

Health and Human Services Task Force

Spring Task Force Summit

Pittsburgh, PA

May 6, 2016

Health and Human Services Task Force Meeting

Spring Task Force Summit | Pittsburgh, PA

Friday May 6, 2016

2:30 PM - 5:00 PM

- 2:30 PM** **Call to Order**
Welcome and Introductions
Approval of Minutes from State and National Policy Summit 2015
- 2:35 PM** **Presentation:** Work Requirements and the Food Stamps Program
- 2:50 PM** **Presentation:** The Right to Try to Save Your Own Life
- 3:05 PM** **Presentation:** PhRMA Perspective on Right To Try
- 3:20 PM** **Model Policy Consideration:** First Responder Immunity Act: Relating to prescription, dispensing, and delivery of opioid antagonists.
- 3:35 PM** **Model Policy Consideration:** Prescription Drug Monitoring Act: Reporting, Disclosure, and Practitioner Review Requirements Under the Prescription Drug Monitoring Program.
- 3:50 PM** **Model Policy Consideration:** Opioid Treatment Programs Act: Creates regional pilot programs to address opioid addiction.
- 4:05 PM** **Model Policy Consideration:** State Higher Education Institutions Suicide Prevention Program.
- 4:20 PM** **Sunset Policy Review**
- 4:55 PM** **For the Good of the Order**
- 5:00 PM** **Adjournment**

First Responder Immunity Act

Summary

Training and agreements for administering the drug naloxone, requiring emergency medical technicians to carry naloxone, and immunity for certain individuals who administer naloxone.

Section 1.

(1) In this section:

- (a) "Department" means [insert agency responsible for EMS in the state].
- (b) "Fire fighter" means any person employed by the state or any political subdivision as a member or officer of a fire department or a member of a volunteer fire department.
- (c) "Law enforcement agency" means an agency of a federally recognized Indian tribe or band or a state or political subdivision of a state, whose purpose is the detection and prevention of crime and enforcement of laws or ordinances.
- (d) "Law enforcement officer" means any person employed by a law enforcement agency who is authorized to make arrests for violations of the laws or ordinances that the person is employed to enforce.
- (e) "Opioid antagonist" has the meaning given in section 2 (1) (b).
- (f) "Opioid-related drug overdose" means a condition including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or the ceasing of respiratory or circulatory function resulting from the consumption or use of an opioid, or another substance with which an opioid was combined.

(2) (a) Subject to par. (b), the department shall permit all emergency medical technicians to administer naloxone or another opioid antagonist to individuals who are undergoing or who are believed to be undergoing an opioid-related drug overdose.

(b) The department shall require emergency medical technicians to undergo any training necessary to safely and properly administer naloxone or another opioid antagonist as specified under par. (a).

(c) A certified first responder is authorized to administer naloxone or another opioid antagonist if the first responder has received training necessary to safely administer naloxone or the other opioid antagonist, as determined by the department.

(c) Every ambulance service provider shall do all of the following:

1. Ensure that every emergency medical technician under the ambulance service provider's supervision who has obtained the training necessary to safely and properly administer naloxone

or another opioid antagonist has a supply of naloxone or the other opioid antagonist available for administration when he or she is performing his or her duties as an emergency medical technician, to the extent that naloxone or the other opioid antagonist is available to the ambulance service provider.

2. Require each certified first responder and emergency medical technician under the supervision of the ambulance service provider to, in the manner prescribed by the department, keep a record of each instance in which the certified first responder or emergency medical technician administers naloxone or another opioid antagonist to an individual who is undergoing or who is believed to be undergoing an opioid-related drug overdose.

3. Submit records under subd. 2. to the department in the manner prescribed by the department.

(3) (a) A law enforcement agency or fire department may enter into a written agreement to affiliate with an ambulance service provider or a physician for all of the following purposes:

1. Obtaining a supply of naloxone or another opioid antagonist.

2. Allowing law enforcement officers and fire fighters to obtain the training necessary to safely and properly administer naloxone or another opioid antagonist to individuals who are undergoing or who are believed to be undergoing an opioid-related drug overdose.

(b) A law enforcement officer or fire fighter who, reasonably believing another person to be undergoing an opioid-related drug overdose, administers naloxone or another opioid antagonist to that person shall be immune from civil or criminal liability for any outcomes resulting from the administration of the opioid antagonist to that person, if the law enforcement officer or fire fighter is acting pursuant to an agreement and any training obtained under par. (a).

Note: Definitions for terms such as “ambulance service provider,” “first responder,” and “emergency medical technician” will probably vary by state, or different concepts may apply.

Section 2.

(1) In this section:

(a) "Administer," "deliver," and "dispense," have the meanings given [under the state's pharmacy practice act].

(b) "Opioid antagonist" means a drug, such as naloxone, that satisfies all of the following:

1. The drug binds to the opioid receptors and competes with or displaces opioid agonists at the opioid receptor site but does not activate the receptors, effectively blocking the receptor and preventing or reversing the effect of an opioid agonist.

2. The drug is not a controlled substance.

- (c) "Opioid-related drug overdose" has the meaning given in Section 1 (f).
- (d) "Standing order" means an order transmitted electronically or in writing by a practitioner for a drug or device for multiple patients or for one or more groups of patients.
- (2) (a) A physician, physician assistant, or advanced practice nurse authorized to issue prescription orders may do any of the following:
1. Prescribe an opioid antagonist to a person in a position to assist an individual at risk of undergoing an opioid-related drug overdose and may deliver the opioid antagonist to that person. A prescription order under this subdivision need not specify the name and address of the individual to whom the opioid antagonist will be administered, but shall instead specify the name of the person to whom the opioid antagonist is prescribed.
 2. Issue a standing order to one or more persons authorizing the dispensing of an opioid antagonist.
- (b) A physician, physician assistant, or advanced practice nurse who prescribes or delivers an opioid antagonist under par. (a) 1. shall ensure that the person to whom the opioid antagonist is prescribed has or has the capacity to provide the knowledge and training necessary to safely administer the opioid antagonist to an individual undergoing an opioid-related overdose and that the person demonstrates the capacity to ensure that any individual to whom the person further delivers the opioid antagonist has or receives that knowledge and training.
- (3) A physician, physician assistant, or advanced practice nurse who, acting in good faith, prescribes or delivers an opioid antagonist in accordance with sub. (2), or who, acting in good faith, otherwise lawfully prescribes or dispenses an opioid antagonist, shall be immune from criminal or civil liability and may not be subject to professional discipline for any outcomes resulting from prescribing, delivering, or dispensing the opioid antagonist.
- (4) (a) 1. A pharmacist may, upon and in accordance with the prescription order of a physician, physician assistant, or advanced practice nurse authorized to issue prescription orders under sub. (2) (a) 1. that complies with [the requirements under the state's pharmacy practice act relating to prescription orders], deliver an opioid antagonist to a person specified in the prescription order and may, upon and in accordance with the standing order of a physician, physician assistant, or advanced practice nurse under sub. (2) (a) 2. that complies with [the requirements under the state's pharmacy practice act relating to prescription orders], deliver an opioid antagonist to an individual in accordance with the order. The pharmacist shall provide a consultation in accordance with [the requirements under the state's pharmacy practice act relating to consultations].
2. A pharmacist who, acting in good faith, delivers an opioid antagonist in accordance with subd. 1., or who, acting in good faith, otherwise lawfully dispenses an opioid antagonist, shall be immune from criminal or civil liability and may not be subject to professional discipline under for any outcomes resulting from delivering or dispensing the opioid antagonist.

