



HOUSE V. PRICE:

An Ongoing Threat to Cost-Sharing Reductions and Marketplace Stability

EXECUTIVE SUMMARY

As the U.S. Congress grapples with the potential repeal, replacement, or alteration of the Affordable Care Act (ACA), a more immediate threat to the law is currently pending in the federal courts. The case, *United States House of Representatives v. Price* (*House v. Price*), concerns whether Congress properly appropriated money to fund the ACA's cost-sharing reductions (CSRs) for consumers making up to 250 percent of the federal poverty level. In 2016, the federal district court for the District of Columbia ruled that money was not appropriated properly, putting billions in payments to insurers at risk, but delayed implementation of its ruling until the appeals process concluded. The case now remains in abeyance as the Trump Administration considers whether to move forward with the appeal and continue reimbursing insurers for the CSRs during that process. The loss of CSR funding could lead to reduced insurer participation and higher premiums on the Massachusetts Health Connector (Massachusetts's state marketplace) and increased spending on premium subsidies for the federal government.

Please note that this Issue Brief provides an assessment of CSR funding concerns as of July 11, 2017. However, this issue is rapidly evolving and may be impacted by current federal health care reform efforts as they progress.

The Center for Health Law & Policy Innovation provides information and technical assistance on issues related to health reform, public health, and food law. This document should not be considered legal advice. For specific legal questions, consult with an attorney.

Center for Health Law
and Policy Innovation

122 Boylston Street
Jamaica Plain, MA 02130

chlpi@law.harvard.edu
www.chlpi.org

ABOUT THE AUTHORS

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, government officials, and others to expand access to high-quality healthcare; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health and public health law and policy.

House v. Price: An Ongoing Threat to Cost-Sharing Reductions and Marketplace Stability is written by CHLPI, Michael Cunniff, Katie Garfield, and Amy Rosenberg.

CASE BACKGROUND

The ACA provides for two forms of assistance for middle and lower-income consumers on the individual market: **Advance Premium Tax Credits (APTCs)** and **Cost-Sharing Reductions**. APTCs are available to individuals with incomes between 100-400 percent of the federal poverty level (FPL).¹ These credits help consumers afford coverage under qualified health plans (QHPs) on the individual exchanges by defraying premium costs.² Since APTCs are tax credits, they are administered through the tax code.³ APTCs are not at issue in *House v. Price*. Instead, *House v. Price* concerns the second category of assistance provided under the ACA: Cost-Sharing Reductions (CSRs). The ACA mandates that insurers further assist low-income consumers by providing CSRs to reduce out-of-pocket costs, such as deductibles, co-pays, and out-of-pocket maximums, for consumers with incomes between 100-250 percent of FPL who enroll in silver-level plans on the individual exchanges.⁴ The federal government then periodically reimburses insurers for these reductions.⁵ The Congressional Budget Office has projected that the federal government will provide insurers with \$7 billion in CSR payments in 2017 and \$10 billion in 2018.⁶

In *House v. Price*, the House of Representatives argued that Congress never properly appropriated money to fund the CSR payments. They argue that the ACA created the CSR program, but that the program required annual appropriation from Congress.⁷ This, they say, violates the Appropriations Clause of the Constitution,⁸ a provision that prohibits spending federal money without appropriation.⁹ In May 2016, the D.C. District Court agreed with the House, granting the plaintiffs summary judgment and an injunction that would prohibit any more reimbursements until Congress had properly appropriated funds to the CSR program.¹⁰ However, the court stayed its ruling, allowing the Obama Administration to continue to reimburse insurers while the case was on appeal.¹¹

