



PROPOSED ACTION
MEMORANDUM

Issuing an Executive Order to Reverse Trump-Era
Policies and Protect People with Preexisting
Conditions

Executive Office of the President
December 2020

I. Summary

Even as the uninsured rate has risen and in the face of a pandemic, the Trump administration took steps to undermine the Medicaid program and access to Affordable Care Act (ACA) coverage. As addressed elsewhere in Roadmap 2021 memoranda, reversing these and other Trump-era policies will require a series of short-term and long-term executive actions. While much may be undone through notice-and-comment rulemaking, those efforts will take time and may not result in immediate action to show the administration's commitment to promoting affordable and comprehensive coverage, especially for those with preexisting conditions.

To underscore this commitment and help ensure that these actions are treated as a coherent and deliberate policy shift, this memorandum recommends that the Executive Office of the President immediately issue an Executive Order (EO) to:

- (1) Direct federal agencies to increase access to comprehensive coverage, reduce out-of-pocket costs for patients, protect people with preexisting conditions, and ensure that consumers understand their coverage options and rights.
- (2) Revoke Trump administration EOs that were hostile to the ACA.
- (3) Direct the Department of Health and Human Services (HHS) to consider immediate operational changes that make ACA coverage more available.
- (4) Direct HHS and other federal agencies to consider longer-term rulemaking to make coverage more affordable, ensure access to Medicaid, and protect people with preexisting conditions.

This memorandum identifies some of the policies that could be included in an EO, but there is flexibility to include more, fewer, or different policies than those outlined here.

II. Justification

The ACA contains powerful tools to extend quality, affordable health insurance to millions more Americans. But these tools have been undermined or ignored by the Trump administration, leading to the lowest Exchange enrollment levels since 2016 and a pre-pandemic decline in Medicaid and CHIP enrollment.¹ Given the rising uninsured rate and the COVID-19 crisis, there is an urgent need to permanently reverse Trump-era policies and adopt near-term changes that enable more people to enroll in Medicaid and ACA coverage. These changes are needed to ensure a safety net during the pandemic, to advance health equity, and to reverse significant coverage losses.

Many of the Trump administration's policies can only be reversed using notice-and-comment rulemaking. But that approach will take time and likely will not increase public awareness to help compensate for years of ACA neglect. An immediate EO that clearly states the policy positions of the new administration and encourages short- and long-term action may help increase this awareness and ensure that consumers enroll in comprehensive coverage during the pandemic.

¹ See Kaiser Family Foundation, Marketplace Enrollment, 2014–2020 (2020), <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/>; Kaiser Family Foundation, Analysis of Recent Declines in Medicaid and CHIP Enrollment (Nov. 25, 2019), <https://www.kff.org/medicaid/fact-sheet/analysis-of-recent-declines-in-medicaid-and-chip-enrollment/>.

III. Proposed Action

This memorandum proposes that the Executive Office of the President immediately issue an Executive Order on the ACA. A comprehensive EO would underscore the administration's commitment to increasing access to coverage, improving affordability, advancing health equity, and protecting people with preexisting conditions. The EO could be issued at any time—including immediately upon assuming office²—to publicly communicate a shift in ACA implementation and initiate key operational changes to expand access to coverage through the Exchanges and Medicaid.

Presidents can issue directives to federal agencies via an EO so long as doing so is consistent with federal law, including the Administrative Procedure Act, and the Constitution. EOs must have a suitable title, cite the basis for underlying legal authority, and be published in the *Federal Register*.³ The Office of Management and Budget prepares a “budgetary impact statement” for each EO, and the Department of Justice Office of Legal Counsel reviews for “form and legality.”⁴ The budgetary analysis requirement has been treated as a low bar, leading to many *de minimis* impact statements.⁵ EOs can take an omnibus approach by addressing multiple facets of a key issue.⁶

This EO should specifically address the President's health care priorities, along with directives to agencies to consider implementing short- and long-term changes to achieve those priorities. The EO should also include “general” provisions and a standard severability provision. The “general” provisions are included in most, if not all, modern EOs, and affirm that the EO does not disturb existing law, or create new rights or benefits. Although there is little risk of litigation over the proposed EO, a severability provision would be good practice.⁷

