

Health Reform Update – Week of September 10, 2018

CONGRESS

House to vote on delaying employer mandate and “Cadillac” tax, despite \$58.5 billion cost

The House is set to vote next week on legislation that would relax the definition of full-time employee under the employer mandate in the Affordable Care Act (ACA), as well eliminate any penalties on employers from 2015-2018. It would also further delay the 40 percent excise tax on high-cost or “Cadillac” health plans until 2023.

The Save American Workers Act of 2018 (H.R. 3798) appears likely to pass, despite projections released this week by the Congressional Budget Office (CBO) showing that it would cost the federal government \$58.5 billion over the next ten years. However, if also approved by the Senate, the measure would give Republicans their long-sought goal of raising the threshold for the employer mandate, so that penalties would only be assessed on large employers (those with 50 or full-time employees) if they fail to offer minimum essential coverage to full-time employees working 40 or more hours per week (instead of the 30-hour per week threshold under the ACA.)

The legislation would not alleviate or eliminate the requirement that large employers report the number of workers meeting that threshold, nor would it have a significant budgetary impact as CBO projects it will only save \$1 billion over ten years. By contrast, the four-year moratorium on employer mandate enforcement would cost the federal government nearly \$26 billion in lost revenue over a decade, while postponing the “Cadillac” tax would cost another \$15.5 billion. The “Cadillac” tax had been slated to go into effect in 2018 but was delayed until 2022 (see Update for Week of January 22nd).

The Senate is not likely to pass the bill in its current form as it would require the support of at least nine Senate Democrats to reach the 60-vote threshold to advance to the floor and Democrats are not likely to support the measure without other provisions to offset the \$58.5 billion cost.

Congress likely to ban pharmacy “gag clauses” but not require price disclosures in drug advertisements

The House and Senate have advanced several measures that seek to prohibit contract clauses restricting a pharmacist from informing consumers when a prescription drug or biologic would be cheaper without using insurance.

The House Energy and Commerce Committee passed their so-called “gag clause” bill last week (H.R. 6733), which would prohibit such prohibitions in private insurance (which includes Affordable Care Act Marketplaces) and Medicare Advantage and Part D contracts. The Senate passed a similar measure restricting the clauses in the Medicare market (S.2553), while the measure that would apply to the commercial market (S. 2554) awaits a floor vote after clearing committee in late July.

All three measures were approved with bipartisan support and scant opposition, indicating they are likely to eventually be enacted. They have the backing of the Pharmaceutical Care Management Association, which insists that most pharmacy benefit management companies already exclude the clauses. The chairman of the Energy and Commerce health subcommittee Michael Burgess (R-TX) also acknowledged that Medicare already prohibits such “gag clauses” but was adamant that the prohibition be codified in statute in order to accomplish one of the bullet points in the President’s drug pricing “blueprint” released earlier this year (see Update for Week of May 7th).

However, House Republicans blocked another of the President’s “blueprint” items when they forced conferees to remove a provision from short-term spending legislation (H.R. 6157) that provided \$1 million for the Department of Health and Human Services to promulgate regulations requiring drug manufacturers disclose drug prices in direct-to-consumer advertisements (see Update for Week of May 7th). That part of the “blueprint” also has bipartisan support but was

opposed by the Pharmaceutical Research and Manufacturers of America (PhRMA), which insists that it will not benefit consumers and could be barred by the First Amendment.

HHS' proposed rule implementing the drug advertising requirement continues to await final paperwork clearance from the White House Office of Management and Budget.

FEDERAL AGENCIES

Census data shows uninsured rate stopped improving in 2017

The U.S. Census Bureau released new data this week showing that the nation's uninsured rate stopped declining during the first year of the Trump Administration

Roughly 28.5 million Americans or 8.8 percent of the population lacked health insurance coverage during 2017, the same percentage as the year before. The uninsured rate had previously been cut in half since the Affordable Care Act (ACA) was enacted in 2010, falling by at least 0.3 percentage points every year.

The Bureau's Current Population Survey found that only three states (California, Louisiana, and New York) continued to see improvement in their uninsured rate in 2017. Louisiana experienced the greatest decrease of nearly two percent due to their recent expansion of Medicaid (see Update for Week of June 20, 2016). California, whose uninsured rate fell by only 0.2 percent last year, still has an unprecedented ten percent drop from 2013-2017, the most of any state.