CURRENT STATUS OF THE CASE

The election of President Donald Trump, and his Administration's inheritance of the *House v. Price* case, has made the fate of the CSR program even more uncertain. Shortly after his election win, the D.C. Circuit Court of Appeals agreed on a motion to hold the case "in abeyance"¹² – essentially pausing the progression of the case. Since that time, the Circuit Court has agreed to continue to hold the case in abeyance, with status reports provided to the court every three months.¹³ In the most recent status report, submitted on May 22, 2017, the parties to the case asked that the abeyance continue as they "discuss measures that would obviate the need for judicial

determination of this appeal, including potential legislative action.”¹⁴ This language suggests the possibility of a legislative solution – such as congressional appropriation of the CSR funds. The Senate health care reform package – the “Better Care Reconciliation Act” – includes provisions that would provide funding for the CSRs through 2019 and then eliminate the obligation for insurers to provide CSRs thereafter.¹⁵ Political analysts predict that Republican senators will attempt to bring this bill to a vote at some point during the summer of 2017.¹⁶

In the absence of such a congressional appropriation, the Trump Administration can choose to continue providing the reimbursements so long as the appeal is pending.¹⁷ However, although the Administration has funded the CSRs up to this point, the Department of Health and Human Services has refused to confirm whether it will continue to do so, stating that “we are weighing our options and still evaluating the issues.”¹⁸ Additionally, if the Trump Administration decides to drop the appeal altogether, the district court ruling would become final, and the Administration would be required to halt payments to insurers. Fearing this eventuality, the Attorney Generals of 15 states, including Massachusetts, and the District of Columbia recently submitted a motion to intervene in the case, stating that the Trump Administration does not adequately represent their interests and that termination of the CSRs would harm states and millions of state residents by driving up premiums and uninsurance rates.¹⁹ The D.C. Circuit Court has yet to rule on this motion.

IMPACT ON COVERAGE ON HEALTH CARE EXCHANGES

Elimination of CSR funding, either because the Trump administration loses or decides to drop the appeal in *House v. Price*, would have a significant impact on the availability and pricing of plans on the state and federal exchanges. In interviews with health insurers operating in 28 states, Urban Institute found that most respondents would withdraw from the exchanges if the federal government stopped funding CSRs.²⁰ Insurers that continue to offer plans on the exchanges would remain obligated under the ACA to offer CSRs to individuals buying silver plans who are making less than 250 percent of FPL.²¹ To mitigate these new uncompensated costs, analysts predict that insurers that remain in the exchanges will charge higher premiums for their silver plans.²² Specifically, the Kaiser Family Foundation estimates that insurers participating in the federal exchange (i.e., Healthcare.gov) would need to raise silver plan premiums by an average of 19% to make up for the loss of CSR funding.²³ These changes to plan rates and participation would, in many cases, not occur until the subsequent plan year. If CSR payments end abruptly in the midst of a plan year, insurers may attempt to make more immediate changes, but may face challenges under state and federal laws and regulations.²⁴

The current uncertainty surrounding the fate of CSR funding is therefore already impacting insurer decision-making regarding their 2018 plans. Insurers had to make an initial determination of whether they will participate in the 2018 federal health care exchange (HealthCare.gov) by June 21st.²⁵ Insurers then have until September 2017 to finalize their participation.²⁶ Similar deadlines are also approaching in states, such as Massachusetts, which operate state-run exchanges.²⁷ Already, some insurers have decided to exit the exchanges, potentially leaving some states – such as Indiana, Ohio, and Nevada²⁸ – with counties where no plans are available. Furthermore, some plans are requesting significant rate increases in anticipation of the potential loss of CSR reimbursement.²⁹

Elimination of CSR funding is also predicted to result in a significant increase in federal health care costs. Because APTCs are calculated based upon the premium for a benchmark silver plan (the second lowest-cost silver plan in each region),³⁰ an across-the board increase in silver plan premiums would result in higher APTCs.³¹ As a result, the federal government would see an increase in costs to pay for the higher APTCs. The Kaiser Family Foundation predicts that the federal government would experience a net increase in costs of \$2.3 billion for fiscal year 2018 – 23% more than what it would save from the elimination of the CSRs.³² In contrast, many individuals who receive APTCs would be at least somewhat protected or potentially benefit from the premium increase, as their tax credits

would rise to help them afford the higher premiums for low-cost silver plans or could be used to pay for bronze, gold, or platinum plans that may not have experienced premium increases.³³

