THE STATE LEGISLATORS GUIDE TO

REPEALING OBAMACARE

American Legislative Exchange Council

The State Legislators Guide to Repealing ObamaCare

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The American Legislative Exchange Council (ALEC) is the nation's largest nonpartisan individual membership association of state legislators, with nearly 2,000 members across the nation and more than 100 alumni members in Congress. ALEC's mission is to promote free markets, limited government, individual liberty, and federalism through its model legislation in the states.

Guided by the principle that the best health care is patient-driven, not government-driven, ALEC's Health and Human Services Task Force has been a national leader in promoting free-market, pro-patient health care reform at the state level. Since 2005, 38 states have enacted model legislation developed by ALEC's Health and Human Services Task Force.

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How to Use This Guide

The *Patient Protection and Affordable Care Act*, otherwise known as "ObamaCare," is truly an unprecedented piece of federal legislation. Unfortunately for states, the precedent it sets is a bad one—one that will result in overburdened Medicaid programs, higher taxes, an unconstitutional requirement that individuals purchase health insurance, and a federal takeover of health insurance regulation.

As a state legislator, you know that any health reform legislation should mirror the Hippocratic Oath that guides the practice of medicine—"First, do no harm." The best health care is patient- and market-driven, not government-driven—and ObamaCare embodies neither of these qualities.

The State Legislators Guide to Repealing ObamaCare will be an essential tool as you look to halt ObamaCare's harmful effects and implement real healthcare reform that is both market-oriented and patient-centered. Specifically, this guide will help you:

- Learn about ObamaCare's negative effects on Medicaid, taxes, mandates, and insurance regulation;
- Discover some state-level, defensive tactics that you can use to slow or stop ObamaCare's most harmful provisions; and
- Promote "The Health Care Freedom Agenda" through ALEC model legislation.

Now is the time to act. If you would like more information about the issues discussed in this guide, or any technical assistance on health reform activities, contact Christie Herrera, ALEC's Health and Human Services Task Force Director, at (202) 466-3800 or at christie@alec.org.

About ALEC

The American Legislative Exchange Council (ALEC) is the nation's largest nonpartisan individual membership association of state legislators, with nearly 2,000 state legislators across the nation and more than 100 alumni members in Congress. ALEC's mission is to promote free markets, individual liberty, and federalism through its model legislation in the states.

For more than 35 years, ALEC has been the ideal means of creating and delivering public policy ideas aimed at protecting and expanding our free society. Thanks to ALEC's legislators, Jeffersonian principles advise and inform legislative action across the country.

Literally hundreds of dedicated ALEC members have worked together to create, develop, introduce, and guide to enactment many of the cutting-edge policies that have now become the law in the states. The strategic knowledge and training ALEC members have received over the years has been integral to these victories.

Since its founding, ALEC has amassed an unmatched record of achieving groundbreaking changes in public policy. Guided by the principle that the best health care is patient-driven, not government-driven, ALEC's Health and Human Services Task Force has been a national leader in promoting free-market, pro-patient health care reform at the state level. Since 2005, 38 states have enacted legislation developed by ALEC's Health and Human Services Task Force.

About the Author

Christie Herrera is director of the Health and Human Services Task Force at the American Legislative Exchange Council (ALEC), the nation's largest nonpartisan individual membership association of state legislators.

At ALEC, Christie drives model legislation, conducts research, builds coalition support, and heightens media awareness in support of pro-patient health care policy. Since Christie joined ALEC in 2005, 38 states have enacted model legislation drafted by ALEC's Health and Human Services Task Force.

Christie has been a key figure in galvanizing state pushback against the federal requirement to purchase health insurance. Legislators in 42 states have introduced or announced ALEC's *Freedom of Choice in Health Care Act*, model legislation mirrored on Arizona Proposition 101 and designed to block an individual mandate and protect patients' rights. The model—named by Governing Magazine as one of the "Top 10 Issues to Watch in 2010"—was enacted in seven states via the legislature or the ballot box, and serves as the basis of *Commonwealth v. Sebelius*, Virginia's first-in-the-nation lawsuit against the federal individual mandate.