As noted above, this memorandum identifies some of the policies that could be included in an EO, but there is flexibility to include more, fewer, or different policies than those outlined here based on the administration's priorities. In particular, this memorandum recommends that an immediate EO:

- (1) Direct federal agencies to increase access to comprehensive coverage, reduce out-of-pocket costs for patients, protect people with preexisting conditions, and ensure that consumers understand their coverage options and rights.
- (2) Revoke Trump administration EOs that were hostile to the ACA.
- (3) Direct HHS to consider immediate operational changes that make ACA coverage more available.
- (4) Direct HHS and other federal agencies to consider longer-term rulemaking to make coverage more affordable, ensure access to Medicaid, and protect people with preexisting conditions.

² President Trump's first EO was on the ACA and issued on inauguration day. Exec. Order No. 13765 of January 20, 2017, 82 Fed. Reg. 8351-52 (Jan. 24, 2017) (stating that the new administration's policy is to seek repeal of the ACA, minimize its burdens, and provide state flexibility).

³ Exec. Order No. 11030 as of June 19, 1962, 27 Fed. Reg. 5847-48 (Jun. 19, 1962). EO 11030 has been amended over time, but its core requirements remain in effect. See 44 U.S.C. §§ 1501, 1501(a).

⁴ Exec. Order No. 11030 (as amended). The budgetary impact statement can be prepared by the Acting Director of the Office of Management and Budget and does not have to be issued concurrent with the EO. See, e.g., Office of Management and Budget Director Mark Sandy, Budgetary Impact Analysis for Executive Order Entitled “Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal (Jan. 26, 2017), <https://www.whitehouse.gov/sites/whitehouse.gov/files/docs/omb-statement-01262017.pdf> (issued six days after the EO was signed by President Trump).

⁵ See Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 tit. II § 203, 128 Stat. 1902, 2347 (2014); Gregory Korte, “How Much Do Executive Orders Cost? No One Knows,” *USA Today* (Mar. 21, 2015).

⁶ See, e.g., Exec. Order No. 13890 of October 3, 2019, 84 Fed. Reg. 53573-76 (Oct. 8, 2019); Exec. Order No. 13625 of August 31, 2012, 77 Fed. Reg. 54783-86 (Sep. 5, 2012).

⁷ See Gregory Korte, “Trump Tries Little-Known Legal Tactic to Protect Controversial Executive Orders from the Courts,” *USA Today* (Dec. 5, 2017).

(1) Direct Federal Agencies to Adopt Policies Consistent with the President's Health Care Priorities

The EO should first identify the administration's health care priorities in its initial two sections on purpose and policy. The "purpose" section justifies the need for the EO and includes relevant data.⁸ Depending on its scope, this EO might cite data regarding the rising uninsured rate, the impact of the pandemic on coverage and job loss, and the need to address health care affordability. The "policy" section states the policy of the executive branch and identifies guiding principles for EO implementation. This EO might set forth the policy of protecting and improving coverage options for people with preexisting conditions; increasing access to comprehensive coverage; reducing out-of-pocket costs for patients; advancing health equity and improving health disparities; and ensuring that consumers understand their coverage options and rights.

After outlining the purpose and policy, the EO should include general directives across all agencies that are inverse to President Trump's EOs on the ACA. To the maximum extent permitted by law, the Secretary and the heads of all other executive departments and agencies should be directed to exercise all authority and discretion available to maximize access to comprehensive coverage options and reduce out-of-pocket costs for patients and consumers.

(2) Revoke ACA-Related Trump Administration EOs

The EO should revoke, at a minimum, EO 13765 ("Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal") and EO 13813 ("Promoting Healthcare Choice and Competition Across the United States").⁹ These EOs were issued by President Trump with the express goal of undermining the ACA.

