

Health Reform Update – Week of March 5, 2012

CONGRESS

CBO says that repeal of Medicare cost-cutting panel would cost over \$3 billion

The House Energy and Commerce and Ways and Means committees both passed legislation this week that would repeal the Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA).

Eliminating the Medicare cost-cutting panel drew the support of 17 House Democrats; largely because it would cede power of politically-sensitive Medicare spending cuts away from Congress (see Update for Week of February 27th). However, Senate Democrats and the White House remain staunchly behind the IPAB and were able to use this week's cost estimates from the Congressional Budget Office (CBO) to buttress their defense.

According to CBO, repealing the IPAB would add \$3.1 billion to the deficit over ten years. However, this figure is down significantly from initial CBO scores of the ACA that predicted the IPAB would save up to \$15 billion.

House Republicans still pursuing Medicaid block grants, spending caps

Four House members from the conservative Republican Study Committee are pushing new legislation that revisits the House-passed plan to turn Medicaid into unfettered state block grants.

Rep. Tim Huelskamp (R) insisted this week that the measure would be incorporated as part of the House Republican budget plan to be released later this month. It follows the plan introduced by Rep. Paul Ryan (R-WI) that was strongly supported by Republican governors seeking to be free of restrictions on how they can use federal Medicaid matching funds. However, the Congressional Budget Office (CBO) and consumer advocates warned that the roughly \$11,000 per enrollee block grant would be far from enough to maintain current benefit and eligibility levels (see Update for Week of April 4th).

The four cosponsors acknowledge they have yet to receive any commitment from Budget Committee chairman Ryan or other House leaders on moving the bill. The Medicaid block grant proposal and the Medicare "premium support" or voucher plan failed to achieve popular support in the polls and are both dead on arrival in the Democratically-controlled Senate. However, Rep. Huelskamp insisted that Republicans need to press ahead of the structural reforms so that they are ready to pass should Republicans take control of the White House and Senate this fall.

Rep. Bill Cassidy (R-LA), a physician, was one of a handful of Republicans to come out against the block grant proposal. He is instead seeking to set per enrollee caps on the growth of federal Medicaid expenditures that vary by type of beneficiary, as well as give bonuses to states that achieve positive health outcomes. Cassidy compares his proposal to a plan advanced by former President Bill Clinton in 1998 that CBO estimated would have saved roughly \$4 billion over the first four years. Consumer groups largely opposed that Clinton plan, arguing that it would restrict access and quality of care.

MedPAC calls for varying Medicare cost-sharing by setting

Draft recommendations unveiled this week by the Medicare Payment Advisory Commission (MedPAC) would cap out-of-pocket costs for Medicare enrollees, combine Part A and B deductibles, and vary co-payments by the type of service and provider.

The proposal by the influential panel is designed to discourage Medicare enrollees from getting unnecessary or inefficient treatment. It would do so by increasing, decreasing or eliminating out-of-pocket payments, depending on the efficiency and quality of the service. For example, \$20 copayments for primary care visits would rise to \$40 for specialists, or higher amounts for imaging services. However, MedPAC emphasized that the overall cost-sharing liability for Medicare enrollees would not change.

Panel members stressed that the new cap on out-of-pocket costs would protect enrollees from unexpected expenses and make it more palatable for them to assume more of the initial cost of their care.

Under the draft MedPAC language, the Department of Health and Human Services would have the authority to alter beneficiary cost-sharing "based on evidence of the value of services." Insurers would also be required to pay a surcharge on the Medigap coverage they offer.

MedPAC commissioners are expected to vote on the draft later this spring and include it in their June report to Congress.

Republicans query stakeholders on drug discount program

Republican leaders from the House and Senate asked drugmakers and safety net hospitals this week for a "detailed accounting" of how they operate the Section 340B drug discount program for safety net healthcare providers.