- (b) 1. Any person may possess an opioid antagonist.
- 2. a. Subject to subd. 2. b. and c., any person may deliver or dispense an opioid antagonist.
- b. A physician, physician assistant, or advanced practice nurse may only deliver or dispense an opioid antagonist in accordance with sub. (2) or in accordance with his or her other legal authority to dispense prescription drugs.
- c. A pharmacist may only deliver or dispense an opioid antagonist in accordance with par. (a) 1. or in accordance with his or her other legal authority to dispense prescription drugs.
- (c) 1. Subject to par. (a) 2. and sub. (3), any person who, acting in good faith, delivers or dispenses an opioid antagonist to another person shall be immune from civil or criminal liability for any outcomes resulting from delivering or dispensing the opioid antagonist.
- 2. Subject to section 1 (3) (b), any person who, reasonably believing another person to be undergoing an opioid-related drug overdose, administers an opioid antagonist to that person shall be immune from civil or criminal liability for any outcomes resulting from the administration of the opioid antagonist to that person.

Note: In Wisconsin, we strongly disfavor the use of phrasing such as “notwithstanding any other provision of law.” Our practice is instead to look for provisions that would potentially conflict and amend them to clearly resolve any conflict. In Wisconsin, it was necessary to amend a number of provisions relating to prescription drugs, but in other states, the phrasing “notwithstanding any other provision of law” may be used instead.

Prescription Drug Monitoring Act

Summary

This Act changes authorizes the requirement for those who dispense certain prescription drugs to submit information to the state Prescription Drug Monitoring Program (PDMP) from 7 days to 24 hours. This will also require a practitioner to review a patient’s record when initially prescribing a monitored prescription drug (for example, a Schedule II drug).

Section 1. Prescription drug monitoring program.

(1) In this section:

(a) "Administer" means the direct application of a monitored prescription drug, whether by injection, ingestion, or any other means, to the body of a patient by any of the following:

- 1. A practitioner or his or her agent.

2. A patient at the direction of a practitioner.
 3. A pharmacist.
- (b) "Agent" means an authorized person who acts on behalf of or at the direction of another person.
- (c) "Board" means the **[appropriate board or state agency administering the program under this section]**.
- (d) "Business day" means any day on which the offices of board are open.
- (e) "Deliver" or "delivery" means the actual, constructive, or attempted transfer of a monitored prescription drug from one person to another.
- (f) "Dispense" means to deliver a monitored prescription drug pursuant to the lawful prescription order of a practitioner, including the compounding, packaging, or labeling necessary to prepare the monitored prescription drug for delivery.
- (g) "Monitored prescription drug" means a substance identified in Schedule II, III, IV, or V, or a drug identified by the board by rule as having a substantial potential for abuse.
- (h) "Patient" means an individual or animal for whom a monitored prescription drug is prescribed or to whom a monitored prescription drug is dispensed or administered.
- (i) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy or licensed in another state and recognized by this state as a person authorized to engage in the practice of pharmacy in the state in which the person is licensed.
- (j) "Pharmacy" means a place licensed in this state at which the practice of pharmacy occurs.
- (k) "Practitioner" means a person licensed in this state to prescribe and administer drugs or licensed in another state and recognized by this state as a person authorized to prescribe and administer drugs, but does not include a licensed veterinarian.
- (L) "Prescription order" means an order transmitted orally, electronically, or in writing by a practitioner or a licensed veterinarian for a monitored prescription drug for a particular patient.
- (2) The board shall establish by rule a program for monitoring the dispensing of monitored prescription drugs. The program shall do all of the following:
- (a) Require a pharmacy or a practitioner to generate a record documenting each dispensing of a monitored prescription drug at the pharmacy or, if the

- (b) monitored prescription drug is not dispensed at a pharmacy, by the practitioner and to submit the
- (c) record to the board no later than 11:59 p.m. of the next business day after the monitored prescription drug is dispensed, except that the program may not require the generation of a record in any of the following circumstances:

1. A monitored prescription drug is administered directly to a patient.
2. A monitored prescription drug is compounded, packaged, or labeled in preparation for delivery but is not delivered.
3. The prescription order is for a monitored prescription drug that is a substance listed in Schedule V and is not a narcotic drug, and the prescription order is for a number of doses that is intended to last the patient 7 days or less.

(b) Identify specific data elements to be contained in a record documenting the dispensing of a monitored prescription drug, including the method of payment. In identifying specific data elements, the board shall consider data elements identified by similar programs in other states and shall ensure, to the extent possible, that records generated by the program are easily shared with other states.

(c) Specify the persons to whom a record may be disclosed and the circumstances under which the disclosure may occur. Except as otherwise provided under this section, the rule promulgated under this paragraph shall comply with applicable state laws concerning the confidentiality of patient health care records.

(cm) Permit the board to disclose a record generated by the program to any of the following:

1. A practitioner, pharmacist, registered nurse, or substance abuse counselor or other individual authorized in this state to treat alcohol or substance dependency or abuse as a specialty if any of the following is applicable:

- a. The practitioner, pharmacist, registered nurse, or substance abuse counselor or other individual is directly treating or rendering assistance to the patient.

- b. The practitioner, pharmacist, registered nurse, or substance abuse counselor or other individual is being consulted regarding the health of the patient by an individual who is directly treating or rendering assistance to the patient.

2. A person who medically coordinates, directs, or supervises, or establishes standard operating procedures for, a practitioner, pharmacist, registered nurse, or substance abuse counselor or other individual authorized in this state to treat alcohol or substance

dependency or abuse as a specialty to whom records may be disclosed under subd. 1., if the person is evaluating the job performance of the practitioner, pharmacist, registered nurse, or

substance abuse counselor or other individual, or is performing quality assessment and improvement activities, including outcomes evaluation or development of clinical guidelines, and if the disclosure does not contain personally identifiable information of a patient and is limited to only those records about the practitioner, pharmacist, registered nurse, or substance abuse counselor or other individual the person medically coordinates, directs, or supervises, or for whom the person establishes standard operating procedures.