IMPACT ON COVERAGE IN MASSACHUSETTS

In past years, Massachusetts has experienced fairly robust participation in its individual health care exchange (i.e., the Massachusetts Health Connector). In 2017, 10 insurance carriers participated in the Health Connector.³⁴ Insurers were required to indicate their intention to participate in the 2018 exchange by responding to the state's Request for Response by May 12, 2017.³⁵ They will then submit proposed rates for their plans in July 2017.³⁶ Plans will be approved by the Health Connector in September 2017.³⁷ While exact information on the submitted responses does not yet appear to be available, early participation projections released by the Centers for Medicare & Medicaid Services (CMS) indicate that more than three carriers will be operating in each Massachusetts county in 2018.³⁸ Thus, despite concerns regarding CSR funding, many insurers are predicted to continue operating in the Massachusetts exchange, meaning that state residents will hopefully continue to have a variety of options when purchasing insurance on the individual marketplace.

However, failure by the federal government to fund the CSRs, or ongoing uncertainty regarding that funding, could yet have serious repercussions for insurers and consumers participating in Massachusetts's Health Connector, and especially the **ConnectorCare** program. In the wake of the ACA's passing, Massachusetts reshaped its individual market to take advantage of the federal subsidies (both tax credits and cost-sharing reductions).³⁹ ConnectorCare, which provides subsidized insurance with standardized out-of-pocket costs for individuals making up to 300 percent FPL, makes use of APTCs, cost-sharing reductions, and additional "wrap-around" state funding to reduce cost-sharing further than the ACA requires.⁴⁰ Although all Massachusetts insurers participating in the Health Connector are required to propose a ConnectorCare plan, only certain plans are chosen to actually participate.⁴¹ In 2017, 7 insurance carriers participated in the ConnectorCare program.⁴² As of May 2017, 245,748 individuals were enrolled in coverage on the Massachusetts Health Connector.⁴³ Of those individuals, 184,838 – or roughly 75% – were enrolled in ConnectorCare.⁴⁴

According to a May 2017 letter from Governor Baker to Senate Finance Committee leaders Orrin Hatch and Ron Wyden, Massachusetts insurers stand to lose \$63 million in unreimbursed CSR costs for 2017 and \$123 million in 2018.⁴⁵ Insurers participating in the ConnectorCare program would bear the brunt of these losses, as CSR subsidies are only available to ConnectorCare plan members in Massachusetts.⁴⁶ If uncertainty regarding CSR funding continues or the federal government stops payment of CSRs, ConnectorCare insurers may pass the costs of providing unreimbursed cost-sharing reductions back onto the federal government and consumers in the form of higher premiums. These changes would likely have little immediate impact on individuals in the ConnectorCare plans or otherwise receiving APTCs, as tax credits would rise to allow them to afford the increases. However, consumers who are not eligible for APTCs could be driven towards bronze plans, which have lower premiums but higher cost-sharing, or out of the marketplace entirely.

Alternatively, insurers may attempt to flee the individual market prior to finalizing their contracts with the Health Connector in the fall of 2017 or decide not to return in the 2019 plan year. Massachusetts could attempt to encourage insurers to stay in the marketplace by allocating additional state funds to support the ConnectorCare program. However, such a move could be unlikely in the current political environment, as Massachusetts is experiencing lower than predicted revenues⁴⁷ and considering changes to its health care programs to cut costs.⁴⁸ Therefore, although the Massachusetts marketplace currently appears robust and stable, it remains at risk until the question of CSR funding is permanently resolved.

If the current Senate health care reform proposal is passed, Massachusetts insurers will be assured of receiving CSR funds for the next two years, providing greater stability in the Massachusetts state marketplace in the short term. However, passage of that bill would likely result in broader issues for Massachusetts's insurance market in the long term. The bill completely eliminates CSRs beginning in 2020.⁴⁹ Since the ConnectorCare program relies on a combination of CSRs, APTCs, and state funds to keep out-of-pocket costs low for consumers, this change would significantly undermine the structure of the program. As a result, the state would either have to provide additional funding to maintain the ConnectorCare program in its current state or raise costs for ConnectorCare participants.