The uninsured rate actually worsened last year for 14 states. However, the vast majority of the increase occurred in four states that remain adamantly opposed to Medicaid expansion (Florida, Georgia, South Carolina, and Texas). Despite enrolling more ACA Marketplace consumers than any other state, Florida's uninsured rate actually increased by nearly half a percentage point to 12.9 percent, far above the national average of 8.8 percent.

Employer-based insurance remained the most common coverage type in 2017, accounting for 56 percent of the population. Another 36.5 percent were enrolled in either Medicaid or Medicare, while 16 percent subscribed to individual market plans or other direct-purchase coverage.

Trump Administration supporters insisted that the uninsured rate stalled due to the unaffordability of post-ACA coverage. Critics warned that the uninsured rate was likely to spike for 2018 and beyond after the Administration terminated ACA cost-sharing reductions for insurers, causing premiums to spike by more than 30 percent (see Update for Week of November 13th). The also pointed to a Government Accountability Office (GAO) report last month concluding the Administration's decision to slash the advertising and marketing budget for federally-facilitated Marketplaces by 90 percent, in addition to halving the open enrollment period, directly caused Marketplace enrollment to be depressed (see Update for Week of August 27th).

Health groups, states attempt to block Trump Administration's expansion of "junk" insurance

Seven consumer and provider groups filed a federal lawsuit this week seeking to block the Trump Administration's expansion of short-term health plans that do not comply with Affordable Care Act (ACA) consumer protections, while a dozen state attorneys general are taking legal action to prevent the Administration's similarly non-compliant association health plans (AHPs).

The Departments of Health and Human Services, Labor and Treasury finalized regulations last month that removed the Obama Administration's three-month limit on short-term health coverage and extended it up to the pre-ACA limit of 364 days (see Update for Week of August 13th). Insurers offering these plans will be allowed to limit benefits, impose annual and lifetime caps, and deny coverage to persons with pre-existing conditions or charge higher premiums based on health status.

The groups that filed the suit in the U.S. District Court for the District of Columbia include the National Alliance on Mental Illness, AIDS United, Association for Community Affiliated Plans, the American Psychiatric Association, and the Little Lobbyists, which represents children with complex medical needs. They allege that by siphoning away healthier and lower-cost consumers, the “junk” short-term plans will make ACA-compliant coverage “more expensive, and perhaps impossible, for some individuals with pre-existing conditions to obtain health care and health insurance coverage,” thereby undermining the legislative intent of the ACA.

Several Democratically-controlled states have already responded by enacting legislation or rules that more narrowly limit the use of short-term coverage (see Update for Week of August 27th). In addition, a dozen attorneys general led by New York and Massachusetts filed suit last summer in the District of Columbia federal court seeking to prevent the Administration from allowing the use of limited-benefit association health plans (AHPs). The attorneys general insist the AHP regulations finalized in June violated the federal Administrative Procedures Act (APA) and cited statements made by the President indicating that the rule is essentially a “politically-motivated attempt to dismantle the ACA.”

The AHP rule promulgated by the Department of Labor would allow small businesses and other groups in the same trade or profession to band together and purchase coverage in the large group market that does not comply with the ACA’s mandated package of essential health benefits (see Update for Week of June 25th). AHPs could vary premiums based on age and geography but unlike short-term health plans would not be allowed to discriminate based on pre-existing conditions.

Hospitals refile lawsuit to block Medicare Part B payment cuts for Section 340B drugs

The American Hospital Association and other hospital groups have refiled their federal lawsuit seeking to block a 27 percent cut in Medicare Part B payments for discounted drugs that safety-net hospitals purchase through the federal Section 340B program.

The cut was part of the Centers for Medicare and Medicaid Services (CMS) final rule governing the Medicare outpatient prospective payment system (see Update for Week of November 13th). Since it did not go into effect until January 1st, a federal judge dismissed the “premature” lawsuit the plaintiffs brought immediately after the final rule was published but allowed them to refile once their appeals process through federal agencies was exhausted (see Update for Week of January 8th). That ruling was upheld by an appellate court (see Update for Week of July 23rd).

The CMS action drew strong opposition from both sides of the aisle and House legislation (H.R. 4392) to overturn the cut quickly gained 174 cosponsors. However, legislative fixes were ultimately not included in spending bills for fiscal year 2018 (see Update for Week of March 19th).