3. Relevant state boards and agencies, relevant agencies of other states, relevant law enforcement agencies, and relevant prosecutorial units, if any of the following is true:

a. The state board or agency, agency of another state, law enforcement agency, or prosecutorial unit makes a written request for the record and is engaged in an active and specific investigation or prosecution of a violation of any state or federal law involving a monitored prescription drug, and the record being requested is reasonably related to that investigation or prosecution.

b. The state board or agency, agency of another state, law enforcement agency, or prosecutorial unit makes a written request for the record and is monitoring the patient as part of a drug court.

c. The circumstances indicate suspicious or critically dangerous conduct or practices of a pharmacy, pharmacist, practitioner, or patient. The board shall define what constitutes suspicious or critically dangerous conduct or practices for purposes of this subd. 3. c.

4. An agent of a practitioner or pharmacist if disclosure to the practitioner or pharmacist is authorized subject to subd. 1.

(cs) 1. Require a practitioner to review a patient's records under the program before the practitioner issues a prescription order for the patient. This subdivision does not apply after April 1, 2020.

2. The requirement under subd. 1. that a practitioner review a patient's records under the program before the practitioner issues a prescription order for the patient does not apply if any of the following is true:

a. The patient is receiving hospice care.

b. The prescription order is for a number of doses that is intended to last the patient 3 days or less and is not subject to refill.

c. The monitored prescription drug is lawfully administered to the patient.

d. Due to emergency, it is not possible for the practitioner to review the patient's records under the program before the practitioner issues a prescription order for the patient.

- e. The practitioner is unable to review the patient's records under the program because the digital platform for the program is not operational or due to other technological failure if the practitioner reports that failure to the board.
- (d) Specify a secure electronic format for submittal of a record generated under the program and authorize the board to grant a pharmacy or practitioner a waiver of the specified format.
- (e) Specify a deadline for the submittal of a record to the board.
- (f) Permit the board to refer to the appropriate licensing or regulatory board for discipline, or the appropriate law enforcement agency for investigation and possible prosecution, a pharmacist, pharmacy, or practitioner that fails to comply with rules promulgated under this subsection, including by failure to generate a record that is required by the program.
- (g) Maximize the potential for funding the operation of the program with available federal funding sources.
- (h) Ensure that the program complies with applicable state laws concerning the confidentiality of patient health care records, except as otherwise provided in this section, and 45 CFR part 164, subpart E.
 - (i) Disclose information concerning potential abuse of monitored prescription drugs submitted to the program by a law enforcement agency to relevant
 - (ii) practitioners, pharmacists, and others to whom the board may make disclosures under par. (c).
- (3) (a) A pharmacy, pharmacist, or practitioner is immune from civil or criminal liability or professional discipline arising from the pharmacy's, pharmacist's, or practitioner's compliance in good faith with this section or with rules promulgated under this section.
- (b) Nothing in this section may be construed to require a pharmacy or pharmacist to obtain, before dispensing a monitored prescription drug to a patient, information about the patient that has been collected pursuant to the program established under sub. (2).
- (4) Records generated under the program under this section are not subject to inspection or copying under the state's open records law.
- (5) (a) Beginning with the 3rd calendar quarter of 2016, no later than 30 days after the end of each calendar quarter, the board shall conduct a review of the program under this section to evaluate the actual outcomes of the program compared with projected outcomes, as determined by the board. The board's review shall include an evaluation of all of the following:
 1. The satisfaction with the program of pharmacists, pharmacies, practitioners, and other users of the program.

2. The program's impact on referrals of pharmacists, pharmacies, and practitioners to licensing or regulatory boards for discipline and to law enforcement agencies for investigation and possible prosecution.

(b) This subsection does not apply after October 30, 2020.

(6) Beginning with the 3rd calendar quarter of 2016, no later than 30 days after the end of each calendar quarter, the board shall provide a report to both houses of the legislature and the governor that includes all of the following:

(a) The results of the board's review under sub. (5). This paragraph does not apply after October 30, 2020.

(b) An assessment of the trends and changes in the use of monitored prescription drugs in this state.

(d) The number of practitioners, by profession, and pharmacies submitting records to the board under the program in the previous quarter.

(e) A description of the number, frequency, and nature of submissions under sub. (2) (i) by law enforcement agencies in the previous quarter.

(f) A description of the number, frequency, and nature of requests made in the previous quarter for disclosure of records generated under the program.

(g) The number of individuals receiving prescription orders from 5 or more practitioners or having monitored prescription drugs dispensed by 5 or more pharmacies within the same 90-day period at any time over the course of the program.

(h) The number of individuals receiving daily morphine milligram equivalents of 1 to 19 milligrams, 20 to 49 milligrams, 50 to 99 milligrams, and 100 or more milligrams in the previous quarter.

(i) The number of individuals to whom both opioids and benzodiazepines were dispensed within the same 90-day period at any time over the course of the program.

(7) (a) The board may contract with an analytics firm to augment the program under this section with an analytics platform that provides data integration, advanced analytics, and alert management capabilities to detect problematic behaviors of practitioners, pharmacies, pharmacists, and patients.

(b) If the board augments the program under this section as specified in par. (a), the goals of that augmentation shall include all of the following:

1. Allowing the board, with the assistance of the analytics firm, to identify past patterns of abuse, addiction, or criminal activity.

2. Proactively improving painkiller prescribing, informing clinical practice, and protecting patients at risk.
3. Measuring program outcomes at an individual level to minimize the abuse of monitored prescription drugs in this state.
 - (j) For purposes of this subsection, the board may disclose records generated under the program to an analytics firm with which the board contracts.

Opioid Treatment Programs Act

Summary

This Act authorizes the creation of treatment programs to address the growing opioid addiction epidemic in the state of XX.

SECTION 1. Opioid treatment programs.

(1) DEFINITION. In this section, “department” means the department of health services [or state department that regulates substance abuse treatment programs].

(2) PROGRAM CREATION. The department shall create 2 or 3 new, regional comprehensive opioid treatment programs to provide treatment for opiate addiction in rural and underserved, high-need areas. The department shall obtain and review proposals for opioid treatment programs in accordance with its request-for-proposal procedures. A program under this section may not offer methadone treatment.

(3) PROGRAM COMPONENTS. An opioid treatment program created under this section shall offer an assessment to individuals in need of service to determine what type of treatment is needed. The program shall transition individuals to a licensed residential program, if that level of treatment is necessary. The program shall provide counseling,

medication-assisted treatment, including both long-acting opioid antagonist and partial agonist medications that have been approved by the federal food and drug administration, and abstinence-based treatment. The program shall transition individuals who have completed treatment to county-based or private post-treatment care.