According to a recent Government Accountability Office (GAO) report, the federal 340B program has nearly doubled over the past decade. It now covers more than 16,500 entities, the vast majority of whom are safety net hospitals (see Update for Week of September 19th).

However, both GAO and the Department of Health and Human Services Inspector General have questioned the integrity of the program due to lack of proper fiscal oversight by the Health Resources and Services Administration. As a result, Congressional Republicans want to determine to what extent this reliance on "self-policing" by manufacturers and covered entities is attributing to "improper purchases or diversion of 340B drugs."

The letters to 340B entities were signed by the chairman of the House Energy and Commerce Health subcommittee, Rep. Joe Pitts (R-PA), as well as Senators Charles Grassley (R-IA), Michael Enzi (R-WY) and Orrin Hatch (R-UT).

FEDERAL AGENCIES

CMS set to release final rules defining the structure for new health insurance exchanges

The acting Administrator for the Centers for Medicare and Medicaid Services (CMS) disclosed this week that the agency will shortly release final rules defining how states should design the new health insurance exchanges required by the Affordable Care Act (ACA).

States have until January 2013 to make "substantial progress" towards exchange implementation or allow CMS to instead operate a federal fallback exchange in their state. However, many states have elected to wait until the U.S. Supreme Court resolves the constitutionality of the new law before proceeding, while others have complained that they lack sufficient guidance from CMS on how to move forward (see Update for Weeks of November 21st and 28th).

Although most of the final rules are under the last stage of review at the Office of Management and Budget, the director of the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS told members of America's Health Insurance Plans this week that CCIIO still needs to flesh out the remaining details of how the federal fallback exchange will work. State officials and private insurers have been anxious to learn whether the fallback exchange would follow the "active purchaser" model where the exchange negotiates rates and the more passive clearinghouse model where any plan that meets minimum requirements can participate (see Update for Weeks of November 21st and 28th).

The CCIIO Director emphasized that two proposed rules issued last summer (see Update for Week of July 11th) and subsequent guidance have given states a great deal of flexibility in how to proceed with exchange implementation, including the possibility of partnering with the federal government during the first few years of operation (see Update for Weeks of November 21st and 28th). He did not confirm rumors that CMS would extend the January 2013 deadline for at least 15 states that have failed to move forward (see Update for Weeks of January 16th and 23rd) and warned that those states risk falling "pretty far behind if they don't start to take action now."

Affordable Care Act ended lifetime caps for 105 million Americans

A state-by-state report released this week by the Department of Health and Human Services proclaims that the Affordable Care Act (ACA) has already eliminated lifetime caps for 105 million Americans enrolled in private health plans.

Effective for plan years that started on or after September 23, 2010, the ACA banned all plans from imposing a lifetime maximum benefit. According to the report, 59 percent of those covered under employer-sponsored plans and 89 percent of individual plan subscribers were subject to lifetime caps in 2009. This translates to 70 million people in large group plans, 25 million in small group plans and ten million in individual plans—or a total of 105 million who are no longer subject to these limits.

FDA mulls fast-track approval pathways for life-saving drugs

The Food and Drug Administration (FDA) is considering new approval pathways for drugs to treat life-threatening conditions for which there are few, if any, approved therapies.

The head of FDA's Center for Drug Evaluation and Research (CDER) floated the concept this week during one of several hearing held by the House Energy and Commerce health subcommittee regarding the reauthorization of industry user fees to fund product approvals (see Update for Week of January 9th). She disclosed that CDER has been in discussion with the Infectious Disease Society of America (IDSA) and other groups on an abbreviated approval process for "special population limited medical use drugs." The idea differs from the Orphan Drug Pathway, under which the FDA grants approval for drugs to treat rare diseases (those that affect fewer than 200,000 people). The goal would be to quickly bring life-saving but costly treatments onto the market after fewer clinical trials but with labels highly restricting its use to a very narrow population.