The new EO should confirm that revocation of the prior EOs does not affect any rules, regulations, or other forms of administrative action that occurred while the prior EOs were in effect. Rules promulgated pursuant to the prior EOs will remain in effect unless and until the relevant agency takes appropriate action to amend or revoke those rules.

(3) Direct HHS to Consider Immediate Operational Changes that Make ACA Coverage More Available

The EO should direct HHS to consider immediate operational changes related to the ACA, consistent with the policies outlined in the EO and federal law. In particular, HHS should be instructed to consider: (i) authorizing a six-week special enrollment period (SEP) for HealthCare.gov, (ii) increasing federal funding toward HealthCare.gov marketing, coupled with targeted outreach to the uninsured; (iii) restoring complete, accurate information about the ACA, its benefits, and enrollment options on government websites; and (iv) adopting any other policies to maximize enrollment in coverage and ensure that consumers can maintain

⁸ E.g., Exec. Order No. 13877 of June 24, 2019, 84 Fed. Reg. 30849-52 (Jun. 27, 2019) (discussing the need to improve transparency in health care); Exec. Order No. 13879 (discussing the prevalence of kidney disease and the number of Americans on the waiting list to receive a transplant); Exec. Order No. 13890 (discussing Medicare for All).

⁹ See Exec. Order No. 13813 of October 12, 2017, 82 Fed. Reg. 48385-87 (Oct. 17, 2017); 82 Fed. Reg. 8351-52. Other EOs to consider revoking include EO 13798 ("Promoting Free Speech and Religious Liberty"), 82 Fed. Reg. 21675, and EO 13951 ("An America-First Healthcare Plan"), 85 Fed. Reg. 62179, and the Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System, <https://www.whitehouse.gov/presidential-actions/presidential-proclamation-suspension-entry-immigrants-will-financially-burden-united-states-healthcare-system/>.

coverage.¹⁰ Each of these changes could be made under the Secretary's general authority in 42 U.S.C. § 18041 to establish Exchange standards and regulations. These actions are also consistent with adoption of the "market modernization" rule recommended in a separate memorandum.

While HHS could initiate these operational changes on its own (without the need for a presidential directive), doing so may receive less media attention than if these policies are included in an EO. Prominently featuring these policies in an EO could help increase awareness and educate the public about the availability of Exchange coverage and the fact that the ACA remains the law of the land.

Authorize a Six-Week Special Enrollment Period

The EO should encourage HHS to authorize immediately a six-week SEP through HealthCare.gov. This SEP would allow anyone who is uninsured to enroll in Exchange coverage without needing to claim a qualifying life event or submit paperwork to verify their SEP eligibility. The six-week open enrollment period (OEP) would bolster the forty-five-day OEP for 2021, which will have run from November 1 to December 15, 2020.

The Secretary has broad authority to establish Exchange SEPs for "exceptional circumstances" and regulate the Exchange generally.¹¹ Both the Obama and Trump administrations have leveraged this authority to extend prior OEPs and adopt extra-statutory SEPs.¹² In authorizing a six-week SEP, HHS could consider the effects of COVID-19, the higher uninsured rate, and the need to encourage enrollment among younger and healthier individuals in need of more time to enroll. The new SEP could also be used to help settle litigation over the Trump administration's refusal to allow a broad-based SEP in response to the COVID-19 pandemic.¹³

This SEP will also help ensure that as many consumers as possible can enroll in comprehensive coverage and, as such, is consistent with the EO and overall goal of the ACA to expand health coverage and promote Exchange viability. This temporary SEP can be announced and implemented without rulemaking, but HHS should issue a general guidance document and press release (as it has done in announcing other SEPs).¹⁴ This operational shift is an important stop-gap measure until a new regulation is put in place to permanently extend the annual OEP to ninety days.