(4) REPORT. By the first day of the 24th month beginning after the effective date of this subsection, and annually thereafter, the department shall submit to the joint committee on finance [or committee of the legislature that oversees the state budget [and finances] and to the appropriate standing committees of the legislature a progress report on the outcomes of the program under this section.

Note: The Wisconsin act also included a mechanism for appropriating moneys for the purposes of creating opioid treatment programs.

Suicide Prevention in Higher Education Resolution

Summary

This Resolution encourages each state institution of higher education to develop and implement a policy to advise students and staff on suicide prevention programs available on and off campus. The {insert state} Department of Mental Health and Addiction Services is also required to post free suicide prevention materials and program information on their websites, and provide incoming students with information about mental health topics, including local suicide prevention and depression resources.

WHEREAS, Suicide is the second leading cause of death among college and university students;

WHEREAS, The National Action Alliance for Suicide Prevention's research strategy for reducing national suicide rates by demonstrated suicide prevention programs can reduce college suicide rates on campus by forty percent.

Be it therefore RESOLVED that the {insert state} Department of Mental Health and Addiction Services, in conjunction with the institutions of higher education in {State} be encouraged to offer free suicide prevention materials, including program information on their websites, and to provide incoming students with information about mental health topics, including local suicide prevention and depression resources.

Be it further RESOLVED that the [State/Commonwealth] of {State} encourages each institution of higher education to develop and implement a policy and programs to advise students and staff on suicide prevention programs available on and off campus, including, but not limited to:

- (1) Crisis intervention access, which shall include information for national, state, and local suicide prevention hotlines;
- (2) Mental health program access, which shall provide information on the availability of local mental health clinics, student health services, and counseling services;
- (3) Multimedia application access, which shall include crisis hotline contact information, suicide warning signs, resources offered, and free-of-cost applications;
- (4) Student communication plans, which shall consist of creating outreach plans regarding educational and outreach activities on suicide prevention; and
- (5) Post-vention plans, which shall consist of creating a strategic plan to communicate effectively with students, staff, and parents after a loss of a person to suicide.

Be it further RESOLVED that each state institution of higher education be encouraged to make available to all incoming students information about mental health topics, including depression and suicide prevention resources available to all students. This information provided to students should include available mental health services and other support services, including student-run organizations for individuals at risk of or affected by suicide.

Spring Task Force Summit 2016

HHS Task Force: 5-Year Review

Resolution Supporting Choices for Americans with Disabilities – Five Year Review

Summary

This resolution urges states to close state operated facilities and move persons with intellectual and developmental disabilities (ID/DD) to home and community based waiver services (HCBS).

Model Resolution

WHEREAS, 32,909 Americans with intellectual and developmental disabilities (ID/DD) lived in 162 large, state operated facilities—with 16 beds or more—in 42 states as of June 30, 2009; and

WHEREAS, Persons with ID/DD have a fundamental right to be given choice in services that provide respect and dignity; and

WHEREAS, Persons with ID/DD have the right to live in the least restrictive environment consistent with the *Olmstead v. L.C. and E.W.* Decision (98-536) 527 U.S. 581 (1999); and

WHEREAS, Individuals with ID/DD living in integrated community settings are afforded an improved quality of life and a higher level of personal independence; and

WHEREAS, It is cost effective to move persons with ID/DD from large, state operated facilities to home and community based services (HCBS); and

WHEREAS, Average costs in 2009 totaled \$196,735 per person/per year in state operated facilities, versus \$43,969 per person/per year in HCBS waiver settings, a 77.7 percent cost savings; and

WHEREAS, The federal government provides funding to assist in moving persons with ID/DD from state operated facilities to HCBS; and

WHEREAS, 10 states, plus the District of Columbia, have already closed their large state operated facilities for Americans with ID/DD.

THEREFORE BE IT RESOLVED THAT, {Insert state legislature} take action to transition or right-size state operated facilities for Americans with ID/DD as appropriate, to assure care in the least restrictive environment; and

BE IT FURTHER RESOLVED THAT, Copies of this resolution be distributed to the governor, officials in {insert name of state HHS agency}, and members of {insert state}'s Congressional delegation.

Approved by ALEC Board of Directors on October 13, 2011.

Resolution Against PPACA Health Insurance Exchanges – Five Year Review

Summary

Twenty-six states have joined in a lawsuit to have the federal Patient Protection and Affordable Care Act (PPACA) ruled unconstitutional. Nevertheless, many of the plaintiff states continue to plan PPACA health insurance exchanges, using federal funds to do so, undermining their own position as plaintiffs. This resolution urges state officials to stop planning PPACA exchanges and urges Congress to defund such efforts.

Model Resolution

WHEREAS, The federal government has enacted the Patient Protection and Affordable Care Act (PPACA) ostensibly for the purpose of making health insurance more affordable for American citizens; and

WHEREAS, PPACA includes a provision requiring the creation of health insurance exchanges (exchanges) in each state where only health insurance policies that meet certain requirements determined by the federal government may be bought and sold; and

WHEREAS, Exchanges may only be established by each state subject to approval by appointed federal officials; and

WHEREAS, If a state does not establish an exchange, appointed federal officials will establish one in that state; and

WHEREAS, State-created PPACA exchanges put states in the position of ceding their resources and sovereignty to the service of the federal government, sacrificing their ability to flexibly serve their own citizens; and

WHEREAS, Twenty-six states are suing to have PPACA struck down partly due to the arguable unconstitutionality of the individual mandate, and briefs submitted by the federal government in Florida v. U.S. Department of Health and Human Services make clear that exchanges are a key part of the individual mandate; and

WHEREAS, The United States Supreme Court states in part, in its recent ruling in *Bond v. United States*, “Federalism secures the freedom of the individual. It allows States to respond, through the enactment of positive law, to the initiative of those who seek a voice in shaping the destiny of their own times without having to rely solely upon the political processes that control a remote central power,” effectively instructing state leaders that they share in the responsibility to preserve liberty; and

WHEREAS, Judge Vinson, in his order of March 3, 2011 staying his original decision in *Florida v. U.S. Department of Health and Human Services* striking down the PPACA as unconstitutional, stated in footnote 7 that “the severity of that injury [from the PPACA] is undercut by the fact that at least eight of the plaintiff states (noted further infra) have represented that they will continue to implement and fully comply with the Act’s requirements — in an abundance of caution while this case is on appeal — irrespective of my ruling,” clearly implying that as states continue to plan exchanges in preparation for PPACA implementation, the perceived harm to states is reduced, making it less likely the PPACA will ultimately be declared unconstitutional; and

