

### Health Reform Update – Weeks of March 26, 2012

#### CONGRESS

##### ***Supreme Court could lack votes to uphold individual mandate and related provisions***

Three days of oral arguments this week revealed that the U.S. Supreme Court may indeed strike down the “heart” of the Affordable Care Act (ACA) in June.

The Obama Administration was counting on moderate Justice Anthony Kennedy to provide the critical swing vote on a court sharply divided along ideological lines. However, Justice Kennedy joined with his four conservative peers to express deep skepticism that the mandate that everyone buy health insurance fits within Congress’ traditionally broad power to regulate interstate commerce. He also weighed throwing out the entire law, agreeing that the court lacks the time and resources to determine what provisions are not impacted by the so-called “individual mandate”.

The Administration had been confident that the controversial mandate would be upheld, as most legal commentators (including retired Justice John Paul Stevens) believed Justice Kennedy and the more conservative Justice Antonin Scalia would not be willing to undo their own commerce clause precedent relating to medical marijuana and guns near schools. However, both justices, along with Chief Justice Roberts and Justice Alito, echoed themes of “tea party” opponents by suggesting that the individual mandate would go “too far” and effectively give Congress “limitless” power to mandate the purchase of broccoli, burial insurance, cell phones, or anything that Congress deemed to benefit society.

Oral arguments represent the first opportunity for the justices to lobby each other on the case. As a result, they are not always predictive of a judge’s leanings. For example, conservative justices provided the deciding vote in two of three earlier appellate court decisions that upheld the individual mandate, despite expressing similar reservations during oral arguments (see Update for Week of September 5<sup>th</sup>).

However, the current high court justices are not known for playing “devil’s advocate” as their decisions typically reflect their positions in oral argument. As a result, this week’s proceedings strongly suggest that the Administration currently lacks the critical fifth vote to prevail on the individual mandate.

It is widely expected that the Court will rule on the individual mandate one way or the other by June, as all of the justices appeared during the first day to reject the holding of the U.S. Fourth Circuit of Appeals that the mandate was a tax that could not be litigated until it was actually enforced in 2015.

Chief Justice John Roberts was the only conservative justice to open the door slightly to siding with the Administration, when he suggested that the individual mandate could be viewed not as a purchase mandate, but rather a tax incentive that merely makes individuals choose between buying health insurance or paying an assessment to offset the societal cost of his or her uncompensated care. Since the constitutional authority of Congress to tax is even broader than its power to regulate interstate commerce, this suggests he is at least weighing the possibility of upholding the mandate.

Roberts was also the only conservative justice that expressed strong concern about “gutting” the entire law should the individual mandate fail. He appeared to accept the Administration’s position that guaranteed issue and community rating requirements must also be struck down if the individual mandate is removed. However, he also appointed a lawyer to counter the Administration, Congressional Budget Office (CBO), and insurance industry argument that premiums would jump by at least 15-30 percent if insurers had to cover everyone without a concurrent mandate compelling healthy populations to enter the risk pool. (See Update for Week of January 9<sup>th</sup> and Week of March 19<sup>th</sup>).

As a result, the Administration's hopes of prevailing appear to hinge solely on the Chief Justice siding with the four liberal justices to either uphold the individual mandate or remove only those three main provisions. If the individual mandate is removed, it remains unclear what would happen to related elements, such as the exchanges and federal tax credits that were to be partly funded by the penalties collected from those who fail to buy coverage they can afford. Provisions wholly unrelated to health insurance, such as the new regulatory pathway for biosimilar drugs, could also be lost.

Those who lobbied for sending the entire law back to Congress stressed that there has never been a case where the Supreme Court has removed the "heart" of a statute without striking down the entire law, as the 11<sup>th</sup> Circuit Court of Appeals did in this case (see Update for Week of August 8<sup>th</sup>). However, they did not address some of the very politically undesirable consequences for both parties that would result from invalidating the ACA, including whether Medicare Part D enrollees would have to return their rebates, states would have to return millions in federal grants, or the 50,000 uninsurables enrolled in the law's new high-risk pools would lose coverage.

