COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG

THE COMMISSIONER

August 23, 2012

The Honorable Kathleen Sebelius
Secretary, United States Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Sebelius,

On June 28, the United States Supreme Court issued its opinion in *National Federation of Independent Business v.* Sebelius, 132 S.Ct. 2566, 2012 WL 2427810, 2012 U.S. LEXIS 4876 (*"NFIB"*). In its review the Court examined the constitutionality of two provisions of the Patient Protection and Affordable Care Act ("PPACA"): the individual mandate to purchase health insurance and the expansion of the Medicaid program. Despite the individual mandate being upheld as a tax, states are now confronted with a series of critical choices relating to the implementation of PPACA, such as whether or not to build a health insurance exchange or expand their Medicaid programs. The changes being made as a result of PPACA are fundamental and potentially disruptive to Pennsylvania's marketplace, which is why we must be mindful of the consequences, both fiscal and policy, associated with any form of implementation by Pennsylvania. In order to be able to provide the Governor with the necessary information to make a prudent and informed decision on these matters we need – in a timely manner – detailed information and substantive responses from the federal government on many outstanding issues relating to health care reform implementation.

To date, HHS has been slow to provide states with detailed and necessary information on a number of key issues affecting health insurance exchanges and other PPACA-related issues. In light of the *NFIB* opinion, an even greater number of questions remain to be answered relating to the optional Medicaid expansion and its impact on exchanges and other provisions of PPACA.

On July 10, Republican Governors sent a letter to President Obama listing some of these outstanding questions. To date, the response received from your agency lacks the clarity we need to make informed decisions on these issues. Significant concerns remain pertaining to what type of burden the operation of an exchange in Pennsylvania will place on our taxpayers and the state's budget, particularly after the first year of operation when federal grant monies are no longer available. Although the goal of the PPACA with respect to expanding coverage is laudable, we are concerned that the expanded government bureaucracy for an insurance exchange as contemplated by the law may not permit a sustainable approach to improving the affordability and accessibility of health care in Pennsylvania.

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Therefore, in order to allow Governor Corbett to carefully evaluate the decisions facing Pennsylvania, we must receive specific answers to the many important questions left unanswered. In order to assist us in providing our Governor with that information, I respectfully request that you provide detailed responses to the following questions in an expedited manner. Although this is not an exhaustive list of questions about the insurance provisions in the ACA, it captures currently recognized questions and primary concerns confronting the Commonwealth the answers to which will help us determine the correct course for Pennsylvania.

1. The preamble to the final exchange establishment rule includes approximately 100 references to "future" or "forthcoming" guidance or rulemaking. Please provide a detailed timeline of when each of these documents will be released.

2. The exchange establishment final rule had a number of key provisions that were issued as "interim final", impacting such areas as eligibility standards, transmission of information on the advance premium tax credit (APTC) and cost sharing reductions (CSR), and the role of agents and brokers. When will HHS be issuing final rules on these topics?

3. Based on informal communications from HHS, states are being encouraged to make a decision regarding Essential Health Benefits (EHB) by the end of the third quarter of this year, though HHS has not issued any rulemaking (proposed or final) addressing the issue. When will such a rulemaking be released; will states have a reasonable period of time after the final rule is issued before they will be expected to declare their intent with regard to EHB?

4. When will HHS release its rulemaking or detailed guidance on the operation of the Federally-Facilitated Exchange (FFE)? When will a rulemaking or detailed guidance be issued on the specifics of a Partnership FFE?

5. What financial costs will a state face if it elects to default to an FFE? Will a state jeopardize any of the federal funding it currently receives if it does not participate in any necessary interfaces to enable an FFE to operate?

6. If HHS operates an FFE or Partnership FFE in the state, may the state charge the exchange or the federal government for the time spent by its staff on exchange matters, and also charge for any other expenses attributable to the FFE or Partnership FFE?

7. If the state enters into a partnership with an FFE, and the state wants to end the partnership because it is determined not to be in the best interest of the state (for financial or other reasons), what are the applicable requirements on the state to continue performing partnership activities?

8. If HHS operates an FFE in the state, what will it do to assure that it is not undermining the market outside of the exchange?

9. What restrictions or limitations, if any, will the operation of an FFE in a state have on that state's insurance regulator's authority to enforce other insurance laws, including consumer protection statutes, that are currently or may be applicable to health insurance companies licensed by the state?

10. When will the rulemaking detailing the operation of the multi-state insurance plans be released?

11. If HHS operates an FFE in the state, will the multi-state insurance plans be required to adhere to all applicable Pennsylvania insurance laws? Will the multi-state insurance plans be required to meet the same standards for qualifications as a Qualified Health Plan that other insurers must meet to be sold through an FFE?