WHEREAS, The U.S. Department of Health and Human Services recently released 70 pages of new rules regarding exchanges that required 172 pages to summarize and clarify, including numerous references to future rulemaking, bringing into question the idea that states have significant flexibility in the establishment of exchanges, and

WHEREAS, If the PPACA is struck down, states planning PPACA exchanges will have participated in wasting millions of dollars of taxpayer funds in planning defunct exchanges; and

WHEREAS, Despite claims by some that states can create PPACA-compliant exchanges that enjoy the benefits of market forces, these exchanges would be completely artificial devices offering insurance products regulated in their essential characteristics by the federal government, making exchanges anything but free markets; and

WHEREAS, PPACA health insurance exchanges will continue to be subject to the arbitrary whims of the federal bureaucracy which, having extensive ongoing rulemaking authority, can render any plan for a state exchange today, no matter how rational and well-designed, obsolete and irrelevant at a later date; and

WHEREAS, The PPACA does not clearly and unequivocally pre-empt state law, containing only a vague provision that seems to say that federal law does not preempt state laws preserving free enterprise health care systems, but the establishment of exchanges necessitates state laws conform to PPACA and states establishing exchanges will actively participate in the pre-emption of their own laws; and

WHEREAS, There is no penalty for a state in allowing the federal government to implement an exchange and doing so puts federal officials in the position of asking a state for permission to operate an exchange rather than states supplicating to appointed federal officials; and

WHEREAS, States can, and should, develop and implement their own, state-based health reform solutions that are tailored to the targeted needs of their citizens without the mandates within PPACA.

NOW THEREFORE BE IT RESOLVED THAT, {insert state legislature} believes it is not in the best interest of the state for any state official to participate in planning or establishing health insurance exchanges as provided for in the federal Patient Protection and Affordable Care Act; and

BE IT FURTHER RESOLVED THAT, {insert state legislature} urges Congress to defund planning grants to states for the establishment of PPACA health insurance exchanges by the states; and

BE IT FURTHER RESOLVED THAT, Copies of this resolution be sent to the President of the United States, the appropriate leadership of the United States Congress and the United States Department of Health and Human Services, and the entire {insert state} delegation in the United States Congress.

Approved by ALEC Board of Directors on October 13, 2011.

Resolution on Improving Quality and Lowering Costs for States Through Medicaid Managed Care – Five Year Review

Summary

This resolution encourages the implementation of coordinated, risk-based, capitated programs to control costs and improve quality of care for all Medicaid beneficiaries, including those requiring long-term care services.

Model Resolution

WHEREAS, Medicaid is an entitlement program jointly funded by the states and the federal government and plays a significant role in state health care systems; and

WHEREAS, Medicaid is the nation’s primary health insurance program for 60 million low-income Americans, including nearly 30 million low-income children and 8 million non-elderly people with disabilities; and

WHEREAS, Medicaid pays for nearly half of all long-term care in the United States; and

WHEREAS, It is essential that Medicaid achieve transformation to become a sustainable, cost-effective health care program; and

WHEREAS, In most states, costs for the Medicaid program are rapidly growing, claiming an increasing share of state budgets and threatening other state programs; and

WHEREAS, Legislators in all states recognize the important role that Medicaid serves as a provider and purchaser of health care services for vulnerable citizens; and

WHEREAS, Under national health care reform, many states will experience an expansion of persons eligible for Medicaid with many of the attendant cost pressures; and

WHEREAS, The situation for individuals under Medicaid with chronic illness and disabilities is particularly fragmented and uncoordinated, with states spending up to 80 percent of their Medicaid budgets on approximately 20 percent of Medicaid beneficiaries whose needs include long-term care services and supports; and

WHEREAS, Reforming and restructuring state Medicaid programs to provide incentives for high quality, efficient and cost-effective care will help contain the growth of the Medicaid program and help ensure that Medicaid does not threaten other essential state services; and

WHEREAS, Managing the care for those with Medicaid through a risk-based system has demonstrated greater budget predictability, more accountability, improved quality of care for the consumer, and more coordination among service providers.

NOW THEREFORE BE IT RESOLVED that the {insert state legislature} will seek to strengthen the fiscal solvency of {insert state} and improve the health of Americans enrolled in Medicaid by introducing legislation to implement coordinated, risk-based, capitated programs to control costs and improve quality of care for all Medicaid recipients, including those requiring long-term care services.

Approved by ALEC Board of Directors on September 19, 2010.

Health Freedom Compact Act – Five Year Review

Summary

In light of S.C. §112, “two or more states”, may enter into agreements that allow residents of party states to freely choose medical insurance coverage, based on individual need or preference. Moreover, such agreements allow insurers to compete, thus allowing residents to have a plethora of available providers from which to choose. To ensure that such agreements are implemented, the Health Freedom Compact Act holds:

(A) Every state, party to such an agreement, must furnish “good faith and credit” to reciprocal “Health Care Freedom Criminal Laws and “Health Care Freedom Laws”, as defined, of each party state;

a. Government agents may not restrict nor penalize residents for exercising the rights included in such laws.

(B) Any individual, who is a taxpaying resident of a party state, has standing in court to ensure the enforcement of this Act, through the chief presiding officer of the state(s) who must:

a. Maintain a list of all party states;

b. “Receive and maintain” lists of all the above laws for each party state and;

c. Develop all reasonable and necessary enforcement procedures.

Findings and Declaration of Policy

(A) Unites States Code Section 112 gives Congressional consent “to any two or more states to enter into agreements or compacts for cooperative effort and mutual assistance in the prevention of crime and the enforcement of their respective criminal laws and policies, and to establish such agencies, joint or otherwise, as they may deem desirable for making effective such agreements and compacts.”

(B) Pursuant to their police powers to protect public health, safety, welfare, and morals, the party states have enacted or anticipate enacting laws or constitutional provisions to protect and guarantee their residents’ rights and freedom to pay or not to pay directly for health care services and to participate or not participate in health plans and health systems.

(C) The party states have enacted or anticipate enacting laws that make it a crime in their state for anyone to interfere with their residents’ enjoyment of the rights and freedoms guaranteed by their respective health care freedom laws.

(D) The party states find it necessary and deem it desirable for making effective their respective current or anticipated health care freedom criminal laws, as well as this agreement and compact, to do the following:

(1) Prohibit any governmental agent from depriving any resident of any party state of the rights and freedoms guaranteed under their respective current or anticipated health care freedom laws.

(2) Prohibit any governmental agent from penalizing any resident of any party state for exercising the rights and freedoms guaranteed under their respective current or anticipated health care freedom laws.

(3) Cooperate with each other and to give each other mutual assistance in the prevention of crimes under the health care freedom criminal laws of any party state.