Christie has testified before 11 state legislatures, and she has been a featured speaker to legislative caucuses, nonprofit organizations, trade associations, and business groups across the country. A contributing editor to Health Care News, her policy work has been covered by the New York Times, the Washington Post, the Wall Street Journal, the Economist, Politico, and Fox News Channel, among other media outlets.

Christie holds a B.S. in communication studies and an M.S. in political science from Florida State University.

What Does ObamaCare Mean for States?

Overburdened Medicaid Programs

The Patient Protection and Affordable Care Act *will mire states in a poorly-designed Medicaid program and will lead to skyrocketing enrollment in government-run health care and untenable state budgets. Their citizens, meanwhile, will face restricted access to care and worsening health outcomes.*

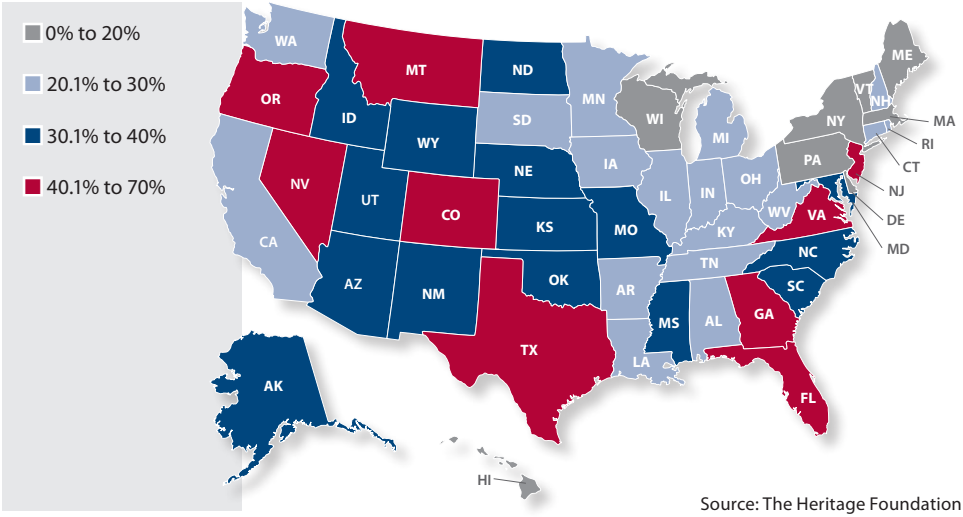
Skyrocketing Enrollment

ObamaCare requires states to extend their Medicaid programs to everyone earning up to 133 percent of the federal poverty level by 2014. Today that is about $30,000 for a family of four. According to The Heritage Foundation, thirty-three states will see their Medicaid rolls jump by at least 20 percent. Six more states will see their Medicaid rolls jump by at least 40 percent. And Oregon, Texas, and Nevada will see their Medicaid rolls increase by 50 percent or more.

Untenable State Budgets

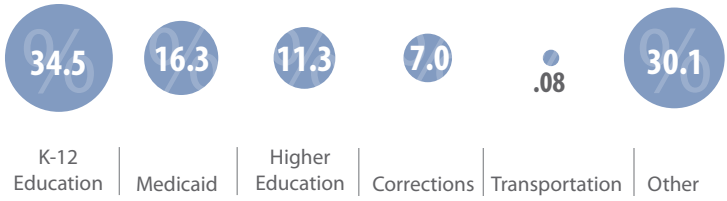
ObamaCare's Medicaid mandates will bring significant fiscal damage to already-strained state budgets, especially when taking into consideration the amount states currently spend on Medicaid. From

Increase in Medicaid Population Under ObamaCare in 2014



Source: The Heritage Foundation

States Spend 1/6 of Their Budgets on Medicaid



Source: StateHealthFacts.org

2001-2004, state Medicaid spending per capita grew an average of about 10 percent per year, according to the Kaiser Family Foundation's StateHealthFacts.org. And from 2004-2007, spending has increased by an average of 4 percent per year, compounding budgetary difficulties for states as the economy has worsened.