FDA officials envision that the new pathway would initially focus on antimicrobial agents, but could be applied to other medications. They indicated that the initial response from professional associations and patient groups has been "very enthusiastic."

The new pathway would need approval by Congress before FDA could issue needed regulations and guidance. Senator Kay Hagan (D-NC) introduced legislation last month (S.2113) that would expedite the approval process for rare diseases (see Update for Week of February 13th), while Reps. Cliff Stearns (R-FL) and Edolphus Towns (D-NY) sponsored a bill this week (H.R. 4132) that revises their earlier proposal to abbreviate the pathway for ultra-orphan drugs (see Update for Week of January 2nd).

GAO says cost-saving impact of generic drugs remains "mixed"

The effect of generic drug spending on overall health care costs remains unclear, according to a Government Accountability Office (GAO) report released last week.

The report found that U.S. prescription drug spending has more than tripled since 2001, reaching \$307 billion in 2010 and accounting for 12 percent of all U.S. health care costs. Generic drugs that cost an average of 75 percent less than brand-name competitors became increasingly prevalent over the decade and were used in place of brand-name drugs 93 percent of the time by 2010.

However, GAO surprisingly found "mixed results regarding the [cost-saving] effect of using these generics" as some studies concluded that they raised health care costs as often as they led to savings.

HEALTH CARE COSTS

New study is latest to affirm that high prices are the reason U.S. leads in health spending

A new report by the International Federation of Health Plans (IFHP) became the latest in a long line of bipartisan studies documenting that Americans pay far more for most medical procedures and services than residents of other countries.

IFHP surveyed medical providers in Argentina, Canada, Chile, France, Germany, India, Spain, Switzerland and the U.S., and found that U.S. residents paid more for 22 of the 23 services and products included in the survey than those living in the other countries. For example, the survey found that hospital stays cost an average of only \$1,825 in Spain and \$5,004 in Germany, compared with a whopping \$15,734 in the U.S. In addition, routine doctor's office visits average only \$9 in Argentina, \$11 in Spain, \$40 in Germany, and \$64 in Switzerland, but average \$89 in the U.S.

The results likewise showed far higher costs for childbirth and prescription drugs. Americans pay an average of \$9,280 per birth, compared to only \$1,291 in Argentina and \$1,967 in Spain. Meanwhile, a popular prescription drug like Nexium averaged \$193 in the U.S. compared with \$69 in Switzerland. (Cataract surgery was the only procedure included in the survey that was less costly in the U.S.)

The study documented that the U.S. continues to far outpace other countries in overall health spending. Americans spend 17.4 percent of their Gross Domestic Product (GDP) on health care, compared with 9.5 percent in Spain and 11.8 percent in France. As a result, our extraordinary rate of total health spending is "mostly attributable to higher prices of goods and services." The authors note that similar findings were previously reached by leading conservative economists like Mark Pauly, as well as the National Journal.

A recent study by the Commonwealth Fund pointed to these higher costs as the primary reason why at least 42 percent of chronically or severely ill Americans surveyed failed to get recommended medical care, a rate that is more than double that in Canada, France, Great Britain and other industrialized countries (see Update for Week of November 7th).

One of five American families struggle to pay medical bills

A new survey by the Centers for Disease Control and Prevention found that one of every five American families are struggling to pay medical bills, with half that number claiming they are unable to pay any of their medical debts.

The survey of 52,000 people was conducted from January through June of last year and represents the first federal government agency survey on the issue. As expected, it showed that lower-income people struggle most, as they were three times more likely to report difficulty paying medical bills last year.

The findings mesh with a survey by the nonpartisan Center for Studying Health System Change (CSHSC) conducted in 2007. However, CSHSC repeated their earlier warning against concluding that the number struggling with medical bills has remained stable despite the swelling of the uninsured population over the last recession (see Update for Week of December 19th). CSHSC instead notes that several studies have documented that many Americans are now simply going without needed health care due to cost (see Update for Week of October 3rd and Week of January 30th).

