Health Reform Update – Week of October 1, 2012

CONGRESS

U.S. Supreme Court weighs whether to revive religious freedom challenge to ACA

The U.S. Supreme Court opened its new term this week by asking the Department of Justice to respond to Liberty University's request to revive its legal challenge to the Affordable Care Act (ACA).

The Court upheld the constitutionality of the entire law last term, ruling that the mandate that everyone buy health insurance they can afford or pay a tax penalty was a valid exercise of Congress' power to tax (see Update for Week of June 25th). However, that challenge from 26 state attorneys general was based solely upon the constitutional powers to tax and regulate interstate commerce.

Liberty University's lawsuit claimed instead that the individual and employer mandates under the ACA violate the constitutional religious freedoms of the university and their employees by forcing them to buy coverage that could even indirectly fund abortion services. A federal appeals court had dismissed their claim, but only on the basis that it was premature because neither mandate had gone into effect.

Because the Supreme Court's decision expressly rejected the claim that challenges to the individual mandate were premature, Liberty University is now requesting a rehearing. While the Supreme Court rarely grants a rehearing, Liberty insists that it meets the standard because it is challenging the individual mandate on a religious freedom basis that the Court has yet to consider.

Liberty University is also participating in separate lower court challenges over the ACA mandate for religiously-affiliated institutions to cover preventive services like contraceptives without imposing cost-sharing. Although the plaintiffs initially prevailed in one of these lawsuits, several have been dismissed (see Update for Weeks of July 23rd and 30th).

Republicans demand greater oversight of federal exchange establishment grants

Senator Chuck Grassley (R-IA) and Rep. Fred Upton (R-MI) demanded this week that the Obama Administration increase its oversight of federal exchange establishment grants.

In a terse letter to the Secretary for the Department of Health and Human Services (HHS), the two Republican leaders blasted California's decision to use part of $900,000 of its grant funding to promote its new exchange on some of the nation's most popular television shows (see Update for Week of September 17th). They insisted that taxpayer dollars should not be used "to subsidize Hollywood and insert propaganda into the popular culture."

The letter notes that the Affordable Care Act (ACA) is "virtually silent" and how these grants are to be used and criticized HHS for failing to create such standards through regulation. As a result, it calls on the Secretary to release to Congress a list of all contracts that exchanges have initiated and track how states are using their grants.

Congressional Republicans have long been critical of the Administration for hiring public relations firms to promote the benefits of the ACA and were equally incensed this week when HHS awarded a $3.1 million contract to Weber Shandwick to market the new federally-facilitated exchanges that will be operated in states that fail to make substantial progress by January on a state-based exchange. According to HHS, the contract simply allows the firm to promote early awareness of the exchanges so that consumers know whether they may be eligible. HHS officials assured Grassley's committee last

week that the FFE would be operational before the January 2014 deadline in the ACA (see Update for Week of September 24th).

New legislation would provide exclusivity add-on for significant drug combinations

Rep. Brian Bilbray (R-CA) introduced legislation on September 21st that seeks to encourage the development of so-called "significant drug combinations" by offering extended marketing exclusivity.

The *Life-Threatening Diseases Compassion through Combination Therapy* Act (H.R. 6502) is supported by the Melanoma Research Foundation and modeled after the *Generating Antibiotic Incentives Now Act (GAIN) Act* that was part of the recent reauthorization of the Food and Drug Administration (FDA) user fee program (see Update for Week of July 9th). The *GAIN Act* granted five years of marketing exclusivity as an inducement for companies to get approval of antibacterial and antifungal drugs that treat serious and life-threatening infections.

H.R. 6502 would similarly amend federal law to add six months to the marketing exclusivity already assigned for chemical entities, clinical investigations, or orphan drugs (all of which range from 3-7 years), so long as the new drug is approved by the FDA and contains a "significant drug combination." The bill also grants a six month priority review of new drug applications for products with "significant drug combination" (meaning it combines two or more unapproved drugs which offer the potential to significantly advance treatment for a life-threatening condition.)