The ongoing uncertainty regarding the future of CSR funding is particularly problematic for individuals living with serious and costly chronic or infectious illnesses such as hepatitis C, HIV, and diabetes. If insurers exit the marketplace, these individuals may be forced to change plans. Such changes can result in disruption or gaps in care due to differences in provider networks, cost-sharing, covered benefits, and utilization management requirements. Moreover, individuals who do not have access to APTCs may face significantly higher premiums when trying to maintain coverage with their current insurer, putting a greater strain on their household resources. Finally, if CSRs are eliminated entirely in 2020, low-income individuals may be required to pay higher cost-sharing when receiving care. Individuals living with chronic and infectious illness will be hit particularly hard by these higher cost-sharing burdens, as they often require access to more frequent or costly services. It is therefore crucial that Massachusetts stakeholders continue to educate federal legislators and Administration officials on the important role that CSR funding plays in our health care system and the urgent need to resolve the uncertainty regarding its future. By establishing stable CSR funding the federal government can better ensure the stability of the individual marketplace and access to affordable coverage for Massachusetts's most vulnerable populations.

ENDNOTES

- ¹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401 (2010).
- ² The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401 (2010).
- ³ See 26 U.S.C.S. § 36B; Nicholas Bagley, *Trump's Ominous Threat to Withhold Payment from Health Insurers, Explained*, Apr. 27, 2017, <https://www.vox.com/the-big-idea/2017/3/29/15107836/lawsuit-aca-payments-reimbursement-unconstitutional> (last visited June 6, 2017).
- ⁴ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1402 (2010); 42 U.S.C. § 18071.
- ⁵ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1402 (2010); 42 U.S.C. § 18071.
- ⁶ *Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline*, Congressional Budget Office (2017), available at <https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf>.
- ⁷ See Memorandum of Points and Authorities in Support of Plaintiff United States House of Representatives' Motion for Summary Judgment, *United States House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016) No. 14-cv-01967-RMC.
- ⁸ U.S. Const. art I § 9, cl. 7 ("No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law . . .").
- ⁹ See Memorandum of Points and Authorities in Support of Plaintiff United States House of Representatives' Motion for Summary Judgment, *United States House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016) No. 14-cv-01967-RMC.
- ¹⁰ *United States House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 189 (D.D.C. 2016).
- ¹¹ *United States House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 189 (D.D.C. 2016).
- ¹² *United States House of Representatives v. Burwell*, No. 16-5202, 2016 WL 8292200, at *1 (D.C. Cir. Dec. 5, 2016).
- ¹³ Joint Status Report, *United States House of Representatives v. Price*, No. 16-5202 (May 22, 2017), available at <http://premiumtaxcredits.wikispaces.com/file/view/DCC%20joint%20status%20report%205%2022.pdf/613338555/DCC%20joint%20status%20report%205%2022.pdf>.
- ¹⁴ Joint Status Report, *United States House of Representatives v. Price*, No. 16-5202 (May 22, 2017), available at <http://premiumtaxcredits.wikispaces.com/file/view/DCC%20joint%20status%20report%205%2022.pdf/613338555/DCC%20joint%20status%20report%205%2022.pdf>.
- ¹⁵ H.R. 1628, Better Care Reconciliation Act, 115th Congress §§ 210 – 211 (amendment in nature of substitute to House bill),