STATES

California

State Supreme Court to decide whether “pay-to-delay” drug settlements violate antitrust law

California is set to become the first state to decide whether brand-name drug manufacturers can pay generic competitors to delay the introduction of cheaper alternatives.

The California Supreme Court has agreed to review a class-action lawsuit from 2002 involving the antibiotic Cipro, which originally was manufactured by Bayer. The suit argues that it was an illegal restraint of trade for Bayer to pay a competitor nearly \$400 million to stay out of the market until 2003, in order to settle a patent dispute. According to the consumer plaintiff, this so-called “pay-to-delay” agreement forced hundreds of thousands of Californians to collectively overpay millions of dollars for Cipro, as Bayer hiked the price by 16 percent after the settlement and reaped over \$5 billion in profit.

The Federal Trade Commission (FTC) has sought for over a decade to ban these “pay-for-delay” arrangements, of which 28 were entered into as recently as fiscal year 2011 (see Update for Week of October 24th). The agency insists that such deals cost American prescription drug consumers at least \$3.5 billion per year.

The Congressional Budget Office has estimated that banning the practice could save \$4.8 billion over the next decade (see Update for Week of November 7th). Despite the support of President Obama, federal legislation to implement a statutory ban has been scuttled for several years by Senators from both parties who come from states with a heavy drug industry presence.

Unlike California’s highest court, the U.S. Supreme Court has declined to intervene in a Second Circuit U.S. Court of Appeals decision upholding the practice (see Update for Week of March 7, 2011). Bayer likewise has already prevailed within the California courts, even though California’s antitrust law is considered to be broader than its federal counterpart. However, a group of 78 law professors have submitted a “friend of the court” brief insisting that such anti-competitive “pay-to-delay” settlements are an illegal, monopolistic practice even under this broader state law.

The ultimate decision this fall by the California Supreme Court is expected to greatly influence the outcome of other state litigation over “pay-to-delay” settlements.

Georgia

Senate to decide fate of bill limiting child-only coverage to one open enrollment period per year

The House passed legislation this week requiring individual health plans in Georgia to offer child-only coverage within a set open enrollment period.

H.B. 1166 sponsored by Rep. Alex Atwood (R) passed with only one dissenting vote. The measure now moves on to the Senate. It was intended to ensure access to child-only policies in the individual market, after Georgia health insurers stopped writing such policies after the Affordable Care Act required guaranteed issue for children starting with the 2011 plan year (see Update for Week of September 20, 2010).

As in many other states, limiting enrollment to a preset window each year successfully persuaded individual health plans to return to the child-only market. Insurers feared that parents would otherwise wait until their children became sick or injured before deciding to buy coverage. H.B. 1166 designates January 2013 as the first open enrollment period for child-only coverage.

Hawaii

Bill limiting specialty tier coinsurance clears Senate, moves on the House

Legislation that bars the use of specialty tier coinsurance by Hawaii insurers cleared the Senate this week with only one dissenting vote and will now be considered by the House.

In addition to prohibiting private health plans from requiring subscribers to pay a percentage of the cost for specialty drugs, S.B. 2106 would prevent any copayments that exceed \$150 month for a one-month supply. PSI Government Relations had urged the passage of the legislation (see Update for Weeks of January 16th and 23rd).

Similar measures were considered by 14 states last session, and are currently moving through a comparable number of state legislatures.

Senate and House pass bills requiring equivalent cost-sharing for oral and IV cancer treatment

The Senate and House passed legislation this week that would Hawaii the latest state to require health insurers apply the same cost-sharing to oral cancer medications that they apply to intravenous chemotherapy, as well as for generic versus non-generic oral cancer medications. The measures also prohibit individual and group plans from increasing enrollee cost-sharing for non-generic cancer medications by any greater extent than they increase enrollee cost-sharing for all other non-generic medications covered under the plan. Differences in S.B. 2087 and H.B. 1964 will have to be reconciled before going to Governor Neal Abercrombie (D).