Justice Kennedy did appear to side with the four liberal justices on upholding the Medicaid expansion under the ACA, which the 26 state plaintiffs insist was "unduly coercive". Lower courts unanimously rejected their claim, noting that states remain free to opt-out of Medicaid should they not wish to comply. Justice Breyer noted that no Medicaid expansion has ever been invalidated by the Court, while Justice Kagan questioned why any state would not accept such a "big gift", since the federal government assumes all of the initial cost and 90 percent thereafter. According to CBO figures released this week, the expansion will increase state spending by less than three percent through 2022.

### ***Democrats scramble for Plan B on individual mandate***

The White House and Congressional Democrats scrambled this week to formulate options to replace the individual mandate in the Affordable Care Act (ACA) should it be struck down as now expected by the U.S. Supreme Court (see above).

Despite publicly insisting for months it had no "Plan B" since the individual mandate was clearly within two centuries of constitutional precedent, the Obama Administration has been privately weighing several alternatives since last year. These include the nine outlined by the Government Accountability Office (see Update for Week of March 28, 2011) that would:

- Modify open enrollment periods in the new exchanges and impose higher premium or cost-sharing penalties for late enrollment (similar to Medicare Part B and D);
- Facilitate auto-enrollment for employer-sponsored health coverage;
- Provide broad access to personalized help with health coverage enrollment by creating access points such as pharmacies, schools and grocery stores;
- Impose a tax to pay for uncompensated care;
- Allow greater variation in premium rates based on the enrollees' age to get more young and healthy people to sign up;
- Restrict access to some federal benefits to people with insurance;
- Pay insurance agents and brokers a flat fee rather than commissions to help people enroll; and
- Require or encourage credit-rating agencies to factor in insurance status in credit ratings.

However, the American Cancer Society, American Medical Association, American Academy of Actuaries, and America's Health Insurance Plan were critical of the alternatives, as none could bring healthier, lower cost people into the risk pool as effectively as the individual mandate that everyone buy insurance or pay a tax penalty. Earlier studies affirmed that none of the alternatives also floated last year in Congress, including auto-enrollment or late enrollment penalties, would insure as many Americans or save as much money as the individual mandate (see Update for Week of February 7, 2010).

However, the deep partisan divisions in the Congress make the passage of even these legislative fixes highly unlikely during an election year—gridlock often alluded to by the justices during their debate over whether the whole law should just be sent back to Congress.

Ironically, the plaintiffs' attorney in the Supreme Court case argued this week that a pending option in the House-passed budget plan (see article below) would pass Constitutional muster, despite striking similarities to the "Obamacare" model. It would create a new health insurance exchange where Medicare beneficiaries can use premium subsidies offered by the federal government to purchase affordable private coverage. Its overhaul of the tax code also gives those who purchase private health insurance a tax credit, while denying that credit to those who cannot afford coverage or choose to go without it.

According to several of the justices, states remain free to enact individual purchase mandates because of their police power, and at least two Democratic governors were quick to propose one this week (see California and Connecticut articles below). However, Massachusetts remains the only state to actually do so, as an individual mandate was subsequently considered but rejected by many others including Alaska, California, Connecticut, Delaware, Kansas, Minnesota, Oregon, Wisconsin, and Wyoming. Vermont chose instead to move towards a single government-run system that will abolish all private insurers by 2015 (see Update for Week of May 23<sup>rd</sup>).

### ***House Republicans pass budget that includes insurance exchange, individual mandate substitute***

The House voted 228-191 this week to pass a budget resolution for FY2013 that would transform Medicare and Medicaid, overhaul the tax code to incentivize the purchase of health insurance, and lower the spending cap agreed to in last year's bipartisan agreement to raise the debt ceiling.

Dubbed "RyanCare 2.0" by Democrats, the measure sponsored by Budget chairman Paul Ryan (R) includes a less severe plan than the House passed last year to move Medicare enrollees into the private market and convert Medicaid into federal block grants with no strings attached (see Update for Week of April 4<sup>th</sup>). Instead, it gives Medicare enrollees the option to remain in traditional Medicare if they do not want to accept premium subsidies to purchase private coverage in a health insurance exchange, while gradually raising the Medicare eligibility age to 67 (see Update for Week of March 19<sup>th</sup>).

