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Federal and National Issues

**Legislative Issues**

**House Approves Health Bills**
During the week of June 12, the House approved three health related bills:

- **H.R. 2581, the “Verify First Act:”** This bill would prohibit advance payments of the Affordable Care Act’s (ACA) premium tax credits – and also of the American Health Care Act’s (AHCA) premium tax credits – unless the Treasury Secretary has received confirmation from the HHS Secretary that the individual’s citizenship or immigration status has been verified, by either the Social Security Commissioner or the Secretary of Homeland Security, under a process “that includes the appropriate use of information related to citizenship or immigration status, such as social security account numbers (but not individual taxpayer identification numbers).”

- **H.R. 2372, the “Veterans Equal Treatment Ensures Relief and Access Now Act:”** This bill would clarify the rules relating to veterans’ eligibility for premium tax credits under both the Affordable Care Act (ACA) and the American Health Care Act (AHCA). It provides that veterans would not be ineligible for premium tax credits based on their eligibility for Veterans Affairs health programs, as long as they are not enrolled in such programs.

- **H.R. 2579, the “Broader Options for Americans Act:”** This bill would include unsubsidized COBRA continuation coverage in the AHCA’s definition of a qualified health plan for purposes of determining eligibility for the new premium tax credit that would be established under this legislation.

**Senate Subcommittee Questions HHS Secretary on Multiple Issues**
Secretary of Health and Human Services (HHS) Tom Price testified at a hearing in the Senate Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies on June 15. While the hearing was scheduled to focus on the President’s FY 2018 budget request for HHS programs and agencies, discussion also included the future of Medicaid, ACA repeal and replace, cost sharing reduction (CSR) payments.

Throughout the hearing, several Democrats raised concerns about deep Medicaid funding cuts that would be imposed under both the ACA repeal legislation and the President’s budget. They emphasized Medicaid’s role in helping people who struggle with addiction. Senator Patrick Leahy (D-VT) questioned what would happen if state Medicaid programs can no longer afford to offer medication-assisted treatments to Medicaid beneficiaries. Secretary Price said the Administration wants to advance structural reforms that empower states with the resources and flexibility to serve their unique Medicaid populations in a way that is both compassionate and sustainable.

Senator Lamar Alexander (R-TN) recommended to Secretary Price that he continue CSR payments through at least 2018 and “probably 2019.” He emphasized that this funding is needed to support the transition from a collapsing market to a stable market. In response, Secretary Price
noted that this case is in the courts and that the President’s budget reflects the continuation of CSR payments until this litigation is resolved.

Democrats repeatedly raised concerns and questions about the development of ACA repeal legislation by Senate Republicans. They expressed concern that the bill is being written without hearings and without public input. Secretary Price said he has not seen legislative language, although HHS has been providing technical assistance. In response to a question from Senator Tammy Baldwin (D-WI), Secretary Price said that coverage of pre-existing conditions is an absolute priority for the President and that this message has been conveyed to Congress.

Subcommittee Chairman Roy Blunt (R-MO) expressed concern that the President’s budget would cut $15 billion from HHS programs and agencies in fiscal year 2018. He cautioned that the subcommittee is unlikely to support such a significant funding reduction, and he highlighted particular concerns about proposed funding cuts for the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMSHA).

**Senators Carper and Kaine Propose Individual Market Reinsurance Fund**

Senators Tom Carper (D-DE) and Tim Kaine (D-VA) have announced the introduction of S. 1354, the “Individual Health Insurance Marketplace Improvement Act.”

This bill would establish an Individual Market Reinsurance Fund that would be used, beginning in 2018, to make reinsurance payments to insurers with respect to high-cost individuals enrolled in qualified health plans (QHPs). In the first three years (2018-2020), the proposed reinsurance payments would cover 80 percent of claims between $50,000 and $500,000. Beginning in 2021, the program would cover 80 percent of claims between $100,000 and $500,000. The bill would appropriate “such sums as are necessary” for this Fund. Grandfathered health plans and transitional health plans would not be eligible for the proposed reinsurance payments.