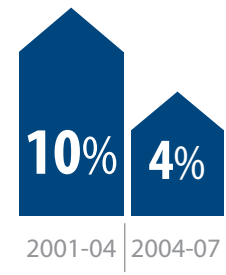
The state fiscal picture gets bleaker when we examine how much Medicaid consumes of each state's budget even prior to expansion required by ObamaCare. According to StateHealthFacts.org, Medicaid currently accounts for about 17 percent of all state-level spending. This is more than what states spend on higher education and transportation combined. Expanding Medicaid will continue to put pressure on state budgets—especially in states like Ohio, which today spends nearly 40 percent of its budget on Medicaid. The state of New Jersey, which already spends the fourth-highest amount per enrollee, will have to endure a nearly 50 percent increase in Medicaid enrollees by 2014.

The "perfect storm" of mandatory Medicaid expansion, tight state budgets, and declining tax revenues means that state legislators will have to make hard choices. But those choices will get even tougher with ObamaCare's "maintenance of effort" requirement, which prevents states from cutting Medicaid eligibility. Legislators may have to cut even more from vulnerable programs or slash Medicaid benefits for existing enrollees.

The federal government already gives states matching funds for what they spend on Medicaid. ObamaCare's supporters correctly point out that the federal government will increase its matching fund ratio for the people who are added as a result of the law. The federal government will pay states up to 100 percent of those new costs between now and 2020, and then 90 percent in 2020 and beyond.

But the ObamaCare Medicaid money comes with its own problems. First, state legislators must take into account that federal money is not free money—their constituents pay federal taxes, too. Second, the federal subsidies don't cover the entire Medicaid expansion that will result from the new law. Roughly one in four uninsured

State Medicaid Spending Has Grown by at Least 4% Per Year in the Last Decade



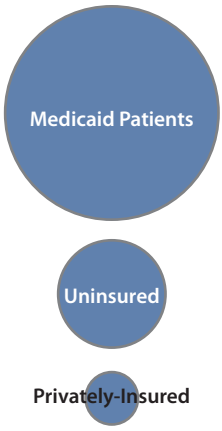
Source: StateHealthFacts.org

people are currently eligible for Medicaid, but not yet enrolled. ObamaCare's requirement that everyone purchase health insurance will likely push those people onto the Medicaid program. It will not, though, give states enhanced matching funds for them. And finally, according to The Heritage Foundation, states will be on the hook for their own $37 billion "doc fix" beginning in 2015, when extra federal money for reimbursing Medicaid doctors runs out.

Restricted Access and Worsening Care

Medicaid is a "lose-lose" proposition. Not only is it expensive for states and taxpayers, but it also is a bad deal for beneficiaries, restricting access and providing poor quality care.

Because the *Patient Protection and Affordable Care Act* effectively outlaws low-cost insurance (more on that later), Medicaid will become the only coverage option for low-income Americans. Unfortunately for them, being enrolled in Medicaid is no guarantee that a person can see a doctor. Medicaid currently pays doctors about 60 cents for every dollar of care they provide. Scott Gottlieb, a resident fellow at the American Enterprise Institute, estimates that 40 percent of doctors restrict access to Medicaid enrollees due to low reimbursement rates, and that only 50 percent of doctors accept new Medicaid patients. By comparison, 70 percent of doctors take new patients from Medicare, which pays more.



Medicaid patients are twice as likely as the uninsured, and four times as likely as the privately-insured, to use the emergency room.

Source: National Center for Health Statistics

Many ObamaCare supporters pushed for a federal requirement to purchase health insurance to ease the burden that uninsured people place on crowded hospital emergency rooms (ERs). Ironically, it is the portion of the population on the Medicaid program—which ObamaCare will expand dramatically—that is the main user of ERs for non-ER care. That is because low reimbursement rates have left many beneficiaries with no choice but to receive routine care in the ER. According to a recent study in the *Annals of Emergency Medicine*, two-thirds of ER "frequent fliers"—those who visit the ER four times or more per year—were covered by either Medicaid or Medicare. And the National Center for Health Statistics reports that Medicaid patients are twice as likely as the uninsured, and four times as likely as the privately-insured, to use the ER.

Restricted access to care for Medicaid patients often results in poor care and worsening health outcomes. A recent University of Virginia study shows that Medicaid patients who need surgery are 13 percent more likely to die than the uninsured, and 97 percent more likely to die than those with private insurance. Scott Gottlieb reveals that Medicaid patients are 50 percent more likely to die after bypass surgery because of poor follow-up care, and that Medicaid patients with cancer are two to three times more likely to die from the disease.