To qualify for the exclusivity extension under H.R. 6502, the drug sponsor must first get an FDA panel to designate the product as a "significant drug combination."

FEDERAL AGENCIES

CMS confirms that states may not receive full federal funding if they delay Medicaid expansion

The Centers for Medicare and Medicaid Services (CMS) issued their first definitive guidance this week on the Medicaid expansion under the Affordable Care Act (ACA).

The U.S. Supreme Court created a great deal of uncertainty around the expansion after it ruled last summer that states may "opt out" without penalty. At least a dozen Republican governors have announced their intent to do so, while the others decided to wait for CMS guidance, cost estimates, and the results of the November elections (see Update for Week of July 9th).

In response to questions posed by the Republican Governors Association, CMS officials previously indicated that states may opt in or out of the Medicaid expansion at any time, and can reverse their decision in future years without penalty. However, federal funding for the expansion will remain as set under the ACA, which is 100 percent through 2016 and then at least 90 percent for subsequent years. As a result, states that wait until 2017 to participate will be ineligible for the 100 percent federal match (see Update for Weeks of August 6th and 13th).

CMS reaffirmed this position in this week's guidance. However, many of the governors' questions remain unanswered. For example, states like New Mexico (see Update for Week of September 17th) and Wisconsin want to know if they can receive all or part of the federal match if they only partially expand Medicaid to those earning up to 100 percent of the federal poverty level (instead of the 133 percent threshold under the ACA).

A report released this week from consultants headed by former CMS Administrator Michael Leavitt suggests state participation ultimately may hinge on the Presidential election. If President Obama is reelected, Leavitt predicts that most states will accept the significant fiscal incentive to participate, even if the Republicans control both the House and Senate. However, a Republican in the White House would

likely to embolden Republican governors to hold out in hopes of an eventual repeal of at least the Medicaid expansion.

Latest Census figures reaffirm that Americans are using less health care due to cost

A new report released this week by the U.S. Census Bureau confirms that working adults are getting medical treatment less frequently did they did ten years ago.

According to the study, those aged 18-64 made an average of only 3.9 visits to doctors, nurses and other medical professionals in 2010, down from 4.8 visits in 2001. The decline in utilization was consistent across all demographics and was not altered by change in insurance or health status, age, ethnicity, or gender.

Women were far more likely than men to have seen a medical provider in 2010 (78 percent compared to 67 percent). However, only 42 percent of Hispanics did so, the lowest of any ethnic group.

Census Bureau officials emphasized that the precise cause of the decline remains unclear but that the aging of baby boomers is no doubt a contributor, as the workforce is gradually becoming more weighted towards younger and healthier employees. However, they acknowledge that is only a partial explanation as baby boomers only began to retire en masse towards the end of the decade.

Another significant factor is that the share of working age adults who are uninsured has dramatically expanded. People without insurance are less likely to visit a doctor, said the report, which was based on the Survey of Income and Program Participation, a long-running survey of more than 80,000 households. The share of working-age Americans without health insurance was 21.8 percent in 2010, according to the Census Bureau, up from 17 percent in 2001.

Census officials also cited the increasing prevalence of health savings accounts as a reason for the dramatic decline, as they have deductibles that average $2,000 and can directly discourage patients from seeking care.

The figures mesh with earlier studies showing that at least 60 percent of Americans are skimping on needed care due to cost (see Update for Week of June 11th). A *Consumer Reports* survey of over 1,110 adults also found that more than 80 percent have skipped a medical test ordered by their physician because of cost in 2012, up from only 29 percent last year (see Update for Week of September 17th).

HEALTH CARE COSTS

Employee health premiums, cost-sharing to jump next year as employers shift cost burden

The latest survey of employer health benefits released this week by Aon Hewitt consultants found that employees of over 460 large companies will likely face an eight percent jump in health insurance premiums in 2013 accompanied by a ten percent hike in cost-sharing.