(4) Cooperate with each other and to give each other mutual assistance in the criminal prosecution of anyone who violates the health care freedom criminal laws of any party state.

Model Policy

Section 1. Short Title. This Act shall be known as the “Health Freedom Compact Act.”

Section 2. Definitions. As used in this compact, unless the context clearly indicates otherwise:

(A) “Compel” includes legal mandates, penalties, or fines.

(B) “Health care freedom laws” means any state law or constitutional amendment that protects and guarantees a resident’s freedom to pay or not to pay directly for lawful health care services and to participate or not to participate in health care plans and health care systems.

(C) “Health care freedom criminal laws” means any state law that makes it a crime for anyone to interfere with a resident’s enjoyment of the freedoms protected and guaranteed by the state’s respective health care freedom laws.

(D) “Health care plan” means any legally binding arrangement under which at least one person or entity promises and undertakes, in exchange for consideration of a set or assessed amount of money, to make a payment to another party or a third party if a specified event occurs involving the provision of health care services.

(E) “Health care system” means any public or private entity whose function or purpose is the management of, processing of, enrollment of individuals in health care plans, or payment for, in full or in part, health care services or health care data or health care information for its participants.

(F) “Lawful health care services” means any health-related service or treatment to the extent that the service or treatment is permitted or not prohibited by law or regulation and that may be provided by persons or businesses otherwise permitted to offer such services.

(G) “Pay directly” means payment for lawful health care services without a public or private third party, not including an employer, paying for any portion of the service.

(H) “Penalty” means any civil penalty, criminal fine, tax, salary, or wage withholding or surcharge or any named fee with a similar effect established by law or rule by a government established, created, or controlled agency that is used to punish or discourage the exercise of rights protected under this state’s health care freedom law.

(I) “State” means a state of the United States.

Section 3. Terms. Notwithstanding any state or federal law to the contrary:

(A) Each party state shall give full faith and credit to the health care freedom criminal laws and health care freedom laws of every party state.

(B) Governmental agents shall not deprive residents of party states of the rights and freedoms protected under their respective state’s health care freedom criminal laws and guaranteed by their respective state’s health care freedom laws.

(C) Governmental agents shall not penalize residents of party states for exercising the rights and freedoms protected under their respective state’s health care freedom criminal laws and guaranteed by their respective state’s health care freedom laws.

(D) The party states shall cooperate with each other and give each other mutual assistance in the prevention of crimes under the health care freedom criminal laws of any party state.

(E) The party states shall cooperate with each other and give each other mutual assistance in the criminal prosecution of any person who violates the health care freedom criminal laws of any party state.

Section 4. Enforcement. Notwithstanding any state or federal law to the contrary:

(A) The chief law enforcement officer of each party state shall enforce this agreement and compact.

(B) A taxpaying resident of any party state has standing in the courts of any party state to require the chief law enforcement officer of any party state to enforce this agreement and compact.

Section 5. Compact Administrator and Interchange of Information.

(A) The governor of each party state or the governor’s designee is the compact administrator. The compact administrator shall:

- (1) Maintain an accurate list of all party states.
- (2) Consistent with Paragraphs C and D, transmit in a timely fashion to other party states citations of all current health care freedom laws and current health care freedom criminal laws of the compact administrator’s respective state.
- (3) Receive and maintain a complete list of the health care freedom laws and health care freedom criminal laws of each party state.
- (4) Formulate all necessary and proper procedures to effectuate this compact.
- (5) Delegate needed tasks to other state agencies.

(B) The compact administrator of each party state shall furnish to the compact administrator of each party state any information or documents that are reasonable necessary to facilitate the administration of this compact.

(C) Within ten days after executing this agreement and compact, and thereafter on the close of each of their respective succeeding legislative sessions, the party state shall notify each other in writing and by appropriate citation of each of their current health care freedom laws, which shall be deemed within the subject matter of this agreement and compact, unless the compact administrator of one or more party states gives specific notice in writing to all other party states within sixty days of such notice that it objects to the inclusion of such law or laws in this agreement and compact.

(D) Within ten days after executing this agreement and compact, and thereafter on the close of each of their respective succeeding legislative sessions, the party states shall notify each other in writing and by appropriate citation of each of their current health care freedom criminal laws, which shall be deemed within the subject matter of this agreement and compact, unless the compact administrator or one or more party states gives specific notice in writing to all other party states within sixty days of such notice that it objects to the inclusion of such law or laws in this agreement and compact.

Section 6. Entry into Effect and Withdrawal.

(A) This compact is deemed accepted when at least two states deliver a notice of confirmation, which is duly executed by their respective authorized representative and

which acknowledges complete agreement to the terms of this compact, to each other's governor, the Office of the

(B) Clerk of the United States House of Representatives, the Office of the Secretary of the United States Senate, the President of the United States Senate, and the Speaker of the United States House of Representatives. Thereafter, the compact is deemed accepted by any state when a respective notice of confirmation, which is duly executed by the state's respective authorized representative and which acknowledges complete agreement to the terms of this compact, is delivered to each party state's compact administrator, the Office of the Clerk of the United States House of Representatives, the Office of the Secretary of the United States Senate, the President of the United States Senate, and the Speaker of the United States House of Representatives.

(B) Four years after this compact first becomes effective, any party state may withdraw from this compact by enacting a joint resolution declaring such withdrawal and delivering notice of the withdrawal to each other party state. A withdrawal does not affect the validity or applicability of the compact to states remaining party to the compact.

Section 7. Construction and Severability.

(A) This compact shall be liberally construed so as to effectuate its purposes.

(B) The compact is not intended to:

(1) Affect which health care services a health care provider or hospital is required to perform or provide under state or federal law.

(2) Affect which health care services are permitted by state or federal law.

(C) This compact is intended to operate as the law of the nation with respect to the party states under 4 United States Code Section 112, to supersede any inconsistent state and federal law and to establish vested rights in favor of residents of the party states in the enjoyment of the rights and freedoms protected by their respective health care freedom criminal laws and guaranteed by their respective health care freedom laws.

(D) If any phrase, clause, sentence, or provision of this compact is declared in a final judgment by a court of competent jurisdiction to be contrary to the Constitution of the United States or is otherwise held invalid, the validity of the remainder of this compact shall not be affected.

(E) If the applicability of any phrase, clause, sentence, or provision of this compact to any government, agency, person, or circumstance is declared in a final judgment by a court of competent jurisdiction to be contrary to the Constitution of the United States or is otherwise

held invalid, the validity of the remainder of this compact and the applicability of the remainder of this compact to any government, agency, person, or circumstance shall not be affected.

(F) If this compact is held to be contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the affected party state as to all severable matters.

Section 9. {Severability clause.}

Section 10. {Repealer clause.}

Section 11. {Effective date.}

Approved by ALEC Board of Directors on June 6, 2011.