Increase Federal Funding toward HealthCare.gov Marketing

The EO should encourage HHS to allocate and begin spending ideally at least \$100 million towards HealthCare.gov marketing until the 2022 OEP, when an additional \$100 million should be made available. This spending is within HHS's discretion and could be drawn from insurer fees for using the Federally Facilitated Exchange. Total user fees amounted to more than \$1.8 billion annually in 2018 and 2019.¹⁵ Although the user fee percentage was lowered beginning in 2020 and some states have transitioned away from

¹⁰ The EO could include additional policies, such as encouragement to upgrade HealthCare.gov consumer tools and the adoption of standardized benefit plans. See Maura Calsyn & Nicole Rapfogel, Administrative Actions to Reverse Sabotage and Lower Costs in the ACA Marketplaces, Center for American Progress (Jul. 14, 2020), <https://www.americanprogress.org/issues/healthcare/reports/2020/07/14/487610/administrative-actions-reverse-sabotage-lower-costs-aca-marketplaces/>.

¹¹ See 42 U.S.C. § 18031(c)(6)(C) (authorizing the Secretary to provide for SEPs under HIPAA and circumstances similar to Medicare Part D); 42 U.S.C. § 300gg-1(b)(3) (directing the Secretary to establish marketwide SEPs for qualifying events under ERISA); see also 42 U.S.C. § 18041(a) (providing broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges).

¹² The Obama administration regularly extended its OEP deadlines, and the Trump administration extended the 2020 OEP due to technical glitches with HealthCare.gov. See Centers for Medicare and Medicaid Services ("CMS"), CMS Statement on Health Insurance Exchange Open Enrollment Extension (Dec. 16, 2019), <https://www.cms.gov/newsroom/press-releases/cms-statement-health-insurance-exchange-open-enrollment-extension>; Timothy Jost, Implementing Health Reform: Open Enrollment Closes, But Door Remains Ajar, Health Affairs Blog (Feb. 17, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150217.044788/full/>.

¹³ See *Chicago v. Azar*, No. 1:20-cv-01566 (D.D.C., filed Jun. 15, 2020).

¹⁴ See, e.g., CMS, Emergency and Major Disaster Declarations by the Federal Emergency Management Agency (Aug. 9, 2018), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf>; CMS, CMS Announces Special Enrollment Periods for Americans Impacted by Recent Hurricanes (Sep. 28, 2017), <https://www.cms.gov/newsroom/press-releases/cms-announces-special-enrollment-periods-americans-impacted-recent-hurricanes>.

¹⁵ See Center for Consumer Information and Insurance Oversight, 2018 User Fee Data (May 9, 2019) and 2019 User Fee Data (Jul. 9, 2019), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

the HealthCare.gov platform, user fees could still easily absorb an investment of \$200 million toward marketing.

The initial \$100 million should be used to advertise the availability of the new six-week SEP noted above, and other SEPs once that period closes. These funds could be used for television ads, and marketing through digital media, email, and text messages. Funding at this level would enable HHS to engage in general marketing as well as targeted outreach to industries most affected by COVID-19; gig workers; and state unemployment offices.¹⁶ Outreach should be targeted to the millions of consumers who will likely be eligible for a no-premium bronze plan for 2021, and HHS should coordinate with the Internal Revenue Service to send outreach letters to uninsured taxpayers, which was shown to save lives.¹⁷

This investment is particularly important because awareness of ACA enrollment opportunities remains low.¹⁸ The Trump administration's shortened OEP, combined with dramatic funding cuts for outreach and education,¹⁹ has led to consumer confusion and contributed to stagnant enrollment through HealthCare.gov. As of 2019, HealthCare.gov had an estimated 2.3 million fewer new enrollees—an important indicator of a healthy risk pool—because of these cuts.²⁰

A \$100 million investment is consistent with prior advertising funding levels under the Obama administration and may even be too low. Covered California, for instance, invested more than \$121 million on marketing and outreach for 2019 to 2020 alone.²¹ Covered California invested an additional \$9 million in pandemic-related advertising and outreach in 2020, which it described as “the main driver of increased enrollment” during the pandemic.²² This investment, coupled with broad SEPs, led to a peak in all-time effectuated enrollment in Covered California as of June 2020.²³ (In contrast, HHS invested only \$10 million in advertising for HealthCare.gov and \$10 million for outreach during prior annual OEPs.) Even before the pandemic, Covered California's commitment to marketing and outreach had been shown to help maintain lower premiums through a healthier, more diverse risk pool.²⁴