Premiums for the average worker are expected to reach $2,385 or roughly 21 percent of the total company-paid premium, which is rising more slowly at only about a six percent clip. Total out-of-pocket costs for the average worker should reach at least $2,429.

Aon Hewitt's figures are comparable to estimates from other recent surveys. For example, Mercer consulting projects a 6.5 percent increase in premiums for 2013 as nearly 60 percent of employers shift more of their health insurance costs to employees. Both consultants cited the increasing use of high-deductible plans by employers as primary factor in the rise of total out-of-pocket costs.

STATES

Some state benchmark plans are going beyond federal minimums for prescription drugs

A new study released this week by Avalere Health consulting found that the benchmark plan that at least eight states have selected for defining essential health benefits exceeds federal minimum standards for prescription drug coverage.

Under initial guidance issued by the Department of Health and Human Services (HHS), states were required to designate the benchmark plan that they intend to use to define these benefits by September 30th, or let HHS designate the most popular small group plan in the state (see Update for Week of February 20th). Consumer advocates and Congressional Democrats had criticized HHS for only requiring coverage of one drug per class under the benefit package that all non-grandfathered individual and small group plans must cover starting in 2014 (see Update for Week of January 30th), insisting that it would be "completely unworkable" for those with chronic conditions. Just this week, over 57 consumer groups signed on to a letter urging the Secretary to expand this coverage.

However, each of the eight states studied by Avalere Health (CA, CT, MS, OR, RI, VT, VA, and WA) have already broadened prescription drug coverage, choosing instead to cover a "significant" number of medicines in each designated drug class (two of these states have Republican governors that are opposed to the ACA.) On average, these eight states covered about 62 percent of the prescription drugs available in each class. The largest state, California, had the narrowest scope, choosing to cover only 26 percent of drugs in each class.

According to Avalere, at least 23 states and the District of Columbia have submitted their benchmark plans to HHS, with 15 of these states selecting a small employer plan. Maryland (see Update for Week of September 10th) and Utah (see Update for Weeks of August 6th and 13th) are the only states that have chosen one of their state employee health plans as a benchmark.

Another 15 states identified potential benchmark plans but asked for additional guidance or ignored the deadline altogether. This includes five states with Democratic governors. One state, Nebraska, stirred some controversy by proposing to go with an unspecified high-deductible plan combined with a health savings account, even though this may not be compatible with the cost-sharing limits in the new health insurance exchanges.

States were required to choose their benchmark plans from among four options: one of the three largest small-group plans in the state by enrollment, one of the three largest state employee plans by enrollment, one of the three largest federal employee health plans by enrollment and the largest HMO plan offered in the state's commercial market by enrollment. In addition to individual and small group plans, the essential benefit package will also apply those who become newly-eligible for Medicaid coverage under the ACA. However, it will not apply to self-insured plans used by many large employers.

The benchmark plan approach is set for 2014-2015 but will then be re-evaluated by HHS.

Most states are unprepared to implement state-based health insurance exchanges

A report released this week by the Health Research Institute concludes that more than 36 states will likely be unprepared to start enrolling subscribers in new health insurance exchange as required by October 2013.

Thirteen states and the District of Columbia have already met the November 16th deadline to formally declare their intent to create the online marketplace authorized by the Affordable Care Act (ACA). However, the report from PricewaterhouseCoopers found that several of those states may not be ready to start enrolling subscribers in October 2013, as required by the new law.

Although only nine states have officially stated that they will default to a federally-facilitated exchange, all but two of the remaining states with Republican governors have elected to "wait and see" if the November elections will give Republicans the federal control needed to repeal all or part of the ACA. The report concludes that these states simply will not have enough time to create the information technology needed for the online marketplace.

Only three states have sought to exercise the option to at least initially partner with the federal government on exchange operation (see Update for Weeks of May 28th and June 4th).