According to CBO, the FY2013 budget bill would save \$205 billion over ten years from Medicare. However, CBO found that it would cut Medicaid spending by nearly four times that amount or over \$40 billion more than Republicans sought last year.

A key feature of the plan would slightly alter the controversial individual mandate in the Affordable Care Act (ACA). Instead of requiring everyone purchase health insurance or pay a \$695 assessment, "RyanCare 2.0" would offer individuals a \$2,300 tax credit (or \$5,700 families) if they purchase private health insurance, but deprive that credit from those who do not. Although this essentially creates a harsher penalty than the ACA, proponents claim that transforming the individual mandate from a penalty to an incentive would make it more palatable for voters and the courts (see above).

As with last year, all Democrats voted no. However, the number of Republicans opposed to the plan increased from four to ten largely due to unease over the severity of the cuts, which go \$19 billion beyond the spending caps under the Budget Control Act of 2011 (see Update for Week of August 1<sup>st</sup>).

The full measure would cut \$2.5 trillion in discretionary spending over the next decade, with 62 percent of savings coming from federal health programs and other assistance for low-income Americans. It is far more aggressive than a bipartisan agreement by Reps. Steve LaTourette (R-OH) and Jim Cooper (D-TN) that was overwhelmingly rejected this week by the House, which followed the recommendations of the Bowles-Simpson deficit reduction committee (see Update for Week of December 6, 2010).

### ***Key Senate Democrat opposes raiding ACA to fund Alzheimer's programs***

Senator Tom Harkin (D-IA) sent a letter to the White House this week warning the Administration to stop raiding the Prevention and Public Health Trust Fund created by the Affordable Care Act (ACA).

Senator Harkin, who chairs the Appropriations health subcommittee, specifically objects to the White House plan to divert \$80 million from the fund towards boosting Alzheimer's research under the National Institutes of Health (NIH) (see Update for Week of February 6<sup>th</sup>). Harkin pushed for the \$15 billion fund during health reform deliberations and pledged not to allow "another nickel" to be removed after it was repeatedly used over the past year to offset spending cuts needed to break legislative stalemates, including a \$4 billion cut that was included as part of the payroll tax holiday extension (see Update for Week of February 13<sup>th</sup>).

Harkin insisted that he is a "strong supporter of Alzheimer's research" but that any further cuts to critical ACA funding is "not going to happen". He was supported by Senator Barbara Mikulski (D-MD), another longtime supporter of increased Alzheimer's research funding.

Chairman Harkin did pledge during this week's hearing to increase the FY2013 overall budget for NIH and avoid the scheduled automatic sequestration under the Budget Control Act of 2011 that would automatically cut discretionary spending for all non-defense agencies by 7.8 percent in January if Congress doesn't pass \$1.2 trillion in deficit reduction. He was joined by Senator Richard Shelby (R-AL), though Shelby criticized the Obama Administration for seeking flat NIH funding in his budget plan (see Update for Week of February 13<sup>th</sup>). Shelby noted that when adjusting for inflation, the NIH budget is 17 percent less than a decade ago.

NIH Director Francis Collins testified that NIH would lose \$2.4 billion in FY2013 funding if the automatic cuts were allowed to occur. This would force a 25 percent reduction in research grants.

### ***Senate HELP Committee ready to mark-up bill to reauthorize FDA user fee programs***

The chairman and the ranking Republican on the Senate Health, Education, Labor and Pensions Committee declared their intent this week to quickly mark-up legislation that allows the Food and Drug Administration (FDA) to collect user fees to help fund its reviews of drugs and medical devices.

Chairman Tom Harkin (D-IA) warned members not to slow down the process by with the usual laundry list of amendments that accompany user fee reauthorizations. Both parties are under pressure to finalize a bill before the current user fee program expires September 30<sup>th</sup>. FDA witnesses emphasized that failing to timely reauthorize the program could result in the loss of at least 2,000 agency personnel.