Higher Taxes

The Cato Institute calculates that the *Patient Protection and Affordable Care Act* will result in more than $669 billion in new or increased taxes over its first 10 years. In the current fiscal crisis, ObamaCare's tax hikes will prevent job growth, stifle small businesses, and postpone economic recovery.

The new law imposes a number of new excise taxes on the health industry, including a $20 billion tax on medical device manufacturers, a $22 billion tax on brand-name prescription drugs, and a $60 billion tax on large health insurers. The new taxes will likely be passed on to consumers through higher prices for the taxed products. The taxes may also bring about reductions in research and development, which will lead to stifled innovation, fewer new products, and less consumer choice. States that house these industries may suffer an additional blow—the new taxes may be absorbed by local workers in the form of layoffs, wage cuts, or benefit reductions.

ObamaCare's tax hikes will affect small businesses, too, primarily through a new requirement that they file a 1099 tax form for each vendor from whom they purchase more than $600 of goods or services in a year. The move, which will add $17 billion to federal coffers, would be a burden for any business, but is particularly harmful for small businesses with limited resources and experience in dealing with bureaucracies. According to the National Federation of Independent Business, small businesses employ about half of private-sector employees, and have generated between 60-80 percent of net new jobs annually over the last decade.

Americans will be subjected to many other ObamaCare-related taxes, with the following costs scored over the first ten years, including:

New restrictions on some previously tax-free spending that uses Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), or Health Reimbursement Accounts (HRAs), generating $1.4 billion in new revenue starting in 2011;

An increase in the penalty for early withdraws from HSAs, generating $1.4 billion in new federal revenue starting in 2011;

A new cap on total FSA spending, generating $13 billion in new federal revenue starting in 2013;

An increase in the threshold for being able to deduct medical expenses on personal tax returns, from 7.5 percent of adjusted gross income, to 10 percent, generating $15.2 billion in new revenue starting in 2013;

A new 3.8 percent tax on investment income for workers making more than $250,000, generating $123 billion in new federal revenue starting in 2013;

An excise tax on high-value health insurance, or "Cadillac," plans, generating $42 billion in new federal revenue starting in 2018.

Source: Americans for Tax Reform

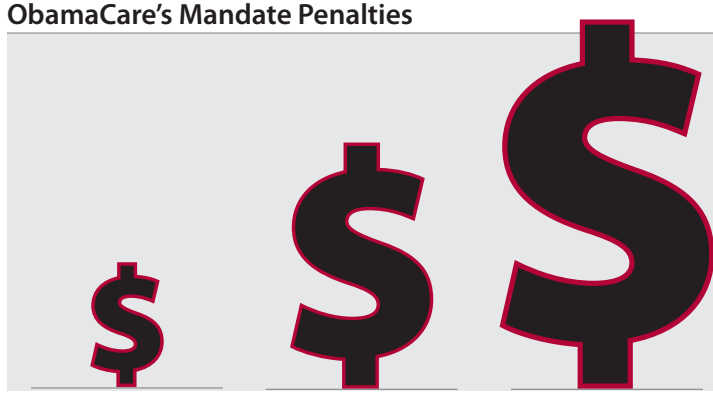
Harmful Individual Mandates

At the heart of the *Patient Protection and Affordable Care Act* is the individual mandate, or the federal requirement that a person purchase government-approved health insurance. In 2014, the uninsured will be fined either $95 or 1 percent of annual income, whichever is greater. So will anyone who has insurance that does not meet ObamaCare's new "minimum essential coverage" criteria. In 2015, the penalties increase to either $325 or 2 percent of annual income. In 2016 and beyond, the penalty is $695 or 2.5 percent of annual income.

But not all Americans would be subject to the new penalties. ObamaCare provides exemptions for those who earn less than 100 percent of the federal poverty level; "hardship" cases for whom insurance will cost more than 8 percent of their income; illegal immigrants; prisoners; religious objectors; Indian tribe members; and those who are uninsured for less than three months of the year.

To date, 22 states have filed suit over the constitutionality of the individual mandate. There are also more than 20 anti-mandate lawsuits filed by private individuals and organizations. Much of the litigation centers on the federal government's claims that the individual mandate is permissible either under the Constitution's Commerce Clause or Congress' taxing power.