As with the six-week SEP, no formal regulatory action is required of HHS to invest these funds in marketing. However, HHS may want to issue brief guidance outlining its plan. The Trump administration issued this type of guidance in cutting marketing funding in 2017.²⁵

¹⁶ Many of these advertising and outreach strategies have been honed by state-based Exchanges. *See, e.g.*, Sabrina Corlette & Rachel Schwab, States Lean In as the Federal Government Cuts Back on Navigator and Advertising Funding for the ACA's Sixth Open Enrollment Period, The Commonwealth Fund (Oct. 26, 2018), <https://www.commonwealthfund.org/blog/2018/states-lean-federal-government-cuts-back-navigator-and-advertising-funding>.

¹⁷ *See* Rachel Fehr, How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020? Kaiser Family Foundation (Dec. 10, 2019), <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/>; Sarah Kliff, “The I.R.S. Sent a Letter to 3.9 Million People. It Saved Some of Their Lives,” *New York Times* (Dec. 10, 2019).

¹⁸ In 2019, only 5 percent of uninsured consumers knew the final deadline to enroll in 2020 coverage. Joshua Peck, 2019 Open Enrollment Preview, Medium (Oct. 30, 2019), <https://medium.com/get-america-covered/get-america-covered-2019-open-enrollment-period-preview-325be4c029c5>; *see also* Ashley Kirzinger et al., KFF Health Tracking Poll—November 2018: Priorities for New Congress and the Future of the ACA and Medicaid Expansion, Kaiser Family Foundation (Nov. 28, 2018), <https://www.kff.org/report-section/kff-health-tracking-poll-november-2018-priorities-for-new-congress-and-the-future-of-the-aca-and-medicaid-expansion-findings/>.

¹⁹ *See* Karen Pollitz et al., Data Note: Limited Navigator Funding for Federal Marketplace States, Kaiser Family Foundation (Nov. 13, 2019), <https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>; Timothy Jost, CMS Cuts ACA Advertising by 90% Amid Other Cuts to Enrollment Outreach, Health Affairs Blog (Aug. 31, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170901.061790/full/>.

²⁰ Oversight Hearing: Impact of the Administration's Policies Affecting the Affordable Care Act of the House Comm. on Appropriations, 116th Cong. (2019) (statement of Joshua Peck, Co-Founder, Get America Covered).

²¹ Covered California, Annual Report: Fiscal Year 2019-20 (Jun. 26, 2019), <https://hbex.coveredca.com/financial-reports/PDFs/2019/fy-2019-20-annual-report-final.pdf>.

²² Covered California, Coverage When You Need It: Lessons from Insurance Coverage Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic, at 10-11 (Sep. 22, 2020), https://hbex.coveredca.com/data-research/library/CoveredCA_Coverage-When-You-Need-It_09-22-20.pdf.

²³ *Id.* at 5.

²⁴ Covered California, Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets (Sep. 2017), https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

²⁵ Center for Consumer Information and Insurance Oversight, Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period (Aug. 31, 2017),

Restore Complete, Accurate Information about the ACA on Government Websites

The EO should encourage HHS (and other federal agencies, where relevant) to review HealthCare.gov and other government websites to restore complete, accurate information about the ACA, its benefits, and enrollment options. A comprehensive review of existing content followed by appropriate, timely website updates is needed to promote accurate information about the ACA, and ensure that consumers understand their coverage options. The Trump administration has made numerous changes to HealthCare.gov, ranging from the promotion of enrollment through agents and brokers to removing links to instructions for enrollment by mail or phone.²⁶ Management of HealthCare.gov and other government websites is entirely within the government's discretion, and no formal regulatory action is required to review and update these resources websites.