**MedPAC Submits Annual June Report to Congress**

On Wednesday, June 14, the Medicare Payment Advisory Commission (MedPAC) issued its annual June report to Congress addressing “Medicare and the Health Care Delivery System.” The report includes ten chapters addressing – among other topics – key design issues in a Medicare premium support system (but no recommendations), an alternative model for MACRA’s Merit-based Incentive Payment System, the implications of provider consolidation, and an overview of the medical device industry. The report does not address major issues affecting the Medicare Advantage and Part D programs.

The report includes recommendations in only two areas: (1) Medicare Part B drug payment policy issues; and (2) implementing a unified Medicare payment system for post-acute care. For Part B drugs, MedPAC recommends establishing, no later than 2022, a “Drug Value Program” that would allow providers to use private vendors to negotiate drug prices with manufacturers. MedPAC states that the intent of this program is “to obtain lower prices for Part B drugs by permitting private vendors to use tools such as a formulary to negotiate prices with manufacturers and by improving incentives for provider efficiency through shared savings opportunities.”

**Regulatory Issues**

**MACPAC Issues June Report to Congress**

The Medicaid and CHIP Payment and Access Commission (MACPAC) released its June report to Congress, which includes a chapter examining how Medicaid programs are responding to the opioid epidemic. According to the report, Medicaid beneficiaries are prescribed pain relievers at higher rates than those with other sources of insurance and have a higher risk of overdose from
opioids. However, they also have higher treatment rates for opioid use disorders than privately insured adults.

While state Medicaid programs are responding to the opioid crisis by covering treatment, innovating in care delivery and working to reduce misuse of prescriptive opioids, they vary considerably in the services they cover because many Medicaid addiction services are optional, MACPAC said.

The report also examines spending on Medicaid’s mandatory and optional populations and services, and federal and state activities to ensure program integrity in Medicaid managed care.

**CMS Extends Comment Deadline for SNF Advance Notice of Proposed Rulemaking**
The Centers for Medicare & Medicaid Services has extended the comment period for its advance notice of proposed rulemaking on potential options the agency may consider for revising the existing skilled nursing facility payment system.

The original June 26 comment deadline was extended through August 25.

**OIG: Some Medicare Electronic Health Record Incentive Payments Were Inappropriate**
The Centers for Medicare & Medicaid Services inappropriately paid $729.4 million in Medicare electronic health record incentive payments to eligible professionals who did not meet meaningful use requirements, the Department of Health and Human Services’ Office of Inspector General estimated in a report.

Based on a review of 100 EPs, OIG said it identified 14 EPs with payments totaling $291,222 between May 2011 and June 2014 that did not meet meaningful use requirements because of insufficient attestation support, inappropriate reported meaningful use periods or insufficiently used certified EHR technology. According to the report, CMS also made more than $2.3 million in incentive payments in the wrong payment year to EPs who switched between the Medicare and Medicaid incentive programs.

The OIG recommended that CMS attempt to recover the payments and any inappropriate incentive payments after the audit period; educate EPs on proper documentation requirements; and employ edits within the National Level Repository to ensure EPs do not receive payments under both incentive programs in the same program year. The OIG also recommended that any modifications to the EHR meaningful use requirements as CMS implements the Medicare Access and Children’s Health Insurance Program Reauthorization Act include stronger program integrity safeguards to ensure that EPs use EHRs consistent with the CMS goal of advancing care information under the Merit-based Incentive Payment System.

**SAMHSA Reports on Behavioral Health and Treatment Trends**
About 12.5 million U.S. residents reported misusing prescription pain relievers in 2015, according to a report released by the Substance Abuse and Mental Health Services Administration. More than half of them obtained their most recently misused pain reliever from a friend or relative, notes the report, which summarizes data on substance use, depression, serious mental illness and related treatment from the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services.