STATES

Federal judge to quickly rule on whether Affordable Care Act can be enforced absent individual mandate

A federal judge in Texas indicated last week that he will soon decide whether to grant a preliminary injunction sought by attorneys general from 20 Republican-controlled states that would halt all enforcement of the Affordable Care Act (ACA).

Judge Reed O’Connor (an appointee of President George W. Bush) appeared to express support during oral arguments for the plaintiffs proposition that “all of Obamacare must fall” after Congress zeroed out the tax penalties for the individual mandate starting in 2019 (see Update for Week of December 18th). Although the U.S. Supreme Court declared the individual mandate to be constitutional under Congress’ power to tax (see Update for Week of June 25, 2012), the plaintiffs, led by Texas Attorney General Ken Paxton (R), note that the court reasoned the individual mandate could not be

severed from the ACA's other consumer protections, including the ban on pre-existing conditional denials and varying premiums based on health status.

The Trump Administration is backing the plaintiff's position, even though Department of Justice lawyers acknowledged during oral arguments that the outcome could not only strip pre-existing condition protections away from more than 133 million Americans in advance of the midterm elections but cause "chaos" in the individual health insurance market. Democratic attorneys general from the 17 states opposing the lawsuit have already asked the Fifth U.S. Circuit Court of Appeals to immediately stay or block any injunction granted by the lower court.

Although the validity of the lawsuit has been widely panned by legal scholars, Judge O'Connor has previously sided with Republican attorneys general on ACA disputes. This past spring, he ordered the federal government to refund nearly \$840 million to state Medicaid programs, ruling that the ACA health insurance provider fee could not be enforced on states. He also blocked Obama Administration regulations seeking to enforce ACA prohibitions on gender discrimination in federally-funded programs.

Despite ACA sabotage, average premium increases likely to be under four percent for 2019

A new analysis of available rate filings from 47 states and the District of Columbia reveal that the Affordable Care Act (ACA) Marketplaces have stabilized following two years of insurer departures and severe premium spikes.

The consulting firm Avalere Health determined that proposed or approved premiums are increasing at only a 3.6 percent average for 2019, a dramatic reversal from this year when premiums jumped by roughly 30 percent nationwide. Average premiums are actually expected to decline in 11 of the states reviewed by Avalere, while 41 of the 47 states will see premiums either fall or increase by only single-digits.

Increasing competition is a major reason for the lower premiums, as 19 states will see either new entrants to the Marketplaces or current insurers choosing to expand their coverage areas. (There will no "bare" counties for 2019.) However, most market analysts attribute the decline to the fact that insurers were allowed to greatly overcharge consumers in 2018 due to the uncertainty over whether Congress would repeal most of the ACA's consumer protections and how the termination of ACA cost-sharing reductions would impact the Marketplaces (see Update for Week of November 13th).

Democratic lawmakers continue to emphasize that premiums would be even lower for 2019 if not for the Trump Administration's efforts to "sabotage" the Marketplaces by repealing the individual mandate tax penalties, dramatically slashing enrollment periods and funding for outreach and marketing, and allowing limited-benefit or "junk" insurance to siphon healthier and lower-cost consumers away from Marketplace risk pools (see Update for Week of August 13th). The Government Accountability Office (GAO) confirmed last week that some of these Administration policies did depress Marketplace enrollment for 2018 (see Update for Week of August 27th) and the Centers for Medicare and Medicaid Services (CMS) actuary as well as the Urban Institute, Avalere, and other organizations have warned that they may put upward pressure on premiums for 2019 and subsequent years.

Arkansas

New work requirements terminate Medicaid coverage for more than 4,300 expansion enrollees

Department of Human Services officials acknowledged this week that more than 4,300 enrollees in Arkansas Works will lose their Medicaid coverage for the rest of 2018 because they did not comply for three consecutive months with new work and reporting requirements.

The Trump Administration approved the unprecedented work requirements for four states starting with Kentucky (see Update for Week of March 19th). However, Arkansas' became the first to go into effect on June 1st after a federal court in the District of Columbia deemed Kentucky's approval to be "arbitrary" and "capricious" because it failed to consider

that 95,000 enrollees would lose coverage (see Update for Week of June 25th). A comparable lawsuit against the Arkansas work requirements will be heard by the same judge (see Update for Week of August 13th).