Illinois

Insurance committee postpones bill mandating specialty tier coinsurance study

The Senate Insurance Committee has postponed consideration of S.R. 432, which sought to require the Department of Insurance to prepare a study by November 1, 2012 on the negative impact of the increasing prevalence of specialty tier coinsurance for the highest cost prescription drugs. Proposed by Senator Linda Holmes (D), the study would have included an assessment of the availability of manufacturer discounts and patient assistance programs to those receiving medications placed by insurers into the highest-cost specialty tier designation and recommend options for mitigating any negative impact of specialty tier pricing. A similar measure failed to clear committee last session (see Update for Week of October 17th).

Louisiana

Insurance vice-chair seeks to expand health plan rate review, bring Louisiana in line with ACA

Rep. Harold Ritchie (D), vice chair of the Insurance Committee, introduced legislation this week that would bring Louisiana insurance law in line with the Affordable Care Act (ACA).

Louisiana is one of the 26 states where the insurance commissioner has the authority to reject or modify unreasonable increases in health insurance premiums for individual and small group plans. H.B. 908 would expand this authority to include large group plans, and require insurers publicly disclose the actuarial justification for any double-digit increase, consistent with regulations issued by the federal

Centers for Medicare and Medicaid Services (CMS). The measure also would prohibit insurers from varying premiums except for those limited situations allowed by the ACA.

H.B. 908 faces an uphill battle in the Republican-dominated legislature.

Maine

Republicans decide to “play chicken” on implementing state-based health insurance exchange

Republican lawmakers have made Maine the latest state to delay all exchange implementation until the U.S. Supreme Court resolves the constitutionality of the Affordable Care Act (ACA).

Senator Rod Whittemore (R) chairs the legislative panel created by L.D. 1582 last session and charged with recommending how Maine should proceed on exchange implementation. Although Republican lawmakers and Governor Paul LePage (R) favor a state-based exchange over a federal fallback exchange (see Update for Week of January 9th), they have elected to take the risk of the latter should the U.S. Supreme Court not overturn the entire ACA law in June.

States have until January 2013 to make “substantial progress” towards an exchange or let the federal fallback exchange go into effect in their state. Republican lawmakers are preparing a “bare bones” exchange that they insist will meet this deadline should the ACA not be overturned.

Governor LePage has accepted over \$6 million in exchange establishment grants, but so far only used the initial \$1 million planning grant obtained by his Democratic predecessor. Democratic and Republican exchange bills have stalled in the Insurance and Financial Services Committee.

One of the bill sponsors, Rep. Sharon Treat (D), blasted Republicans for “playing chicken with the federal government”, noting that despite rumors to the contrary, federal regulators have made no effort to extend the January 2013 deadline (see article above).

Massachusetts

Legislation creating hemophilia advisory committee moves forward

The Joint Committee on Health Care Financing held a hearing this week on legislation introduced by Rep. Jeffrey Sanchez (D), chair of the Joint Committee on Public Health, that would create a hemophilia advisory committee. Under H.B. 3960, the 11-member advisory committee would make recommendations to the Public Health and Insurance committees on legislative or regulatory changes to promote the health and wellness and persons with hemophilia and other bleeding disorders. This includes developing standards of care for the treatment of these conditions and ensuring that patients have open access to care and private plan coverage.

Mississippi

Legislation barring the use of specialty tier coinsurance fails to clear committee

Legislation that would prohibit health plans from creating specialty tiers that require subscribers to pay a percentage the highest-cost prescription drugs died this week in the Insurance committee.

The measure (H.B. 1319) would not have allowed plans to charge a prescription drug copayment that exceeds the lowest prescription drug copayment required by the plan by 500 percent or more. Related legislation (H.B. 1352) that would bar any group health plan from using specialty tiers also died (see Update for Week of February 20th).