Georgetown study shows interest lacking in interstate health plans

A new study released this week by the Georgetown University Health Policy Institute shows that not a single insurer has expressed interest in selling across state lines, despite laws enacted in six states that would allow them to do so.

Interstate health plans among the most prominent of Republican alternatives to the Affordable Care Act (ACA). The laws passed enacted by Republican lawmakers in states such as Georgia, Maine, Oklahoma, and Wyoming allow out-of-state insurers to sell health plans that need to comply only with the insurance regulations of their home state. As a result, health plans could sell bare bones coverage in a heavily-regulated state without complying with that state's high number of costly coverage mandates.

The Georgia Insurance Commissioner expressed surprise earlier this year that not a single health plan has sought to take advantage of that state's interstate health plan law, which went into effect in July 2011. The law's sponsor blamed the lack of interest on the uncertainty created by the ACA (see Update for Week of April 30th).

However, the Georgetown study concluded that even if plans choose to do so, they found "no evidence [to show] that these initiatives actually bring down costs or increase consumer options." To the contrary, researchers found that such new laws "could put consumers at risk by limiting state officials' ability to respond to the needs of their residents and eliminating important state-based protections."

<u>Arkansas</u>

Medicaid and insurance industry collaborate on shared savings plan

The Medicaid program kicked off a new initiative this week aimed at improving care and reducing costs through a partnership with its largest private health plans.

The Health Care Payment Improvement Initiative is a shared-savings plan similar to the accountable care organization demonstration created by the Affordable Care Act (ACA). Approved earlier this month by the federal Centers for Medicare and Medicaid Services (CMS), the program is projected to save up to $4.4 million in fiscal years 2013 and $9.3 million the following year.

Under the new initiative, Arkansas Blue Cross Blue Shield (BCBS), QualChoice, and Medicaid identified the state's highest volume and most costly medical condition. They each then targeted three of these conditions for which they would track the total cost of treating patients per "episode of care".

Initially, Medicaid will target maternal care, the common cold, and attention deficit and hyperactivity disorder, while the insurers chose perinatal care and hip and knee replacements. BCBS will also focus on congestive heart failure.

Starting October 1st, physicians that are deemed "principal accountable providers" will receive bonus payments if their "episode of care" costs for these conditions fall within a range designated by Medicaid and the two insurers as "commendable". Those who fall within an "acceptable" range of costs will be reimbursed as usual while those who exceed "acceptable" costs will have part of their reimbursement withheld.

Despite the fact that provider participation is mandatory, the response has been largely positive even though some continue to express concerns about providers qualifying for savings only by skimping on care. However, Medicaid and the two insurers claim that many providers are “grateful” that they were given the cost data developed by Medicaid and two insurers which enabled providers for the first-time to compare the costs of tests, equipment, or other services, needed as part of a patient’s treatment.

The executive director of the National Association of Medicaid Directors noted that "a lot of other states are looking to Arkansas to see how this turns out.” Oregon already enacted a similar model earlier this year (see Update for Week of April 30th).

California

Governor signs health reform measures, but vetoes ban on pre-existing condition denials

Governor Jerry Brown (D) signed several bills into law last week that comply with or go beyond the provisions of the Affordable Care Act (ACA). These include:

- A.B. 1453/S.B. 951, which sets the level of essential health benefits required by the ACA at that of the Kaiser Small Group plan and gives the Department of Managed Health Care and Department of Insurance oversight for relevant plans;
- S.B. 1410, which sets the standards for independent medical review under the ACA;
- A.B. 1846, which implements the new Consumer Operated and Oriented Plans under the ACA;
- A.B. 1526, which eliminates annual and lifetime caps in the Major Risk Medical Insurance Pool (MRMIP) program (the state high-risk pool).
- A.B. 1083, which conforms the small group market to the ACA and ensures that small employers do not see additional premium spikes based on the health of their workforce.
- A.B.79, which ensures that Californians can easily enroll for coverage during key life changes.