However, the measure is expected to have broad bipartisan support in the Senate as the FDA has already worked out a compromise with drug and device manufacturers to increase user fees by \$100 million in exchange for faster reviews. However, House support remains unclear as several Republicans have objected to the "back-door" negotiations between the Obama Administration and stakeholders (see Update for Week of January 9<sup>th</sup>).

New user fees for biosimilar drugs were supposed to be part of the marked-up legislation. The FDA has already issued guidance on how it intends to implement the new regulatory pathway for biosimilar drugs created by the Affordable Care Act (ACA) (see Update for Week of February 6<sup>th</sup>). However, it remains unclear what will happen to either the biosimilar guidance or user fee program should the entire ACA be struck down by the U.S. Supreme Court (see above).

### ***House and Senate pass legislation that will encourage biotech startups***

The House overwhelmingly approved a Senate-passed bill this week that supporters claim will greatly benefit emerging biotech companies by allowing them to spend more money on research and speed-up the development of new drugs. It is expected to be signed by President Obama.

Among its provisions, the *Jumpstart Our Business Startups Act* (H.R. 3606) exempts companies from full federal reporting requirements for their first five years after going public or until they reach \$1 billion in revenue. According to the Biotechnology Industry Organization (BIO), that provision alone should save emerging companies up to \$2 million a year.

The measure will also will expand Securities and Exchange Commission (SEC) eligibility requirements by raising the \$5 million limit on how much companies conducting direct public offerings can raise to a new \$50 million limit. Companies can also wait until they have 2,000 shareholders to register with the SEC, instead of just 500.

## **FEDERAL AGENCIES**

### ***HHS will soon finalize regulations on insurer rebate notices required by ACA***

The Obama Administration and the health insurance industry are at odds about the language to be included in letters plans must send to subscribers receiving premium rebates this year.

Starting with the 2011 plan year, the Affordable Care Act (ACA) required individual and small group plans to spend at least 80 percent of premium revenue on direct medical care or rebate the excess to subscribers. The first rebates are to be sent out by insurers in August.

Regulations being drafted by the Department of Health and Human Services (HHS) would require the cover letters explaining the rebates to state "This refund is required by the Affordable Care Act - the health reform law" and be sent to all subscribers, even those not receiving refunds.

America's Health Insurance Plans (AHIP) and Republican lawmakers such as Rep. Joe Pitts (R-PA), Energy and Commerce health subcommittee chairman, are pushing back against the proposed language. They insist that the industry should not be forced to pay for "propaganda" that "amounts to Democratic campaign literature weeks before November's elections." However, consumer groups sought the language in order to ensure that the industry does not try instead to take credit for the rebates.

AHIP and the National Association of Insurance Commissioners (NAIC) also object to the proposed requirement to send notices to an additional 100 million subscribers who will not be receiving rebates this year, a move that add \$200-300 million in unnecessary costs (instead of the \$71 million claimed by HHS).

Because of a moderation in 2011 health care spending and unprecedented industry profits, HHS officials expect that up to nine million Americans will receive nearly \$1.4 billion in rebates. Individual health plan subscribers are expected to receive an average of \$164 each.

According to NAIC, 53 percent of individual subscribers, 23 percent of small-group subscribers and 15 percent of large-group subscribers would have received \$978 million in rebates had they been required for the 2010 plan year.

HHS officials are weighing public comments on the proposed notices and told Congress this week that they are "close" to finalizing regulations.

### ***FTC poised to decide on impact of Medco-Express Scripts merger on specialty drugs***

According to the *Wall Street Journal*, the Federal Trade Commission (FTC) is expected to issue a decision "as early as" next week on whether to approve the proposed merger of the second and third largest prescription drug benefit managers (PBMs) in the nation.

FTC commissioners and Congressional lawmakers have held numerous hearings and meetings on whether the \$29 billion merger between Medco Health Solutions and Express Scripts would impede access to high-cost specialty drugs used to treat cancer, hemophilia, multiple sclerosis, rheumatoid arthritis, and other disabling or life-threatening conditions. However, it remains unclear whether the agency will reject the merger or simply place restrictions that will address its antitrust concerns.