Minnesota

Republican exchange alternative would rely on health premium accounts

Republicans lawmakers in charge of the state legislature are pushing new legislation that they claim represents a “free-market alternative” to the health insurance exchanges required by the Affordable Care Act (ACA).

The claim is somewhat ironic given that the health insurance exchanges in the ACA formed the backbone of “free market” alternatives first proposed by the conservative Heritage Foundation in 1989, and featured prominently in the Republican alternative to President Clinton’s health reform plan in 1993 and the landmark Massachusetts reforms enacted by Governor Mitt Romney (R) in 2007. However, Republican lawmakers are intent on blocking the state-based health insurance exchange sought by Governor Mark Dayton (D), in order not to legitimize “Obamacare”.

Rep. Steve Gottwalt (R) emphasized that the Republican alternative differs from the ACA exchange because it would give enrollees access to “health premium accounts”. These accounts allow individuals and third-parties to make contributions to an account that could only be used for health care expenses. Democrats were quick to note that such accounts fail to ensure that the uninsured have access to affordable care—the primary objective of the exchange.

Governor Dayton became the first Democratic governor to rely on an executive order to start implementing an exchange without legislative authorization. However, he acknowledges that authorizing legislation is necessary to make the exchange fully operational (see Update for Week of October 31st).

Democratic measures have gone nowhere in the face of Republican opposition led by Senator David Hann (R), chair of the Senate Health and Human Services Committee. Hann has already threatened to sue the Governor if he attempts to proceed on his own (see Update for Week of August 15th) and encouraged Republican leaders to refuse to fill any of their seats on the Governor’s exchange task force (see Update for Week of January 30th).

The measure introduced this week by Assistant Minority Leader Erin Murphy (D) may only fan Republican opposition, as it requires four of the 19-members of the oversight board to represent individual consumers and bars any from being affiliated with a health insurer. H.F. 2739 also charges the board with being an “active purchaser that would negotiate with health plan companies to obtain the optimal combination of price and quality for plans offered through the exchange.” Republicans that support an exchange largely favor the more passive clearinghouse model where any plan that meets minimum federal and state standards can participate.

New Hampshire

Senate passes measure that implements ACA guaranteed issue mandate for children

The Senate passed legislation this week that would require individual health plans to offer child-only coverage without regards to health status, consistent with the Affordable Care Act (ACA).

S.B. 219 introduced by Senator Raymond White (R) at the request of the Department of Insurance now moves to the House, which has adamantly opposed implementing any provision of the ACA. A majority of Senate Republicans supported S.B. 219—at least the second time this year that they have rebuffed House Republican opposition to ACA provisions (see Update for Week of January 9th).

Oklahoma

Senate passes measure creating sliding-scale subsidies for state premium assistance program

The Senate unanimously passed S.B. 1397 this week, which modifies the Oklahoma Employer-Employee Partnership for Insurance Coverage (O-EPIC).

The O-EPIC premium assistance program has been operated under a federal waiver since 2005. It enables uninsured Oklahomans who are unemployed or work for small businesses to have access to either employer-sponsored or state-sponsored coverage. Individuals earning up to 250 percent of the federal poverty level pay no more than 15 percent of the premium cost.

S.B. 1397 amends the program to allow for “sliding scale” assistance so that the amount of premium assistance for employed recipients is reduced as their income from employment goes up.

Oregon

Legislature approves creation of state-based health insurance exchange

Legislation creating the health insurance exchange required by the Affordable Care Act (ACA) was approved by the Senate this week as the legislative session drew to a close. Governor John Kitzhaber (D) has pledged to shortly sign it into law.

The bill approves the business plan submitted by the Oregon Health Insurance Exchange Board appointed by the Governor (see Update for Week of September 19th). Although it initially was hung-up in the evenly-divided House (see Update for Week of February 13th), it ultimately passed both chambers by wide margins.