12. Assuming that the state opts to allow HHS to operate either an FFE or a Partnership FFE, and the FFE (or Partnership FFE) is not financially self-sustaining, will the federal government (HHS) commit to not assess the state, or otherwise seek financial support from the state?

13. If a state decides to pursue either a Partnership FFE or state-based exchange, would implementation of either of those options dictate that the state also must expand its Medicaid program in accordance with PPACA?

14. What will be the financial costs borne by a state that performs plan management functions in a Partnership FFE? Will the state be expected to independently finance activities performed pursuant to the partnership agreement? Will HHS provide financial support to states to cover the cost of performing plan management partnership activities?

15. How much autonomy will a state have if it elects to participate in a Partnership FFE? Will states be able to deviate from the anticipated but yet to be released Standard Operation Procedures when performing activities covered under the partnership agreement?

16. Will a state need to access the Federal Data Hub if operating in a Partnership FFE? If yes, will HHS charge a state to access the hub, and how much? If no, will HHS guarantee that a state will never face a charge to access the Federal Data Hub?

17. Will a state be charged to access the Federal Data Hub if it operates a state-based exchange, and how much? If no, will HHS guarantee that a state will never face a charge to access the Federal Data Hub?

18. Is the list of Consumer Assistance activities in a Partnership FFE, as shown in the General Guidance document (issued May 16, 2012), exhaustive? Will the state be expected to independently finance activities preformed pursuant to the partnership agreement? Will HHS provide financial support to states to cover the cost of performing consumer assistance partnership activities?

19. What are the specific expectations of HHS as they relate to the scope and level of in-person consumer assistance a state must provide in a state-operated exchange? In a Partnership FFE?

20. If the state initially defaults to an FFE (or Partnership FFE) and subsequently decides it wants to operate a state-based exchange, what are the requirements and timelines associated with transitioning from an FFE (or Partnership FFE) to a state-based exchange? Will there be federal financial support available to cover the costs associated with the transition?

21. The Insurance Department operates Pennsylvania's Children's Health Insurance Program (CHIP). The proposed methodology for modified adjusted gross income (MAGI) being advanced by HHS will result in families with high incomes being made eligible for free or subsidized CHIP (to give but one example, a family business may have significant net operating loss carryover that results in a negative reported taxable income). The same issue arises with respect to the state Medicaid program. Does HHS plan to revise its methodology to ensure that these programs (and their limited taxpayer funding) remain available for those individuals most in need, and only for those individuals?

22. Will a state be allowed to use a Premium Assistance Program/Health Insurance Premium Payment Program to pay for CHIP (or Medicaid) eligible children to be added to a parent's health insurance policy purchased through an exchange?

23. The MAGI criteria used by the IRS for its calculation of eligibility for APTC and CSR is different from CMS' MAGI criteria to be used for CHIP (and Medicaid) eligibility determinations. Will the IRS, CCIIO, and CMS be comparing the methodologies and either aligning them into a single approach or providing states with a template to be used for each specific type of MAGI determination?

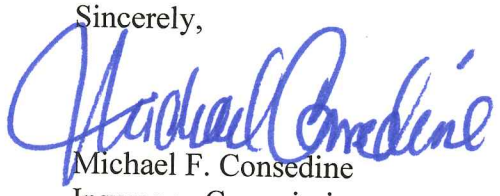
24. In Administrator Tavenner's July 13, 2012 letter to the Republican Governor's Association, she indicated that states do not need to declare whether they are expanding Medicaid eligibility or operating their own exchange in order to receive enhanced funding for IT systems changes. She also indicated that a state would not have to return any funding if it later decides not to take either step. The letter indicated that further guidance would be forthcoming. When will the guidance on this issue be released?

25. Will Pennsylvania be required to convert its CHIP income-counting methodology to MAGI for purposes of determining eligibility if Pennsylvania decides not to expand Medicaid to the optional adult coverage group?

26. Will HHS require a state-based exchange to maintain, for each Qualified Health Plan, a list of participating health providers who are accepting new patients? Will this be a requirement of a state under a Partnership FFE?

We look forward to receiving responses to these inquiries so that we may complete the analysis necessary to permit an informed decision. As has been previously communicated to you by Governor Corbett, Pennsylvania is committed to implementing health reform solutions that work for Pennsylvania – not a one-size-fits-all Washington solution. Given the extent and nature of the questions that remain open, we have determined that at this time it would be imprudent for us to continue extensive planning efforts until we receive answers to these items. Therefore, Pennsylvania will not be expending any of its Level I Establishment grant funding until such a time when the information we require to make an informed decision is provided to us by your Department. Pennsylvania's focus remains on getting healthcare reform done right, not just done quickly. As we await your response, Pennsylvania will be continuing its work towards achieving meaningful and sustainable health care solutions in our state.

Sincerely,



Michael F. Consedine
Insurance Commissioner