Specialty drugs currently represent about one-fourth of the more than \$300 billion spent annually on prescription medication and are expected to climb to 40 percent by 2014. They cost nearly \$2,100 per prescription (or more than 14 times the typical brand-name drug).

Supporters insist that the merged behemoth will have such large-scale purchasing power that it could help stem the rapid price increases for these drugs (20 percent for 2010). However, pharmacy and consumer groups are adamant that it would have the opposite effect by driving out smaller competitors. Over 80 members of Congress have opposed the merger while groups representing drug retailers filed a federal lawsuit this week to block it.

If the FTC decides the deal poses a threat to competition, it could ask either company to divest their specialty pharmacy divisions, or even block the PBMs from requiring that big employers and insurers use the merged company's specialty pharmacies, potentially opening up competition with independent suppliers. The agency could also block exclusive distribution contracts with drug manufacturers.

If approved, the Medco-Express Scripts merger would create a company involved in more than one-third of U.S. prescriptions.

## STATES

### California

#### ***Brown Administration vows to move forward on universal health care if ACA defeated***

The secretary for California's Department of Health Services (DHS) pledged this week that the state will move forward to achieve universal health care if part or all of the Affordable Care Act (ACA) is struck down (see above).

Under both Governor Jerry Brown (D) and his predecessor Arnold Schwarzenegger (R), California has led the nation in implementing provisions of the ACA, including being the first to pass legislation authorizing a state-based health insurance exchange, banning rescissions and pre-existing condition denials, and applying the ACA's higher medical-loss ratios. As a result, Secretary Dooley explicitly stated that the Governor would consider proposing a mandate that everyone purchase health insurance or pay a fee if the analogous provision were removed from the ACA, instead of repealing the interrelated laws that California has already enacted.

California has a long but unsuccessful history of pursuing universal health care, dating back to an employer mandate signed into law in 2003 by Governor Gray Davis (D) that was later repealed by the voters. Governor Schwarzenegger vetoed single-payer legislation before he pushed the same individual mandate that was enacted by Massachusetts in 2007, while renewed single-payer legislation fell only two votes short last session (see Update for Weeks of January 16<sup>th</sup> and 23<sup>rd</sup>).

However, Dooley speculated that the loss of the ACA's individual mandate may give universal health care bills the extra boost they need to become law in California, especially since the Supreme Court justices acknowledged during oral arguments that states could constitutionally mandate the purchase of health insurance through their police power (see above).

### ***Health committee passes bill to lift annual and lifetime caps in state high-risk pool***

The Assembly Health Committee unanimously passed legislation this week sponsored by chairman Bill Monning (D) that would remove caps on annual and lifetime benefits under the state high-risk pool. A.B. 1526 now moves to the Appropriations Committee.

### ***Rate filings show health insurance premiums could jump 20 percent***

Health insurance premiums are expected to increase by as much as 20 percent in coming months, according to rate increases filed with the California Department of Insurance.

Aetna is seeking a nearly ten percent average increase for individual subscribers and another eight percent for small groups, with comparable hikes sought by Blue Shield of California, Kaiser Permanente, and United Healthcare. Despite being forced for the fourth time in two years to downgrade its planned increase due to erroneous calculations (see Update for Week of March 19<sup>th</sup>), Anthem Blue Cross proposed an average 6.3 percent increase on individuals and 12-18 percent increase for small groups.

The hikes continue to spur consumer advocate support for a proposed ballot measure that would give the Insurance Commissioner the authority to modify or reject unreasonable rate hikes. The referendum is supported by U.S. Senator Dianne Feinstein (D-CA) after legislation was blocked last summer by the insurance industry (see Update for Week of August 29<sup>th</sup>).

### Connecticut

### ***Governor may propose individual mandate if U.S. Supreme Court strikes it down***

The special health reform advisor to Governor Daniel Malloy (D) insisted this week that the Governor will seriously consider pursuing an individual mandate for Connecticut if the new federal mandate is indeed struck down by the U.S. Supreme Court (see above).