Under former Governor Mike Beebe (D), Arkansas became the first state in the nation to receive federal approval to use ACA Medicaid expansion funds to instead purchase ACA Marketplace coverage for newly-eligible Medicaid enrollees (see Update for Week of September 25, 2013). Nearly 280,000 Arkansans are currently enrolled in the program.

The work requirements imposed by the Republican-controlled legislature initially only apply to the 27,140 Arkansas Works enrollees who are age 30-49. This group must file reports each month through an online portal showing that they spent 80 hours either working, volunteering, going to school full-time, or receiving job training. There is no option for reporting by phone, mail, or in-person.

The 4,353 enrollees who failed to submit online reports for the first three months make-up nearly 17 percent of age 30-49 enrollees. At that pace, nearly 20,000 Arkansas Works could lose coverage once the work requirements expand in January to those age 19-29.

Governor Asa Hutchinson (R) praised the success of the work requirements in saving taxpayers nearly \$30 million per year. However, he did not account for the costs of having to cover those newly-uninsured enrollees in other safety net programs or as uncompensated care.

At least nine other Republican-controlled states are seeking federal Section 1115 waivers that would allow them to impose similar work requirements (see Michigan below).

District of Columbia

Mayor signs alternative to ACA individual mandate into law

Mayor Muriel Bowser made the District of Columbia the fourth jurisdiction this week to create their own alternative to the individual mandate under the Affordable Care Act (ACA).

The mandate, which was part of the *Fiscal Year 2019 Budget Support Act* (B22-0753), was initially proposed by the ACA Working Group of insurers, small business owners, insurance brokers, consumer groups and health providers that was started in 2017 by DC Health Link, the ACA Marketplace created and operated by the District. The Working Group unanimously recommended last winter that DC Health Link create their own individual mandate (see Update for Week of February 26th) after the tax penalty for the ACA version was repealed by Congress (see Update for Week of December 18th), citing studies showing that the Marketplace was likely to suffer at least a 15 percent drop in enrollment without it (resulting in at least an immediate seven percent jump in premiums).

The mandate approved by the DC Health Link board will take effect on January 1st. It largely follows the ACA mandate. However, the maximum penalty (the greater of \$695 per uninsured adult or 2.5 percent of household income in 2018) will be tied to the average cost of a bronze plan in the District, as opposed to the average nationwide cost of a bronze plan. The ACA penalty was inflation-adjusted, so the District will now be responsible for setting that adjustment each year.

DC Health Link will retain most of the ACA exemptions. However, those covered under the DC Healthcare Alliance and Immigrant Children's Program will be exempt despite not being considered to have minimum essential coverage as defined by the ACA. In addition, those eligible but not enrolled in Medicaid will also be exempt from penalties.

The DC Health Link board refused to allow association health plans (AHPs) that do not need to comply with the ACA as minimum essential coverage, meaning those enrollees would be subject to the District's mandate penalty unless

they are enrolled in AHPs that met federal regulations as of 2017, before AHPs were expanded by the Trump Administration (see Update for Week of January 8th).

Congressional Republicans in the House attempted to block the District from implementing their own mandate (see Update for Week of July 23rd). However, the legislation they passed before the summer recess failed to advance in the Senate.

Massachusetts retained the individual mandate that it already had in place prior to the ACA, and New Jersey enacted its own individual mandate this summer, which will also start in 2019 (see Update for Week of May 7th). Vermont will have an individual mandate starting in 2020.

Maine

Governor submits court-ordered Medicaid expansion plan but asks Trump Administration to reject it

Governor Paul LePage (R) complied this week with the order from the Maine Supreme Judicial Court to submit a State Plan Amendment (SPA) to the federal government that expands Medicaid under the Affordable Care Act (ACA).

Voters overwhelmingly made Maine the first to expand Medicaid by the ballot box last fall (see Update for Week of November 6th). The referendum required the governor to submit the required paperwork to the federal Centers for Medicare and Medicaid Services (CMS) by April 3rd and start enrolling everyone earning up to 138 percent of the federal poverty level by July 2nd. However, the governor insisted that Maine could not afford the ten percent share of expansion costs under the ACA and waited to submit the SPA until his appeal of an adverse lower court order was ultimately heard by the Supreme Judicial Court (see Update for Week of August 27th).