The number of people receiving buprenorphine to treat opioid use more than doubled between 2013 and 2015 to nearly 76,000. Among other findings, an estimated 13% of youth aged 12-17 experienced a major depressive episode in 2015, including one in five girls. “This analysis can help public health authorities and others determine the best ways of meeting behavioral health care needs and disparities among various communities,” said Acting Deputy Assistant Secretary Kana Enomoto.
The QHP Application Submission Deadline Is June 21, 2017
All Qualified Health Plan (QHP) applications for plan year 2018 must be submitted to the Health Insurance Oversight System (HIOS) or the System for Electronic Rate and Form Filing (SERFF) by noon ET on June 21, 2017. Issuers’ Plans & Benefits Template(s) must include all plans that issuers want the Centers for Medicare and Medicaid Services (CMS) to consider for certification on the Federally-facilitated Exchange (FFE). Applications received after this deadline will not be considered for PY2018 certification.

CMS Extending the Network Breadth and Quality Rating System (QRS) Star Ratings Pilots
The Centers for Medicare and Medicaid Services (CMS) issued guidance to extend both the network breadth and QRS star ratings pilot to 2018. Network breadth information will display for Maine, Ohio, Tennessee, and Texas during Open Enrollment, with the intent of helping enrollees choose plans by providing them with more information that will help them better understand plan designs. The QRS information will display for both Virginia and Wisconsin during Open Enrollment, with the intent of providing consumers with comparable and useful information about the quality of health care services and enrollee experience with the Exchanges’ health plans.

Iowa to Seek Federal Approval of Individual Market to Address Potential Bare Spots
Iowa’s Insurance Division, on June 12, announced on its website that it will submit a Proposed Stopgap Measure (PSM) Plan to the Centers for Medicare and Medicaid Services (CMS) to ensure that all Iowans have access to health insurance in 2018. According to the press release, Iowa’s health insurance market has collapsed and 72,000 Iowans are in danger of having no insurance options in 2018 if the proposed action is not taken. The press release also notes that this plan is a short-term solution. Iowa acknowledges that it, like other states, need a long-term fix from Congress to stabilize the market. The Division will submit this proposal under the Affordable Care Act’s Section 1332 as an innovation waiver; however, the Division acknowledges that the proposal does not conform to all 1332 requirements. If CMS deems that this proposal cannot be submitted as, or does not qualify as, an innovation waiver, the Division requests that CMS consider this proposal as a formal request for emergency relief pursuant to President Trump’s Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.

Under the Iowa Insurance Division’s proposal, the standard plan will be the only plan available for purchase in the individual market in 2018 and will be the only plan offering tax credits and qualifying for reinsurance. The Iowa PSM plan will comply with guaranteed issue, EHB, and other ACA benefits requirements. The proposal also would change the structure of federal tax credits provided by the ACA and subsidies would become available to those with higher incomes. The Iowa proposal also would eliminate “cost-sharing reduction” funds for low-income residents by redirecting the money to mitigate likely premium increases. In addition, Iowa regulators are calling for a “reinsurance” program to help insurers cover the cost of patients with high-cost medical conditions. The Iowa proposal includes about $80 million for reinsurance, with all money coming from the federal government.

CMS Projected Insurer Participation in Health Insurance Exchanges
The Centers for Medicare & Medicaid Services (CMS), on June 13, released a county-level map of 2018 projected Health Insurance Exchanges participation based on the known issuer participation public announcements through June 9, 2017. Plan options have decreased since last year and, in some areas, there will be no coverage options on the Exchanges.

It currently shows that 47 counties nationwide are projected to have no insurers, meaning that Americans in these counties could be without coverage on the Exchanges for 2018. It is also projected that as many as 1,200 counties - nearly 40% of counties nationwide – could have only
one issuer in 2018. Currently, for 2018 at least 35,000 active Exchange participants live in the counties projected to be without coverage in 2018, and roughly 2.4 million Exchange participants are projected to have one issuer. It is expected that the number of consumers with no coverage choices will rise. CMS continues to work with state departments of insurance and issuers to address bare counties, exploring all options available under current law to provide Americans with access to coverage.