The Legislature weighed but ultimately rejected legislation that would have enacted an individual purchase mandate, shortly after neighboring Massachusetts became the first state to do so in 2007. However, Connecticut is one of the states that have already made "substantial progress" towards implementing the ACA (see Update for Week of January 9<sup>th</sup>), much of which the state may have to undo if the federal individual mandate is lost.

This may likely make it not only cost-efficient but politically feasible for the state to enact an analogous mandate, given the cost of going backwards. However, the Connecticut Health Policy Project and consumer groups doubted the individual mandate would have sufficient legislative support, even given the U.S. Supreme Court's apparent acknowledgment this week that it would pass constitutional muster at the state level (see above).

The Legislature could also consider following the lead of Vermont and moving towards the single-payer system that it has debated for many years. However, single-payer would be strongly opposed by the insurance industry which retains a dominant presence in Connecticut.

### ***Appropriations committee reverses Governor's cuts to Medicaid eligibility for childless adults***

The Appropriations Committee voted 34-15 this week along party lines to restore Medicaid funding for childless adults that Governor Daniel Malloy (D) had sought to cut.

Committee Democrats were skeptical that the reduced benefits and eligibility proposed by the Governor would be federally approved. As a result, their budget plan will maintain existing benefits and eligibility for childless adults, and instead achieve the Governor's \$22 million in projected savings by increasing efforts to recover funds from private insurers that participate in Medicaid managed care.

## District of Columbia

### ***D.C. to move forward on health insurance exchange, regardless of U.S. Supreme Court decision***

The Department of Health Care Finance awarded an \$800,000 contract this week to Accenture LLP, who will create the information technology needed to operate the new health insurance exchange required by the Affordable Care Act (ACA). District of Columbia officials pledged that the online marketplace will go forward even if the ACA is struck down by the U.S. Supreme Court (see above).

## Georgia

### ***Governor to decide whether individual plans must return to child-only market***

The Senate overwhelmingly passed H.B. 1166 this week, which would require all individual health plans to offer child-only coverage during set open enrollment periods every January and July.

Georgia was one of at least 20 states where individual health plans abandoned the entire child-only market after the Affordable Care Act (ACA) mandated guaranteed issue for children starting with the 2011 plan year (see Update for Week of September 20, 2010). However, insurers have resumed writing child-only policies in most of these states after insurance departments and state legislatures established set open enrollment periods to prevent parents from waiting until children became sick or injured to enroll.

Consumer advocacy groups are urging Governor Nathan Deal (R) to sign the legislation, which has already passed the House (see Update for Week of March 5<sup>th</sup>).

## New Mexico

### ***Office of Health Reform director resigns to protest exchange slowdown***

The physician tabbed by Governor Susana Martinez (R) to lead New Mexico's creation of a health insurance exchange resigned last week to protest resistance from top officials to move forward.

Dan Derksen (R) headed the New Mexico Office of Health Care Reform, a panel charged with implementing the exchange required by the Affordable Care Act (ACA). However, Derksen acknowledged that his efforts to implement the exchange in advance of the January 2013 federal deadline have been blocked by the Martinez Administration, which now wants to "wait and see" if the U.S. Supreme Court overturns the entire ACA (see above).

Dr. Derksen was adamant that New Mexico could not afford to take the risk that the law will be struck down or the deadline extended, given that 23 percent of the state is uninsured—a rate topped only by neighboring Texas.

Governor Martinez had initially been on board with Derksen's effort to win a \$34 million federal exchange establishment grant and begin building the technology infrastructure for the new online marketplace. However, he admits that he "lost the policy battle" to obtain additional federal funds.

In the wake of Derksen's resignation, Governor Martinez ordered a hold on the current Request for Proposal (RFP) that seeks to award a \$24 million contract to upgrade the state's computers. Bids had been submitted to weeks ago, however it remains unclear when or if a contract will be finalized.

The Department of Human Services insists that the state's \$34 million federal grant will not have to be returned if the ACA is overturned and that the agency remains committed to awarding \$24 million of that amount through the bidding process.