State Employee Health Savings Account Act – Five Year Review

Summary

This legislation requires the state to offer state employees a health benefit plan that utilizes Health Savings Accounts (HSAs) paired with high-deductible health plans. The legislation further requires that the employer cost of the HSA-compatible health plan not exceed the average per person employer cost of traditional insurance plans the state is currently offering.

Health Savings Accounts, paired with high-deductible health plans, can create a win-win situation for taxpayers and public employees. The plans provide state employees more savings, choice, and control over their healthcare needs and expenses, while offering an opportunity for the state to reduce its health insurance costs for state employees.

This legislation is modeled off of public policy in Indiana and legislation that has passed in Illinois. In 2006, the first year of implementation, just over 4 percent of Indiana state workers signed up for the Health Savings Account option. In 2010, 70 percent of Indiana state workers selected the HSA option, and only 3 percent have opted to return to the standard PPO after signing up for an HSA. It is estimated that in 2010, Indiana state employees enrolled in the HSA option saved more than \$8 million compared to their counterparts in the traditional PPO option, and the state saved \$20 million in healthcare costs.

For further reading, see: Jim Porterfield and Kristina Rasmussen, “Health Savings Accounts: A win-win for Illinois public employees and taxpayers,” Illinois Policy Institute, September 29, 2010, www.illinoispolicy.org/HSA.

Model Legislation

Section 1. Short Title. This Act shall be known as the “State Employee Health Savings Account Act.”

Section 2. Health Savings Accounts.

(A) The program of state employee health benefits shall offer, as an alternative and on an optional basis, a program for the use of Health Savings Accounts with a qualifying state-sponsored, high-deductible health plan. This optional coverage alternative shall be available no later than {insert date}.

(B) On or before {insert date}, the {insert state agency in charge of state employee health insurance programs} shall:

(1) Submit the program designs to the {insert government accountability agency responsible for estimating costs [See FN1]} for review. The report on program designs may include multiple options for final implementation, which may, in turn, include various levels of state participation or types of benefit designs. The program designs shall include:

- (a) Benefit designs, including deductible amounts, for the high-deductible health plans.
- (b) Premium amounts for the high-deductible health plans.
- (c) Employee and employer contribution strategies for the high-deductible health plan premiums.
- (d) Employer and employee contribution strategies for the Health Savings Account deposits.
- (e) The ability for employees to make pre-tax contributions through a salary deferral arrangement for the Health Savings Accounts.
- (f) Options for custodial arrangements for the Health Savings Accounts.
- (g) Investment options for Health Savings Account holders.
- (h) Assessment of administrative and claim costs.
- (i) Statements of the actuarial assumptions, including demographic, participation, and utilization assumptions, used in program designs.
- (j) An analysis of the impact on existing health plans of offering the option of Health Savings Accounts paired with a high-deductible health plan.

Program designs shall also be based on the creation of coverage options so that the average per person employer cost of the program, including the contributions for the Health Savings Accounts and high-deductible plan, does not exceed the average per person employer cost of the traditional state employee health benefits program for the same fiscal year.

(2) Offer to all employees training regarding all health plans offered to employees.

(3) Prepare online training as an option for the training required by this Section.

(C) Employers participating in a state employee health benefit plan shall require each employee to complete training on the health plan options available to the employee. This training:

(1) May be completed online; and

(2) Shall be completed:

(a) Before the end of the {insert year} open enrollment period for current employees; and

(b) For employees hired on or after {insert date}, prior to the employee's selection of a plan in the program.

Section 3. {Severability Clause.}

Section 4. {Repealer Clause.}

Section 5. {Effective Date.}

Approved by ALEC Board of Directors on October 13, 2011.

Unintended Consequences Prevention Act – Five Year Review

Summary

This Act provides that no state department or agency shall implement or enforce any provision of the federal Patient Protection and Affordable Care Act unless the department or agency provides a certain report to the legislature, and the legislature authorizes such implementation or enforcement by statute.

Model Legislation

Section 1. Findings. The legislature finds that:

(A) {Insert state}'s health care system has been developed to address the unique circumstances in {insert state} and to provide solutions that work for {insert state}; and

(B) The federal Patient Protection and Affordable Care Act:

(1) Infringes on state powers;

(2) Imposes a uniform solution to a problem that requires different responses in different states;

(3) Threatens the progress {insert state} has made towards health care system reform; and

(4) Infringes on the rights of citizens of this state to provide for their own health care by:

(a) Requiring a person to enroll in a third-party payment system;

(b) Imposing fines on a person who chooses to pay directly for health care rather than use a third-party payer;

(c) Imposing fines on an employer that does not meet federal standards for providing health care benefits for employees; and

(d) Threatening private health care systems with competing government supported health care systems.

Section 2. Model Legislation

(A) A department or agency of this state shall not implement or enforce any part of the federal Patient Protection and Affordable Care Act unless:

(1) The department or agency reports to the legislature in accordance with Subsection B of this section; and

(2) The legislature passes legislation specifically authorizing the state's implementation or enforcement of the federal Patient Protection and Affordable Care Act, if such implementation or enforcement authority does not already exist.

(B) The report required under Subsection A of this section shall include:

(1) The specific section of the federal Patient Protection and Affordable Care Act that requires the state to implement or enforce a federal reform provision;

(2) Whether the reform provision has any state waiver or options;

- (3) Exactly what the reform provision requires the state to do and how it would be implemented;
- (4) Who in the state will be impacted by adopting the federal reform provision or not adopting the federal reform provision;
- (5) The cost to the state or citizens of the state to implement the federal reform provision;
- (6) The consequences to the state if the state does not comply with the federal reform provision.

Section 3. {Severability Clause.}

Section 4. {Repealer Clause.}

Section 5. {Effective Date.}

Approved by ALEC Board of Directors on January 7, 2011.

Optional Medicaid Benefits Evaluation Act – Five Year Review

Summary

This resolution urges states to close state operated facilities and move persons with intellectual and developmental disabilities (ID/DD) to home and community based waiver services (HCBS).

Section 1. Title. This Act shall be known as the “Optional Medicaid Benefits Evaluation Act.”

Section 2. Definitions.

(A) “Medicaid” is the federal Title XIX Medical Assistance program administered by states and funded in part by the federal government.

(B) “Independent third party” is a public or private entity or private person having no ongoing financially dependent relationship with the {insert appropriate state agency}, the Auditor General, or the {insert name of state Medicaid Agency}, and that possesses the necessary expertise to conduct the evaluation and/or write the report as described in this Act.

(C) “Optional benefits” are medical services potentially or currently provided under the Medicaid program of this state that are categorized as optional by the federal Centers for Medicare & Medicaid Services, including recipient populations that are not required to be covered under federal law.