ObamaCare's Mandate Penalties



Source: *Patient Protection and Affordable Care Act*

But many legal scholars have criticized those claims and say that the individual mandate sets a dangerous precedent. Never before has the federal government used the Commerce Clause to require individuals to engage in an economic activity—in this case, buying health insurance. And Congress has never before implemented a penalty on certain individuals and called it a "tax" that is allowed under its taxing authority.

The unconstitutionality of the individual mandate was bolstered in December 2010, when District Judge Henry Hudson struck down the requirement in *Commonwealth v. Sebelius*, Virginia's first-in-the-nation healthcare lawsuit. In the ruling, Hudson said that the individual mandate was "beyond the historical reach of the Commerce Clause" and that its fines constituted a penalty, not a tax.

An individual mandate does not automatically mean universal coverage. In Massachusetts, more than 167,000 people lack coverage despite the mandate.

The individual mandate not only raises serious constitutional concerns, but it also presents a number of issues for health policy. First, a government requirement to purchase health insurance does not automatically mean universal coverage. In Massachusetts, a state that has imposed an individual mandate since 2006, varying reports suggest that more than 167,000 people still lack coverage. This does not bode well for the federal individual mandate, which imposes weaker penalties for non-compliance.

Ironically, those who might be most affected by the individual mandate are people who already have health insurance. ObamaCare's "minimum essential coverage" requirement forces the already-insured to drop their current insurance by 2014 if the plans do not cover all the services the law says must be covered. These include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services; prescription drugs, rehabilitative and habilitative services; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.

Even worse, the *Patient Protection and Affordable Care Act* gives the Secretary of the U.S. Department of Health and Human Services (HHS) the final say over which new benefits will be added to this list—which opens the door to a flurry of special-interest lobbying in order to gain HHS designation of products or services as "essential." As more "essential benefits" are added to the minimum level of coverage, premiums will increase and price more Americans out of the insurance market. The new mandates may also force people who have low-mandate, high-deductible health policies to drop their current plans in favor of government-approved coverage.

Job-Killing Employer Mandates

The employer mandate in the *Patient Protection and Affordable Care Act* requires employers with more than 50 workers to provide federally dictated "minimum essential coverage," or else pay a $2,000 fine per worker, starting in 2014. If an employer offers health insurance that does not provide "minimum essential coverage" and at least one worker qualifies for ObamaCare's new federal subsidies, the penalty can be as much as $3,000 per worker.

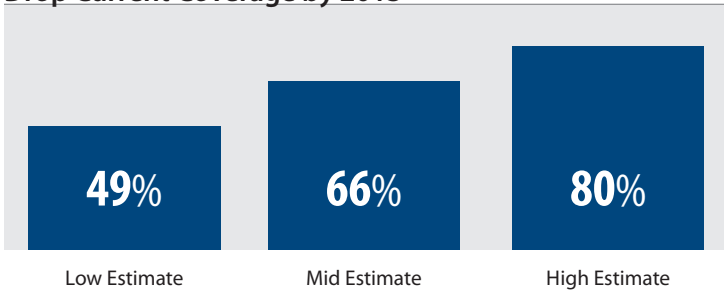
Just as the individual mandate will harm the people who already have health insurance, the employer mandate will inflict the most harm on businesses that already offer coverage. Although HHS has issued rules that allow some employee health insurance plans to be grandfathered into the new law, any change to current coverage, no matter how small, will result in a loss of grandfathered status.

ObamaCare will cause 51% of employers to drop current coverage by 2013.

In fact, the Obama Administration itself predicts that more than half of all employers, and as many as 80 percent of small businesses, will have to give up their current coverage because they will lose their grandfathered status by 2013. In recent years, an increasing number of firms have been dropping coverage for their workers. ObamaCare's treatment of insurance plans offered by small employers has the potential to cripple health insurance coverage rates.

Unsurprisingly, the employer mandate might be as ineffective as the individual mandate, as many firms will decide that it is cheaper to pay the penalty than purchase federally designed insurance.