State Issues

Delaware

Legislative

House Introduces Legislation creating the Addiction Action Committee
House Bill 220 establishes the Addiction Action Committee as a means to establish a comprehensive, coordinated strategy to address addiction in Delaware. The committee is authorized to make recommendations on a comprehensive approach to address and monitor the addiction crisis. This bill was released from the House Health and Human Development Committee. To view this legislation go to: [http://legis.delaware.gov/BillDetail?legislationId=25944](http://legis.delaware.gov/BillDetail?legislationId=25944)

DE Legislature Introduces several Bills Impacting Medicaid

- **Senate Bill 109**: Extends the same access to treatment of a substance use disorder within the Medicaid framework that Senate Bill 41 of the 149th General Assembly afforded to individuals covered by private health insurance, except that a 72 hour supply instead of a 5 day supply of emergency medication is required. Senate Bill 41, recently signed into law, prohibits insurance carriers from imposing precertification, prior authorization, re-admission screening, or referral requirements for the diagnosis and treatment during the first 14 days of residential treatment for serious mental illness and/or substance abuse treatment. Senate Bill 109 also clarifies that Medicaid health plans must use the full set of American Society of Addiction Medicine criteria when determining whether "medical necessity" exists for the placement, continued stay, and transfer/discharge of patients with a substance use disorder in treatment programs. Additionally, this Act aligns protections relating to services, specifically 5 days of treatment in detox centers and 30 days of treatment in Intensive Outpatient Programs, with the residential treatment option that is protected pursuant to Senate Bill 41 of the 149th General Assembly. Senate Bill 109 passed the Senate and is in the House Health and Human Development Committee. To view this legislation go to: [http://legis.delaware.gov/BillDetail?LegislationId=25905](http://legis.delaware.gov/BillDetail?LegislationId=25905)

- **House Bill 203**: This Act directs the Division of Medicaid and Medical Assistance, Division of Public Health, and Office of Management and Budget – Human Resources Management to report to the General Assembly every 2 years the impacts and costs associated with diabetes. The first report is due by June 30, 2019. The report shall include: (1) Data reflecting the prevalence and burden of diabetes in Delaware. (2) Activities related to diabetes programs and initiatives throughout the State. (3) An estimate of the financial impact of diabetes on each of the Agencies. (4) The number of people impacted or served by each of the Agencies with regard to diabetes, including programs and initiatives designed to reach individuals with diabetes and prediabetes. (5) A description of each of the Agencies’ implemented programs and activities aimed at improving diabetes care and preventing the disease, and an assessment of the expected benefits and outcomes for each program and activity. (6) Current funding levels for each of the Agencies to implement programs and activities aimed at reaching individuals with diabetes and prediabetes. (7) Each of the Agencies’ individual plans, including recommendations to address the
prevention and control of diabetes, the intended outcomes of the recommendations, and estimates of the funding and time required to implement the recommendations. House Bill 203 was released from the House Health & Human Development Committee. To view this legislation go to http://legis.delaware.gov/BillDetail?LegislationId=25862

- **House Bill 200**: This bill sets a minimum reimbursement rate for home health care nursing services paid for by Medicaid-contracted organizations. The rate shall be at least equal to the rate set by the Division of Medicaid for equivalent services. Home care nurses and aides give Delawareans with disabilities the option to remain at home with their families and would prevent unnecessary use of higher-cost hospitals, nursing homes and rehabilitation facilities. House Bill 200 was released from the House Health & Human Development Committee. To view this legislation go to: http://legis.delaware.gov/BillDetail?LegislationId=25864

**Pennsylvania**

**Legislative**

**Bill to Improve PA Stroke Care Signed into Law**
Governor Wolf has signed [House Bill 23](http://legis.delaware.gov/BillDetail?LegislationId=25862) into law, creating Act 4 of 2017. This law seeks to ensure that patients are taken to stroke centers that deliver appropriate levels of care.