- available at <https://www.budget.senate.gov/imo/media/doc/BetterCareJuly13.2017.pdf>.
- ¹⁶ Jennifer Haberkorn et al., *Republicans scramble to revise health bill in 48 hours*, POLITICO (June 28, 2017), <http://www.politico.com/story/2017/06/28/republicans-health-bill-240073>.
- ¹⁷ See Paul Demko et al., *White House Seeks 90-day Delay in Obamacare Subsidy Suit*, POLITICO (May 22, 2017), <http://www.politico.com/story/2017/05/22/white-house-to-seek-90-day-delay-in-obamacare-subsidy-suit-238674>.
- ¹⁸ Paul Demko, *Looming Obamacare deadline forces decision from skittish insurers*, POLITICO (June 20, 2017), <http://www.politico.com/story/2017/06/20/insurers-obamacare-markets-239779>.
- ¹⁹ Motion to Intervene, *United States House of Representatives v. Price*, No. 16-5202 (D.C. Cir. May 18, 2017), available at https://ag.ny.gov/sites/default/files/2017-05-18_-_states_motion_to_intervene.pdf.
- ²⁰ Sabrina Corlette et al., *Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices*, URBAN INSTITUTE, at 7 (Jan. 2017), available at <http://www.urban.org/research/publication/uncertain-future-affordable-care-act-leads-insurers-rethink-participation-prices>.
- ²¹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1402 (2010); 42 U.S.C. § 18071.
- ²² See Linda Blumberg and Matthew Buettgens, *The Implications of a Finding for the Plaintiffs in House v. Burwell*, URBAN INSTITUTE, at 4 (Jan. 2016), <http://www.urban.org/sites/default/files/publication/77111/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf>; Larry Levitt et al., *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments*, KAISER FAMILY FOUNDATION, at 1 (Apr. 2017), available at <http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>.
- ²³ *Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies*, KAISER FAMILY FOUNDATION (Apr. 6, 2017), <http://kff.org/health-costs/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/>.
- ²⁴ See, e.g., Brief for America's Health Insurance Plans as Amicus Curiae, *House v. Burwell*, No. 16-5202, at 22-23 (D.C. Cir. Oct. 31, 2016), available at <http://premiumtaxcredits.wikispaces.com/file/view/Corrected%20AHIP%20amicus.pdf/597610986/Corrected%20AHIP%20amicus.pdf>.
- ²⁵ Paul Demko, *Looming Obamacare deadline forces decision from skittish insurers*, POLITICO (June 20, 2017), <http://www.politico.com/story/2017/06/20/insurers-obamacare-markets-239779>.
- ²⁶ Paul Demko, *Looming Obamacare deadline forces decision from skittish insurers*, POLITICO (June 20, 2017), <http://www.politico.com/story/2017/06/20/insurers-obamacare-markets-239779>.
- ²⁷ In Massachusetts, insurers must submit Request for Response responses on May 12, 2017 and must submit proposed rates for their plans in July 2017. Plans will be approved by the Health Connector in September 2017. See *Request for Responses Health Benefit Plans – Seal of Approval*, COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY, at 15 (June 30, 2017), available at <https://www.commbuys.com/bsi/external/bidDetail.sdo?docId=BD-14-1175-1175C-1175L-14119&external=true&parentUrl=bid>.
- ²⁸ *Counties at Risk of Having No Insurer on the Marketplace (Exchange) in 2018*, KAISER FAMILY FOUNDATION (June 30, 2017), <http://www.kff.org/interactive/counties-at-risk-of-having-no-insurer-on-the-marketplace-exchange-in-2018/>.
- ²⁹ See, e.g., Sarah Liff, *Insurance CEO: I'm raising Obamacare premiums because of Trump*, VOX (May 30, 2017), <https://www.vox.com/2017/5/30/15701986/blue-cross-north-carolina-obamacare-premiums>.
- ³⁰ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401 (2010).
- ³¹ Larry Levitt et al., *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments*, KAISER FAMILY FOUNDATION, at 1 (Apr. 2017), available at <http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>.
- ³² Larry Levitt et al., *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments*, KAISER FAMILY FOUNDATION, at 1 (Apr. 2017), available at <http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>.
- ³³ Linda Blumberg and Matthew Buettgens, *The Implications of a Finding for the Plaintiffs in House v. Burwell*, URBAN INSTITUTE (2017), <http://www.urban.org/sites/default/files/publication/77111/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf>.
- ³⁴ See *CCA Board Report Metrics*, Massachusetts Health Connector (May 4, 2017), available at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/05-11-2017/Summary-Report-April2017.pdf. These carriers were: Blue Cross Blue Shield of MA; BMC HealthNet Plan; CeltiCare; Fallon Community Health Plan; Harvard Pilgrim Health Care; Health New England; Minuteman Health; Neighborhood Health Plan; Tufts Health Direct; and Tufts Health Premier. *Id.*
- ³⁵ See *Request for Responses Health Benefit Plans – Seal of Approval*, COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY, at 15 (June 30, 2017), available at <https://www.commbuys.com/bsi/external/bidDetail.sdo?docId=BD-14-1175-1175C-1175L-14119&external=true&parentUrl=bid>.
- ³⁶ *Id.*
- ³⁷ *Id.*
- ³⁸ *County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges*, CTCS. FOR MEDICARE &

