer Action Network, July 13, 2017, https://www.acscan.org/releases/latest-senate-health-bill-worse-patients.

[21] Jessie Hellman, "Health groups warn Trump's executive order could hurt patients," *The Hill*, October 12, 2017, http://thehill.com/policy/healthcare/355221-health-groups-warn-trumps-executive-order-could-hurt-patients.

[22] American Academy of Actuaries letter, *op cit.*