The bill, sponsored by State Representative Ryan Mackenzie (R-Lehigh), makes important changes to the stoke center law to reflect federal updates, including:
- Changing the name of the current law to the Stroke System of Care Act
  - Creating designations for acute stroke-ready hospitals and comprehensive stroke centers
- Establishing the process to be used to recognize each facility designation
- Calling on the Department of Health to make available location and other information regarding each designated facility
- Requiring the Department of Health to ensure proper protocols related to the treatment of stroke patients
- Providing for completion of a biennial report to identify any changes in the number or location of each facility designation

Primary stroke centers were created through [Act 54 of 2012](http://legis.delaware.gov/BillDetail?LegislationId=25862) to ensure patient access to a network of hospitals fully prepared to evaluate, stabilize, and provide emergency and inpatient care to patients with acute stroke.

**State House Judiciary Committee Passes Bill to Protect Health Care Workers from Assault**
The State House Judiciary Committee unanimously passed [House Bill 646](http://legis.delaware.gov/BillDetail?LegislationId=25864), which would add health care practitioners to a protected class in the event of an assault.

The bill, sponsored by Committee Member Representative Judy Ward (R-Blair), raises the penalty for an assault on an on-duty health care practitioner from a misdemeanor of the second degree to a felony of the second degree.

The definition of health care practitioner in the legislation includes any health care professional who has a license, permit, or certificate from the Bureau of Professional and Occupational Affairs of the Department of State. Similar legislation has been introduced in the Senate by Senator Don White (R-Indiana), [Senate Bill 445](http://legis.delaware.gov/BillDetail?LegislationId=25864).
HAP Highlights Hospital Emergency Preparedness Partnership during Senate Informational Hearing

The Hospital & Healthsystem Association’s Tom Grace, vice president, emergency preparedness, provided lawmakers with an update about the important emergency preparedness work underway as a part of the commonwealth’s Hospital Preparedness Partnership Program between the Pennsylvania Department of Health (DOH) and HAP.

**Grace’s testimony** provided an overview of the DOH/HAP Hospital Preparedness Program Partnership that began in 2012 to promote and facilitate health care emergency preparedness among hospitals, specialty health care facilities, long-term care facilities, and community health centers throughout the commonwealth. The partnership also works to build a regional coalition approach to health care preparedness across the state.

The information was provided during a joint informational hearing of the Senate Health & Human Services Committee and the Senate Veterans Affairs Emergency Preparedness Committee.

“The HAP emergency preparedness team has supported facilities, communities, counties, regions, and statewide emergency response and management activities for the full array of emergencies and events experienced in the commonwealth,” said Grace. He noted that each month, the HAP emergency preparedness team monitors more than 50 incidents that could affect health care facilities and provides follow-up as necessary.

Grace was joined by Ray Barishansky, Pennsylvania Department of Health’s deputy secretary for health planning & assessment, Matthew Linse, Saint Vincent Hospital’s prehospital care coordinator and emergency services liaison for the Northwest PA Health Care Coalition, and Richard Flinn, director of Pennsylvania Emergency Planning Agency. The individuals shared, from their perspectives, the success of current efforts as well as future challenges. Flinn shared that funding cuts are a major challenge to continue emergency preparedness.

**Senate Committees Approve Opioid Proposals**

Several bills addressing Pennsylvania’s ongoing opioid crisis were approved by the Senate Consumer Protection and Professional Licensure Committee (SCPPLC) and the Senate Health and Human Services Committee (SHHSC):

**SCPPLC**

- Senate Bill 472 would limit the prescription for a controlled substance containing an opioid to seven days unless there is a medical emergency that puts the patients’ health or safety at risk. The bill also requires all prescribers who are licensed, registered or otherwise legally authorized to distribute, dispense or administer a controlled substance containing an opioid to discuss the risks of addiction and dangers of overdose associated with the medication.