- MEDICAID SRVS. (June 27, 2017), available at <https://downloads.cms.gov/files/ccii/ccii-exchange-carriers-by-county-06-27-2017.pdf>.
- ³⁹ Jaimie Bern, Stephanie Chrobak & Tom Dehner. *Implementing the Affordable Care Act in Massachusetts: Changes in Subsidized Coverage Programs*, BLUE CROSS BLUE SHIELD OF MASS. FOUND. 8-10 (2015), http://bluecrossmafoundation.org/sites/default/files/download/publication/Changes%20in%20Subsidized%20Coverage%20Programs_final.pdf.
- ⁴⁰ Jaimie Bern, Stephanie Chrobak & Tom Dehner. *Implementing the Affordable Care Act in Massachusetts: Changes in Subsidized Coverage Programs*, BLUE CROSS BLUE SHIELD OF MASS. FOUND. 8-10, 13-14 (2015), http://bluecrossmafoundation.org/sites/default/files/download/publication/Changes%20in%20Subsidized%20Coverage%20Programs_final.pdf.
- ⁴¹ See *Request for Responses Health Benefit Plans – Seal of Approval*, COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY, at 46 (June 30, 2017), available at <https://www.commbuys.com/bsi/external/bidDetail.sdo?docId=BD-14-1175-1175C-1175L-14119&external=true&parentUrl=bid>.
- ⁴² See *CCA Board Report Metrics*, Massachusetts Health Connector (May 4, 2017), available at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/05-11-2017/Summary-Report-April2017.pdf. These carriers were: BMC HealthNet Plan; CeltiCare; Fallon Community Health Plan; Health New England; Minuteman Health; Neighborhood Health Plan; and Tufts Health Direct. *Id.*
- ⁴³ See *CCA Board Report Metrics*, Massachusetts Health Connector (May 4, 2017), available at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/05-11-2017/Summary-Report-April2017.pdf.
- ⁴⁴ See *CCA Board Report Metrics*, Massachusetts Health Connector (May 4, 2017), available at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/05-11-2017/Summary-Report-April2017.pdf.
- ⁴⁵ Letter from Governor Charles Baker to Senators Orrin Hatch and Ron Wyden (May 19, 2017), available at <http://www.statehousenews.com/content/docs/2017/05-19bakerlettertosenate.pdf>.
- ⁴⁶ See *Request for Responses Health Benefit Plans – Seal of Approval*, COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY, at 44 (June 30, 2017), available at <https://www.commbuys.com/bsi/external/bidDetail.sdo?docId=BD-14-1175-1175C-1175L-14119&external=true&parentUrl=bid>.
- ⁴⁷ See e.g., Bob Salsberg & Steve LeBlanc, *Massachusetts Tax Revenues Tick up in May; Shortfall Remains*, U.S. NEWS (June 5, 2017), <https://www.usnews.com/news/best-states/massachusetts/articles/2017-06-05/massachusetts-takes-in-more-than-19b-in-taxes-in-may>.
- ⁴⁸ See Matt Murphy, *Baker Submits Compromise Proposal for Employers to Help Pay for Rising Health Care Costs*, WBUR (June 20, 2017), <http://www.wbur.org/commonhealth/2017/06/20/health-care-costs-baker-employers>.
- ⁴⁹ H.R. 1628, Better Care Reconciliation Act, 115th Congress §§ 210 – 211 (amendment in nature of substitute to House bill), available at <https://www.budget.senate.gov/imo/media/doc/BetterCareJuly13.2017.pdf>.