Governor Martinez's decision to slow-down exchange implementation may be based in part on speculation that she is on the short-list of potential vice-presidential candidates for expected Republican nominee Mitt Romney. As Massachusetts Governor, Romney created the nation's first health insurance exchange in 2007, but has pledged to repeal the entire ACA law including the exchange provision should he be elected President.

#### New York

##### ***Governor pledges to create exchange through executive order after legislative inaction***

With the full support of Senate Minority Leader John Sampson (D), Governor Andrew Cuomo (D) announced this week that he intends to follow the lead of at least 11 other governors and use an executive order to implement the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

The Governor's exchange authorizing bill (A.8514/S.5849) has been blocked by Senate Republicans since passing the Assembly last summer and kept out of the budget deal agreed to this week. Despite pleas from key Republicans such as the Senate Insurance committee chairman to move forward on the exchange (see Update for Week of January 9<sup>th</sup>), the impasse threatens to force a federal fallback exchange on New York if it misses the January 2013 federal deadline for certification, even though the state has already obtained nearly \$40 million in federal grants to create its own exchange.

Governor Cuomo has shown little reluctance to use executive orders. Since taking office in January 2011, he has issued 39 such orders, already approaching the record of 50 set by his predecessor. He would become only the second Democratic governor to implement the exchange via executive order (see Update for Week of October 31<sup>st</sup>). However, other governors who have done so already acknowledge they will ultimately need legislative authorization to make the exchange operational (see Update for Week of March 5<sup>th</sup>).

#### Washington

##### ***Governor signs bill that allows third-party premium assistance within health insurance exchange***

As expected, Governor Christine Gregoire (D) signed into law a measure setting new rules for the health insurance exchange required by the Affordable Care Act (ACA).

H.B. 2319 follows-up on S.B. 5445 last session, which created the Evergreen Health Marketplace and established an oversight board that assumed control of exchange operations on March 15<sup>th</sup> (see Update for Week of March 5<sup>th</sup>). The new law requires the board to report once a year to the Governor and Legislature, and allows them to carry out day-to-day operations without further legislative approval.

The board is also now required under H.B. 2319 to establish rules that permit identified entities (such as non-profit charities) to pay premiums on behalf of qualified individuals.

H.B. 2319 also removes earlier provisions limiting the board's ability to certify which health plans sufficiently meet federal standards imposed by the ACA, as well as any additional consumer protections imposed by the Insurance Commissioner. The Commissioner must also use the state's largest small group health plan as the benchmark plan to define "essential health benefits", as required by federal guidance (see Update for Week of December 12<sup>th</sup>).

Governor Gregoire did use her line-item veto authority to remove a provision that would have automatically closed the exchange if it were no longer self-sustaining, citing an "undue risk of litigation." Republicans who unanimously opposed the legislation had demanded that the exchange also be eliminated if the U.S. Supreme Court strikes down the entire ACA, a possibility that no longer appears remote after this week's oral arguments (see above). However, Insurance Commissioner Mike Kreidler (D) insisted that even if the ACA is overturned, the exchange will remain in place using only state funds.

Wisconsin***Recall elections to proceed for Governor and four Senators***

The Government Accountability Board announced this week that petitioners to recall Governor Scott Walker (R) and four Republican Senators have collected nearly double the amount of verified signatures to order elections this June.

The legislature passed a bitterly-contested measure sought last year by the Governor that stripped state employees of their right to collectively bargain for health benefits and gave him unprecedented authority to cut Medicaid eligibility and benefits with limited legislative oversight. The Wisconsin Supreme Court narrowly upheld the law, which was passed in the absence of Democratic lawmakers who fled the state to prevent a quorum (see Update for Week of June 20<sup>th</sup>).

Republicans cling to a one-seat majority in the Senate after a voter backlash inspired several successful recall elections last summer (see Update for Week of August 8<sup>th</sup>). They now face the very real possibility of losing control of both the Senate and Governor's mansion.

Polls show Governor Walker running even with four likely Democratic candidates, including Milwaukee mayor Tom Barrett whom he defeated in 2010. However, history may be on his side. California Governor Gray Davis (D) in 2003 and North Dakota Governor Lynn Frazier (R) in 1921 are the only two Governors that have ever been defeated in a recall election.