- Senate Bill 542 would require a pharmacist to notify the prescriber within 72 hours if an emergency prescription is dispensed. The measure also clarifies that if the prescription is not dispensed or sold in a 72-hour supply, then an amount not to exceed a 30-day supply may be dispensed or sold.

**SHHSC**

- Senate Bill 533 would establish an Emergency Addiction Treatment Program by expanding upon existing treatment facilities and halfway homes, as well as establishing new facilities. The program would also provide guidance on accessing treatment and understanding addiction for patients and their families.
- Senate bill 655 would enforce mandatory opioid prescribing guidelines that were established by the Safe and Effective Prescribing Practices Task Force in 2016. While the guidelines are being followed by the state Boards of Medicine, Pharmacy and Dentistry, they currently are voluntary.

- Senate Bill 728 amends the 2014 Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) to exempt Schedule V non-opioid, non-narcotic epilepsy drugs from the prescription drug monitoring program requirements. The current law created barriers for patients in obtaining their epilepsy medication – Pennsylvania is the only state that requires a query for epilepsy drugs.

- House Bill 17 allows parents and guardians to consent on behalf of a minor for addiction treatment if the minor faces imminent danger.

- House Bill 118 encourages community hospitals to convert existing beds to provide emergency detoxification.

Report Indicates Pennsylvania Could Lose Thousands of Jobs under ACA Repeal

A new report from George Washington University researchers says changes to the Affordable Care Act (ACA) could mean the loss of the 85,000 jobs in Pennsylvania, the second highest of any state in the country as well as losses in the gross state product and business output. According to the study's profile of Pennsylvania, by 2026, the commonwealth could lose 84,900 total jobs, including 52,500 in the health sector, $8.9 billion in gross state product and $14.2 billion in business output.

The report, supported by the Commonwealth Fund, examines the potential economic and employment effects of American Health Care Act (AHCA) for every state in the nation. Most tax cuts will occur immediately, increasing the federal deficit, while coverage-related federal spending cuts will phase in more slowly over time. As a result, the net effect is additional job growth in 2018 and 2019 and growth in state economies and business output. However, health sector employment would fall immediately by 24,000 jobs in 2018.

West Virginia

Legislative

West Virginia Reaches Budget Agreement

On Friday evening, June 16, the West Virginia House and Senate passed a $4.225 billion budget bill. The legislation, Senate Bill 1013, represents $125 million less that the proposal Governor Justice endorsed and approved by the Senate the day prior, June 15.

The final version of the legislation includes an expansion of the state sales tax base, eliminating certain exemptions. The budget also includes several spending cuts, namely a 6.6 percent reduction in funding to state colleges. Considering all provisions in the legislation, the final budget bill is expected to generate an additional $67 million in revenue.

Industry Trends

Provider / Delivery System Trends

AHA Urges Congress to Address Rising Cost of Drugs

The American Hospital Association is urging Congress and the administration to take immediate action to rein in the rising cost of drugs.
In a statement submitted to the Senate Committee on Health, Education, Labor and Pensions for a hearing on the issue, AHA offered specific recommendations to increase competition, innovation and transparency, promote payment for value, improve access and align incentives. “Hospitals bear a heavy financial burden when drug costs rise unexpectedly and must make tough choices about how to allocate scarce resources,” the association said. “One hospital put the challenge starkly: In a recent year, the overall cost of the price increases for just four common drugs, which ranged from 479% and 1,261%, cost the same amount as the salaries of 55 full-time nurses. And…many hospitals report that annual price increases of 10% or 20% for widely used older generic drugs can have an even greater effect, given the large quantities that a hospital must purchase.”

State
The Pennsylvania General Assembly is in session the week of June 19.

The Delaware General Assembly is in session June 20-22.

The West Virginia Legislature has adjourned for the year.

Congress
The U.S. Congress is in session the week of June 19.

Interested in reviewing a copy of a bill(s)? Access the following web sites:


Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us).

West Virginia Legislation: [http://www.legis.state.wv.us](http://www.legis.state.wv.us).

For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/).