Direct HHS to Adopt Any Other Policies to Achieve the Administration's Goals

The EO should generally encourage HHS to adopt any other policies to maximize new enrollment in ACA and Medicaid coverage and ensure that consumers can maintain their coverage.²⁷ Though the EO would not alter HHS's legal authority in any way, HHS could cite this EO in the future in making additional operational or regulatory changes, such as issuing the "market modernization" rule. The EO could also encourage federal officials to explore more thoroughly all possible changes that would be consistent with the intent of the EO.

(4) Direct HHS and Other Federal Agencies to Initiate Longer-Term Rulemaking Processes

Finally, the EO could direct HHS and other federal agencies to consider rulemaking or other lawful action on a range of topics. This memorandum suggests at least five longer-term priorities that have been briefed in other Roadmap 2021 memoranda, but there is flexibility to include more, fewer, or different policies than those outlined here. These policies are below.

- **Withdraw guidance that promotes the availability of non-ACA plans or unduly restricts access to Medicaid coverage.** The EO could direct HHS and the Treasury Department to withdraw guidance on Section 1332 waivers formally within ninety days. Medicaid work requirements, Medicaid block grants, and any other guidance that promotes the availability of non-ACA plans or unduly restricts access to Medicaid coverage. Withdrawal of non-binding guidance is within the scope of HHS's authority, and the ninety-day period would provide time for the agencies to decide whether to reinstate prior guidance, where relevant. The EO could be cited in pending Supreme Court litigation over the approval of waivers with Medicaid work requirements to request a dismissal or delay.
- **Issue a notice of proposed rulemaking to revise short-term limited duration insurance (STLDI) standards.** The EO could direct the tri-agencies—HHS, Labor, and the Treasury—to issue, within ninety days, a notice of proposed rulemaking to revise STLDI standards in a way that better protects people with preexisting conditions. The goal of this rulemaking is to revert, at a minimum, to an Obama-era rule that limited STLDI to three months and made these products non-renewable.

<https://web.archive.org/web/20170906175907/https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017pdf.pdf>

²⁶ See Rachel Bergman et al., *Erasing the Affordable Care Act: Using Government Web Censorship to Undermine the Law*, Sunlight Foundation (2019), <http://sunlightfoundation.com/wp-content/uploads/2019/05/Erasing-the-ACA-Using-Web-Censorship.pdf>; Calsyn & Rapfogel, *supra* note 10.

²⁷ This could include increased funding for the navigator program, although the Trump administration already finalized funding agreements with navigator entities for 2020 and 2021. Katie Keith, CMS Announces New Navigator Grantees for 2020, 2021, Health Affairs Blog (Sep. 1, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190831.204373/full/>.

- **Fix the family glitch.** The EO could direct the Treasury Department to issue a notice of proposed rulemaking to fix the “family glitch” within ninety days. Doing so would extend Exchange subsidies to millions of family members in low-income families. Including this policy in the EO could help ensure that the rulemaking process is initiated quickly.
- **Provide flexibility on premium tax credit reconciliation.** The EO could direct the Treasury Department to announce, within thirty days, a temporary nonenforcement policy for premium tax credit reconciliation during the 2020 tax filing season. This policy would ensure that millions of consumers are not penalized because of COVID-19-related income fluctuations during the 2020 tax year. Including this policy in the EO could help ensure that this policy is adopted quickly and ideally reflected in notices sent to taxpayers.
- **Develop a multi-agency common rule to further implement Section 1557.** The EO could direct HHS and the Department of Justice to initiate, within ninety days, the development of a multi-agency common rule that implements Section 1557’s protections on a government-wide basis. Doing so is key to advancing health equity, responding to the Supreme Court’s historic decision in *Bostock v. Clayton County, Georgia*, and underscoring the administration’s commitment to equality and nondiscrimination. Including this policy in the EO would show that this multi-agency effort is a priority for the White House and should be initiated quickly.

Note that the timelines listed above for each rulemaking activity are only suggestions. EOs can be used to direct agency action within any timeframe. However, agencies often do not meet the deadlines set in EOs, regardless of how much time is given. Thus, an extended deadline of, say, 180 days, will convey less urgency and could result in delayed rulemaking.