However, the Governor surprised consumer advocates by vetoing A.B. 1461/S.B. 961, which sought to conform state law to the ban on pre-existing condition denials and age rating limits in the ACA. The Governor stated that the bill needed to be more explicitly conditioned on the ACA, in case the federal law is changed or repealed.

Governor Brown also vetoed S.B. 970, which would have streamlined eligibility and enrollment in state health programs and the new health benefit exchange (see Update for Week of August 27th and September 3rd). He stated that the bill was "well-intentioned but overly prescriptive."

His veto of A.B. 1000 perplexed many lawmakers, as it would have made California the 21st state to require parity in health plan coverage between oral and intravenous chemotherapy (see Nebraska article below). The measures have been enacted with little opposition in other states, even from Republican governors. However, Governor Brown insisted that the bill failed to distinguish between health plans who make oral chemotherapy available at a reasonable cost and those who do not. It was twice vetoed by former Governor Arnold Schwarzenegger (R).

The Governor has already called for a special session of the newly-elected legislature in December to finalize any outstanding implementation issues, such as those relating to the new health benefit exchange and the possible creation of a Basic Health Plan option (see Update for Week of August 20th). The vetoed measures are expected to be reconsidered during that session.

Exchange board solicits insurer comment on qualifications for participating plans

The California Health Benefit Exchange Board is soliciting comments about the standards that should be set for participating health plans in the online marketplace being created pursuant to the Affordable Care Act (ACA).

The initial notice issued last week invited health plans to submit bids, but noted that the Board would revise the solicitation by October 16th based upon stakeholder comments. The Board expects to select the participating plans by March 30th, execute contracts by June 1st, and commence open enrollment next October as required by the ACA.

California is the first state to enact legislation authorizing the exchange and has already notified the federal government that it will make "substantial compliance" by January 2013. States that fail to do so will have a federally-facilitated exchange operated in their state.

The exchange board is creating an "active purchaser" model already in place in Massachusetts and also being created in states like Connecticut, Hawaii, and Maryland as well as the District of Columbia. Under this model, the board can negotiate rates with plans and exclude those it deems unaffordable. This differs from the "clearinghouse" model in place in Utah where any plan that meets minimum standards can participate.

The Oregon Health Insurance Exchange issued a similar though final Request for Application this week. Letters of intent from qualified health plans are due by November 1st.

Report predicts that millions will remain uninsured in California despite ACA

A new report from the University of California-Berkeley and the UCLA Center for Health Policy Research estimates that up to four million Californians will remain uninsured after full implementation of the Affordable Care Act (ACA) in 2014.

About half of this group will actually qualify for the expanded Medicaid program or the new premium tax credits to purchase exchange coverage, but will not enroll, according to researchers. Nearly 40 percent of the remaining uninsured will simply not be able to afford coverage, largely due to low-wage jobs that will continue not to provide benefits. Although Latinos with limited English proficiency are likely to make-up two-thirds of the remaining uninsured, three-quarters of this group are expected to be U.S. citizens or legal immigrants.

More than 70 percent of the remaining uninsured will also earn so little that they will be exempt from ACA mandate to buy health insurance they can afford. The study predicts that only three percent of all Californians will be subject to the tax penalty for not buying health insurance, comparable to nationwide estimates by the Urban Institute.

Researchers stressed that the figures "should serve as a wake-up call for the need to maintain the safety net system in California."

<u>Massachusetts</u>

Individual plans in Massachusetts are the most comprehensive yet most expensive in the nation

Massachusetts has the most comprehensive individual health insurance coverage in the nation, according to a first-ever survey of 6,000 plans released this week by *U.S. News and World Report.*

The analysis was intended to show how individual plans can impose devastating out-of-pocket costs on individuals and families. Each of the plans was scored and assigned a rating from 1-5 stars depending on the scope of coverage offered for two dozen service categories (including prescription drugs) and the level of cost-sharing that was required.