However, in the SPA he submitted this week, the governor “strongly encourage[d] CMS to reject” the expansion plan, noting that he was only acting pursuant to the order of an “activist court” that ordered the expansion despite the lack of any legislative appropriation for the state share of costs. The SPA did not reference the fact that the Supreme Judicial Court upheld a lower court ruling concluding the Maine had sufficient reserves to fund the expansion for the upcoming fiscal year (see Update for Week of June 11th) nor that the governor vetoed the \$55 million in expansion funding that the legislature sought to appropriate (see Update for Week of July 7th).

Governor LePage had vetoed five prior attempts by the legislature to expand Medicaid under the ACA and pledged to “go to jail” before he allowed them to do so (see Update for Week of December 18th).

Maryland

Insurers ask for dramatic premium reductions after state enacts reinsurance program

CareFirst BlueCross Blue Shield has asked state regulators for permission to revise initial rate filings so that it can reduce average premiums for individual market consumers by 22.3 percent for 2019, while Kaiser Permanente has decided to seek a 7.8 percent average decrease.

The new rates are a dramatic turnaround from this spring, when both insurers sought increases that averaged 30.2 percent with CareFirst seeking rate hikes as high as 94 percent (see Update for Week of April 16th). This followed the more than 50 percent spike in premiums for silver-tier plans after the Trump Administration eliminated Affordable Care Act (ACA) cost-sharing reductions for 2018.

The increases were among the highest in the nation and compelled the legislature and the Maryland Health Benefit Exchange to seek federal permission to become one of seven states allowed to provide insurers with reinsurance payments for exceptional claims.

The Section 1332 waiver, which was authorized under the ACA, was approved by the Trump Administration last month (see Update for Week of August 27th). It allows Maryland to use a 2.75 percent assessment on insurers and roughly \$380 million in windfall savings from the federal tax reform bill to fund reinsurance payments for plan years 2019 and 2020. They will reimburse insurers for 80 percent of claims between \$20,000 and \$250,000.

Based on the experience of the two initial states to create reinsurance programs (Alaska and Minnesota), the Exchange board predicted that the reinsurance payments would all but wipe out the 30.2 percent average increase sought by the two insurers in their ACA Marketplace (see Update for Week of April 16th). The decreases that both insurers sought following federal approval of the reinsurance waiver has far surpassed those projections. The rates still need to be reviewed by the Maryland Insurance Administration to ensure they are “actuarially justified” before they can receive final approval shortly before the November 1st start of the 2019 open enrollment period.

Attorney General sues Trump Administration over attacks on Affordable Care Act

Attorney General Brian Frosh (D) filed a lawsuit this week against several federal agencies seeking a judgement declaring the Affordable Care Act (ACA) to be constitutional and directing the Trump Administration to cease efforts to “sabotage” or undermine the law.

The lawsuit is in direct response to the effort by 20 Republican attorney generals to have a federal court in Texas block all enforcement of the ACA following Congress’ repeal of the individual mandate tax penalties for 2019 (see above). In his suit filed in the U.S. District Court for the District of Maryland, Frosh echoes the acknowledgement of Department of Justice lawyers in the Texas cause that eliminating ACA consumer protections such as the ban on pre-existing condition insurance denials would immediately destabilize the individual health insurance market and bring “chaos” to insurers and consumers.

Frosh is not one of the 17 Democratic Attorneys General that won standing to defend against the Texas lawsuit but has been very vocal in his efforts to preserve key ACA consumer protections for Maryland, emphasizing that more than 450,000 Marylanders have gained coverage under the ACA and would become uninsured if it were struck down. He acknowledged that the lawsuit is largely an attempt to put the issue before a court where most of the judges were nominated by Democratic presidents (as opposed to the Republican-dominated court in Texas).

Nebraska

State Supreme Court blocks Republican effort to remove Medicaid expansion referendum from ballot

The Nebraska Supreme Court rejected an appeal this week of a lower court decision that will allow voters to decide this fall whether Nebraska should expand Medicaid under the Affordable Care Act (ACA) (see Update for Week of August 27th).

The lawsuit was filed by Senator Lydia Brasch (R) and former Senator Mark Christensen (R) after the consumer group Insure the Good Life submitted far more than the 84,268 signatures to qualify the voter referendum for the November ballot (see Update for Week of July 9th). Secretary of State John Gale has already certified more than 105,000 signatures as valid and with all appeals exhausted, Nebraska will now be the third state behind Idaho and Utah with a Medicaid expansion ballot referendum in November (see Update for Week of June 11th).