The measure is not without controversy as it makes Oregon one of only a handful of states to allow insurer representation on their exchange oversight board.

Utah

Utah becomes fifth state to join compact that would opt-out of Medicare and Medicaid

The Legislature made Utah the fifth state this week to approve plans for an Interstate Health Care Compact that would use unrestricted federal block grants to provide services as they see fit to Medicare and Medicaid enrollees.

Republican legislatures in Texas, Georgia, Louisiana and Oklahoma have already joined the Compact, which is under consideration in several other states (including Idaho and South Carolina). However, the measures are largely symbolic as they would require a federal waiver and may not pass constitutional muster without further Congressional legislation since both Medicare and Medicaid are governed by federal law.

S.B. 208 passed by comfortable margins in the Republican-dominated House and Senate. Supporters insisted that Utah would continue to receive the same \$4.1 billion in Medicaid matching funds under the requested block grants. However, Democrats and the Utah Health Policy Project warned that the proposed block grants would cost the state \$350 million in 2014 and another \$8 billion from 2014 to 2020, as growth in the block grant could not keep pace with growth in Medicaid enrollment.

Washington

Governor to sign legislation refining exchange rules, allowing premium assistance

The House and Senate voted largely along party lines this week to pass legislation setting new rules for the health insurance exchange required by the Affordable Care Act (ACA).

S.B. 5445 created the Evergreen Health Marketplace last session and established an oversight board that will assume control of exchange operations on March 15th (see Update for Weeks of January 16th and 23rd). The latest legislation (H.B. 2319) 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 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.

The Insurance Commissioner will retain regulatory authority over exchange plans, as well as the ability to ensure that individual and small group plans outside the exchange cannot offer the lowest level of coverage under the ACA (bronze-tiered plans) unless they also provide silver and gold tiers within the exchange. These provisions are intended to minimize adverse selection and prevent the exchange from essentially becoming a repository for sicker and more costly populations.

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 and required for participation. The Commissioner, in conjunction with the board and Health Care Authority, must also use the state's largest small group health plan (currently the Regence BlueShield Innova plan) as the benchmark plan to define "essential health benefits", as required by federal guidance (see Update for Week of December 12th).

Republicans largely opposed the measure, claiming the exchange was "an expansion of government" that "go[es] too far." However, an amendment by Senator Randi Becker (R) to slow down implementation and mandate fewer benefits failed by four votes in a Senate chamber narrowly controlled by Democrats.

One of the few Republicans to back H.B. 2319, Senator Cheryl Pflug (R), emphasized the importance of the state "do[ing] it our way" instead of defaulting to a federal fallback exchange. She also was highly critical of local ACA opponents who were threatening Republicans with drastic consequences for supporting the measure.

The insurance industry in Washington remains divided over the bill, with Group Health supporting the "level playing field" it creates, while more dominant insurers like Premera Blue Cross and Regence BlueShield claim that it stifles the free market.

Governor Christine Gregoire (D) is expected to sign the measure into law.

Wyoming

House and Senate vote to extend exchange steering committee

The Wyoming House overwhelmingly approved Senate-passed legislation this week that will continue the health insurance exchange steering committee.

The legislative advisory committee appointed by Governor Matt Mead (R) is charged with making exchange recommendations by October 1st. However, if the federal government does not extend its January 2013 deadline for states to make substantial progress on exchange implementation, the recommendations will come too late for Wyoming to avert a federal fallback exchange.

Republican leaders on the committee have been exploring the possibility of a federal-state partnership for the first few years of exchange operation, as permitted under proposed rules issued by federal regulators (see article above). However, any possibility of federal involvement has met with stiff opposition from the most conservative of Republican lawmakers and caused the legislature to repeatedly delay a final decision (see Update for Week of December 5th).

Governor Mead and committee chair Elaine Harvey (R) strongly support the committee's preliminary recommendation of a state-run exchange, though it is unclear if the Governor will sign-off on any federal-state partnership.