Every one of the 67 Massachusetts plans surveyed received the highest five-star ranking, showing that they consistently offered broad coverage and protection against catastrophic medical bills. The survey noted that this was no doubt due to minimum benefit package and cost-sharing limitations

imposed by Massachusetts' universal coverage reforms in 2006, which became the model for the Affordable Care Act (ACA).

New York was not far behind Massachusetts, with 94 percent of plans receiving four or five stars, followed by the District of Columbia (85 percent), Maryland (76 percent), and Virginia (75 percent). Washington ranked last at four percent, followed by Alaska (ten percent), Wisconsin (15 percent), and South Carolina (19 percent).

However, Massachusetts' high-ranking for scope of coverage did not extend to affordability, where it was ranked the most expensive in the nation with a median premium of $528 per month. This was more than 2.5 times the $196 median for individual plans in Minnesota. The authors noted that Massachusetts does help to defray these costs by offering subsidies to those earning up to 300 percent of the federal poverty level (comparable to the ACA subsidies for those earning up to 400 percent). As with the ACA, Massachusetts plans are also required to accept anyone, even if they have cancer or other costly illnesses.

Minnesota

Health committee chair demands answers on Governor's exchange plans

Following last week's announcement that Minnesota had received an additional $42.5 million federal exchange establishment grant (see Update for Week of September 24th), Rep. Steve Gottwalt (R) issued a letter this week demanding answers from state agencies on how the funds will be used.

Rep. Gottwalt, who chairs the House Health and Human Services Reform Committee, has vigorously opposed the implementation of "Obamacare". He has blocked exchange authorizing legislation, threatened to sue Governor Mark Dayton (D) for creating the exchange oversight board via executive order, and refused to name his designated appointments to the board (see Update for Week of October 31, 2011). He has also joined with the state Chamber of Commerce in criticizing the Governor for his lack of transparency regarding "secretive" exchange plans.

Gottwalt's list of 70 questions go beyond just asking for a spreadsheet detailing exchange grant expenditures. He specifically seeks answers to details of the planned exchange governance, annual budget and salaries, likely benefits and premium costs, and how the state intends to ensure the exchange is self-sustaining as required by 2015 under the Affordable Care Act (ACA). In addition, Gottwalt wants details on who will design, own, and operate the information technology infrastructure, how brokers will play a role in the exchange, and what information will be provided to insurers.

The Governor recently transferred oversight of exchange implementation from the Commerce department to the budget office, whose administrator is a holdover from the prior Republican administration and considered less partisan (see Update for Week of September 17th).

Nebraska

Nebraska becomes 20th state to require parity in oral and IV chemotherapy coverage

State law effective this week made Nebraska the 20th state to require that private plans treat oral chemotherapy the same as intravenous cancer treatments.

Senator Jeremy Nordquist (D) pushed for the legislation, noting that the high and often uncovered costs of oral chemotherapy medications under specialty drug tiers were effectively denying access to the treatment for many Nebraskans. The new law allows the decision about whether a patient receives oral or intravenous medications to be made instead by the physician.

Senator Nordquist, whose brother is an oncologist, cited studies by Milliman consulting documenting the miniscule cost for removing the disparity in oral and intravenous medications. It found

that the per payer increase in premiums ranged from five cents to $1.50. Opponents pointed out that the study was paid for by GlaxoSmithKline, a manufacturer of oral chemotherapy products.

Delaware, the District of Columbia, Hawaii, Louisiana, Maryland, New Jersey, and Virginia are among the states that have enacted analogous legislation this year. However, the California governor vetoed a similar measure last week (see above).

New Jersey

Renewed exchange bill passes the Senate

The Senate voted 21-17 this week to pass renewed legislation authorizing the creation of the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

The measure (S.2135) is very similar to vetoed legislation that the legislature passed earlier this year (see Update for Week of May 7th). As with the earlier version, it follows the "active purchaser" model in Massachusetts where the exchange board can selectively contract only with those health insurers who offer the best value. However, the bill contains several key revisions to mollify the conflict of interest controversy that arose when the initial legislation allowed health insurers to serve on the board.