Maine became the first state last year where Medicaid expansion was approved by the voters (see Update for Week of November 6th), although Maine’s governor continues to resist expanding despite two court orders (see above).

If approved by the voters, the referendum would expand Medicaid coverage to roughly 90,000 more Nebraskans next year. The Republican-controlled legislature had blocked six previous attempts to expand Medicaid legislatively.

Following the Supreme Court ruling, the attorney for the plaintiffs threatened future litigation against any voter-approved expansion.

New Jersey

Governor credits reinsurance payments, individual mandate with nine percent premium decrease for 2019

The Department of Banking and Insurance (DBI) announced last week that average premiums for individual market consumers will fall by an average of 9.3 percent next year, a dramatic departure from the 23 percent average rate hike insurers received for 2018 and the 5.8 percent average increase that insurers had sought for 2019.

Governor Phil Murphy (D) was quick to take credit for savings to consumers, emphasizing that it resulted from two laws he signed earlier this year to combat the Trump Administration's "sabotage" of the Affordable Care Act (ACA) (see Update for Week of May 28th). The first was the law creating a state alternative to the ACA's individual mandate, for which Congress repealed the tax penalties starting next year. The second will use the revenues from the individual mandate to compensate insurers with reinsurance payments for extraordinary claims. It will reimburse insurers 60 percent of costs for claims between \$40,000 and \$215,000 in a single year.

The laws made New Jersey one of four states (including the District of Columbia) with a state alternative to the ACA's individual mandate and the seventh state with a federally-approved reinsurance program to replace the ACA version that expired after 2016 (see Update for Week of August 27th). However, it is the only state with both in place for 2019, which allowed it to have the largest average premium decrease until Maryland insurers revised their rate filings this week (see above).

According to DBI, individual market insurers would have received a 12.6 percent average increase in premiums without the individual mandate and reinsurance payments.

Puerto Rico

House and Senate pass drug pricing transparency legislation

The House passed P.S. 731 earlier this month, which would join Puerto Rico with the list of eight states that have adopted drug pricing transparency laws since Vermont became the first to do so in 2016 (see Update for Week of June 20th).

The measure passed the Senate late last year and must be reconciled with that version before being sent to Governor Ricardo Rosello (D). In its current form, it would simply direct the Department of Consumer Affairs and Department of Health to collect the retail prices of the 300 prescription or most frequently used drugs sold by pharmacies authorized to operate in Puerto Rico and publish them monthly on its Internet portal.

The drug pricing transparency law enacted last year in California is considered the most comprehensive in the nation as it requires manufacturers to notify health insurers and government health plans at least 60 days before increases in drug wholesale acquisition costs (WAC) that exceed 16 percent over a two-year period (see Update for Week of November 6th). It applies to drugs with a WAC of \$40 or more.

Washington

Insurance Commissioner approves nearly 14 percent average rate hike for Marketplace insurers

The Washington Health Benefit Exchange Board announced this week that it has certified 40 quality health plan (QHP) offerings to be offered to Washington Healthplanfinder consumers for the 2019 open enrollment period.

The QHPs will be offered by the seven participating insurers as 2018 but will ensure that at least one plan will be offered in every county, a departure from 2018 when the Insurance Commissioner had to compel insurers to enter two



counties that were initially left bare (see Update for Week of July 10, 2017). The Exchange Board stressed that for 2019 at least 92 consumers will now have a choice of two or more insurers for the Healthplanfinder, the state's Marketplace that it created pursuant to the Affordable Care Act (ACA).

The Insurance Commissioner approved a 13.8 percent average premium increase for 2019, which his office reduced from the 19.8 percent increase the insurers initially proposed. Although the 2019 increase is far above the nearly four percent average that Avalere Health calculated nationwide (see above), the Commissioner emphasized that it is nearly half the average increase that insurers received for 2018 after the Trump Administration eliminated ACA cost-sharing reductions just before the start of the open enrollment period (see Update for Week of November 6th). He blamed Congress' repeal of the ACA's individual mandate tax penalty and Administration's allowed for limited benefit plans for the fact that double-digit increases were still needed.