(D) “Report” means a written document that comprehensively records the methods used and results of an evaluation of optional benefits.

(E) “Recipient” is an individual who receives benefits under the Medicaid program of this state.

(F) “Recipient population” is the group or a sub-group of all individuals or households in the state who receive benefits under the Medicaid program of this state.

Section 3. Evaluations of Proposed and Existing Medicaid Benefits Required.

(A) The {insert appropriate state agency} shall not promulgate and approve rules, apply for federal waivers, or otherwise take any action that would expand optional benefits under the state’s Medicaid program unless the agency.

(1) Provides funding to the Auditor General or the {insert appropriate state agency} who shall then contract with an independent third party to evaluate the proposed expansion and produce a report as described in this Act; and

(2) Presents the proposal and report to the appropriate oversight committees of the legislature for approval to proceed. Majorities of the members of oversight committees from both houses of the legislature must approve the proposal in order for the {insert appropriate state agency} to proceed.

(B) Legislative oversight committees shall consider if an optional benefits expansion:

(1) Creates clear and measurable net economic benefits that accrue generally to all citizens of the state, even in the absence of federal funds;

(2) Does not interfere with citizens’ ability to engage in free enterprise in the medical industry;

(3) Clearly fills a need that only government can fill; and

(4) Is not likely to result in a financial obligation to the state that would necessitate a tax increase at some future time.

(C) The Auditor General or the {insert appropriate state agency} shall contract with one or more independent third parties to evaluate existing optional benefits under the state’s Medicaid program. The evaluation and a report of the evaluation shall be completed within two years of the date of passage of this Act and shall meet the requirements set forth in this Act.

Section 4. Evaluation of Optional Benefits. Any evaluation required by this Act shall at least include an analysis of optional benefits’ effects on:

(A) The health and productivity of the proposed recipient population;

- (B) The health care prices faced by the non-recipient population;
- (C) The demand for medical services separately delineated by recipient and non-recipient populations, including demand for medical services not included in the optional benefit(s) being studied;
- (D) The administrative costs faced by providers of services under the federal Title XIX Medical Assistance program;
- (E) Health insurance premiums;
- (F) Emergency room services for recipient and non-recipient populations;
- (G) The practices and decision of suppliers of health services that would affect the market for medicine and the possible results of those actions; and
- (H) The state's short- and long-term fiscal outlook including the likelihood of future tax increases to pay for the optional benefits under plausible economic scenarios.

Section 5. Report.

(A) A written report shall be prepared by the independent third party describing the evaluation in Section 4 and the methods used to conduct the evaluation. Copies of the written report shall be submitted to the Governor, the presiding officers the legislature, and the members of the relevant oversight committees.

(B) The Auditor General {insert appropriate state agency} shall review the report for:

- (1) Completeness;
- (2) Its adherence to professional standards; and
- (3) Sound methodology.

Section 6. Judicial Review. A resident taxpayer of the state shall have standing to seek de novo judicial review as to whether the criteria set out in this Act regarding review and approval of an optional benefit have been met by filing an action seeking declaratory, injunctive, quo warrantor, or writ of prohibition relief.

Section 7. {Severability Clause.}

Section 8. {Repealer Clause.}

Section 9. {Effective Date.}

Approved by ALEC Board of Directors on January 8, 2010.

Patients First Medicaid Reform Act – Five Year Review

Summary

This legislation would put patients in charge of their care and provide them incentives to control their medical dollars. Although not spelled out in the policy itself, as with all waivers and model legislation, it can be a narrowly targeted pilot program or a full-scale effort to reform the state’s entire Medicaid system, as in Rhode Island.

Section 1. Title. This Act may be cited as the “Patients First Medicaid Reform Act.”

Section 2. Definitions.

(A) “Medicaid Savings Account,” or “MSA,” is an account funded by the {insert state Medicaid agency} which can be used for medical expenses and qualifying non-medical expenses as approved by the {insert state Medicaid agency}.

Section 3. Federal Waiver. The {insert state Medicaid agency} shall seek a Medicaid waiver from the Centers for Medicare and Medicaid Services to receive {insert percentage} of federal funding as a five-year block grant.

Section 4. Qualifying Policies.

(A.) To qualify, a health insurance policy must meet federal requirements for Health Savings Account (HSA) eligibility.

(B) Policies must cover federally mandated Medicaid benefits.

(C) Policies will be exempt from other state mandated benefits.

(D) HSA-eligible policies available through the state or federal high-risk pool are eligible for those individuals who meet enrollment criteria.

Section 5. Establishment of Benefits.

(A) The {insert state Medicaid agency} shall establish Medical Savings Accounts for Medicaid enrollees or their families with the {insert state treasurer} (Drafting Note: Accounts may also be established with the state employee retirement system, or with private vendors).

(B) The amount deposited in an individual's account shall be equal to the amount required to purchase a qualifying individual or family high-deductible policy and fund a portion of a related HSA.

(1) This amount shall be adjusted for age and health status.

(2) Funds shall be made available on a pro-rated basis each month.

(C) Only high-deductible policies that meet federal requirements to be eligible for an HSA shall be eligible for purchase.

Section 6. Continuation of Benefits.

(A) A current Medicaid recipient or guardian who becomes employed may continue to receive premium supports and MSA deposits as long as the recipient continues to qualify and keeps the same policy. Subsidies will phase out with income until the recipient no longer qualifies for Medicaid.

(B) The employer of a current Medicaid recipient or guardian who enrolls in an employer sponsored insurance policy shall receive premium support payments from the {insert state Medicaid agency}. Payments will phase out with income until the recipient no longer qualifies for Medicaid.

(C) A current recipient or guardian shall have the option to continue the same health insurance coverage, without subsidies.

(D) {Insert percentage} of any unspent funds in an MSA account, including earnings, shall vest to a Medicaid recipient or guardian who no longer qualifies for Medicaid.

Section 7. Other Uses of Funds for Individuals.

(A) A Medicaid recipient may apply in writing to the {insert state Medicaid agency} to use MSA funds in excess of any insurance out-of-pocket maximum for education, job training, child care, or other qualifying non-medical expenses.

(B) The {insert state Medicaid agency} shall respond within seven days to each such request and have a final decision within 30 days.

Section 8. Transparency and Accountability.

(A) All transactions involving the state shall be considered public information and posted in an online database after redaction of personal identifying information.

(B) The {insert state Medicaid agency} shall provide an annual report on cost savings, use of preventive care services, enrollee transition from Medicaid, and other appropriate information.

Section 9. {Severability Clause.}

Section 10. {Repealer Clause.}

Section 11. {Effective Date.}

Approved by ALEC Board of Directors on September 19, 2010.