Under S. 2135, board members would be barred from employment in the health care or insurance industries while serving and for two years thereafter. In addition, board members would no longer receive a $50,000 annual salary and compensation for the executive director could not exceed $141,000 per year, the salary for cabinet-level officials in the state. The number of voting members would increase from five to seven in order to allow input from two members of the public.

The bill would also no longer require the state to exercise the discretion under the ACA to create a Basic Health Plan option for those earning from 133-200 percent of the federal poverty level. Exchange boards in states like California have vigorously opposed the option for fear it would siphon away so many exchange participants that the exchange would not be financially self-sustaining as required by 2015 (see Update for Week of July 25, 2011).

One of the bill's primary sponsors and chair of the Health, Human Services, and Senior Citizens Committee, Senator Joseph Vitale (D), was adamant that New Jersey needed to move quickly forward on exchange implementation in order to meet upcoming federal deadline. States have only until November 16th to certify to the U.S. Department of Health and Human Services (HHS) that they will make substantial progress on a state-based exchange by January 1st. Otherwise, HHS will operate a federally-facilitated exchange (FFE) in their state.

The ultimate fate of S. 2135 remains very much in doubt. Despite vetoing the initial legislation, Governor Chris Christie (R) had pledged to create a state-based exchange in the wake of the "screwy" decision by the U.S. Supreme Court to uphold the entire ACA (see Update for Week of June 25th). However, he subsequently has taken a "wait and see" posture to the entire law, suggesting that New Jersey would be better off defaulting to a FFE and opting-out of the Medicaid expansion under the ACA (see Update for Week of July 2nd). Christie was also one of the 27 or so governors to miss this week's deadline to designate a benchmark plan to define essential health benefits that must be covered under the new law, insisting that he lacked sufficient federal guidance to move forward (see article above).

The exchange measure now heads to the full Senate. Companion legislation (A.3186) remains under consideration in the Assembly.

Pennsylvania

Republican bill would block state creation of health insurance exchange

Legislation introduced this week by Rep. Scott Perry (R) would prohibit any state agency of the Commonwealth from planning, establishing or participating in a state-based health insurance exchange authorized by the Affordable Care Act (ACA). H.B. 2655 would only allow a state agency to interact with the federal government regarding a federally-facilitated exchange that would be operated by default in Pennsylvania. State agencies could also not pursue the federal-state exchange partnership allowed by federal regulations (see Update for Week of May 14th).

The measure follows analogous legislation sought last week by Rep. Steve Sayler (R) that would bar state agencies from participating in the Medicaid expansion under the ACA (see Update for Week of September 24th). Rep. Mark Cohen (D) responded by introducing H.R. 884 this week, which urges the House to authorize participation in the expansion.

Governor Tom Corbett (R) has indicated that he will not decide whether to pursue exchange implementation or the Medicaid expansion until after the November election.

West Virginia

Governors questions HHS on essential benefits

As expected, Governor Earl Tomblin (D) was one of five Democratic governors this week that declined to designate a benchmark plan to define essential health benefits under the Affordable Care Act (ACA).

Federal guidance had directed states to do so by September 30th or allow the Centers for Medicare and Medicaid Services (CMS) to simply designate the most popular small business plan in the state (see Update for Week of February 20th). However, as with the upcoming health insurance exchange deadline, Governor Tomblin attempted to buy himself more time to make the politically-sensitive decision by submitting a list of seven questions that he wanted CMS to answer before he would move forward. Tomblin is seeking re-election this fall in a state where the ACA is especially unpopular and as a result has postponed most implementation decisions (see Update for Week of September 24th).

The Governor's questions seek guidance on issues that CMS has yet to address in delayed regulations (see Update for Week of September 24th). These include an explanation of how the essential health benefits to be required of all private plans might impact the cost of Medicaid.