ObamaCare Will Cause Up to 80% of Small Businesses to Drop Current Coverage by 2013



Source: U.S. Departments of Treasury, Labor, and Health and Human Services

The mandate might also shift employment from full-time workers to part-time workers, who are partially exempt from the new law. In 1974 Hawaii became the first state to implement an employer mandate. The number of Hawaii's uninsured has remained relatively constant, because many Hawaiian employers escaped the mandate by shifting work to exempt, part-time employees. In July 2009, the Federal Reserve Bank issued a report on Hawaii's mandate, saying that "An employer mandate is not an effective means of achieving universal coverage."

The states collectively employ more than 3.8 million workers, according to the U.S. Census Bureau, and in 2014 will also be subjected to the new requirement. But the most troubling aspect of the employer mandate is the enormous cost-shift from businesses to their workers, which will impede economic recovery. Employers that face extra costs—either through complying with the "minimum essential coverage" requirement or paying the penalty—will adjust for them by raising prices, cutting wages and benefits, or laying off workers. The National Federation of Independent Business predicts that ObamaCare's employer mandate will result in a loss of 1.6 million jobs by 2014—with 66 percent of those lost jobs coming from small businesses—and a real GDP contraction of approximately $200 billion by 2013.

ObamaCare's Employer Mandate Will Cause a Loss of 1.6 Million Jobs by 2013

Source: National Federation of Independent Business

Federal Takeover of State Insurance Regulation

The *Patient Protection and Affordable Care Act* ushers in a federal takeover of health insurance regulation, which has primarily been the purview of states since the 1945 *McCarran-Ferguson Act*. Many of ObamaCare's new regulations not only restrict states' ability to regulate health plans, but they also override patient protections already adopted by the states.

The most high-profile change prohibits insurance companies from fully taking into account a customer's pre-existing medical conditions when deciding how much to charge, or even whether to offer insurance at all. Known colloquially as "prohibiting insurance companies from discriminating against sick people," it goes by the technical term "guaranteed issue." What it means in practice is that individuals who are in good health can wait to purchase insurance until they are sick. They can use the guaranteed-issue rule to force insurance companies to bail them out at the last minute.

Many of ObamaCare's new regulations not only restrict states' ability to regulate health plans, but they also override patient protections already adopted by the states.

The negative effect of this government-aided technique is known as "adverse selection," in which the health insurance pool is mostly populated by the sick. In extreme cases, this can lead to a "death spiral" for the insurance plan, leaving ever-smaller pools with increasingly sicker, and more expensive, people in them.

Knowing that adverse selection can happen, the framers of ObamaCare instituted an individual mandate. In theory, the mandate will get "everyone into the market" and spread the risk around. The problem is that the ban will make coverage more expensive for the young and healthy, while the individual mandate's penalties might be too weak to force them into the marketplace.

It is bad enough that ObamaCare will usurp state authority, but even worse that it will replace state oversight with poorly-designed federal "reforms" like the following:

- A requirement that insurers offer parents the option of extending coverage for "children" up to age 26, which will make coverage more expensive while ignoring market-based approaches to cover the young and healthy, starting in 2010;

- A requirement that insurance companies spend at least 80-85 percent of premium dollars on medical care, which will lead to less consumer choice and higher prices, starting in 2011;

- New limits on insurance deductibles and a ban on policies with lifetime limits, which may eliminate popular coverage options such Health Savings Accounts, starting in 2011; and

- New requirements to establish federally designed health insurance exchanges, which will erect massive new bureaucracies that are unresponsive to local needs, starting in 2014.

How Can You, As a State Legislator, Stop ObamaCare?

Decline to Build the ObamaCare Edifice

State legislators have a tremendous opportunity to fight the Patient Protection and Affordable Care Act *through legislation, oversight, reframing the debate, and by enacting true healthcare reform at the state level.*

Introduce ALEC's *Freedom of Choice in Health Care Act,* the primary legislative vehicle for state pushback of the individual mandate and Canadian-style, single-payer health care.

In 2008, ALEC endorsed this model language co-authored by the Goldwater Institute, Arizona's free-market think tank, and Dr. Eric Novack, a Phoenix-area orthopedic surgeon and founder of the U.S. Health Care Freedom Coalition.

The legislation—which can be introduced as a statute or a constitutional amendment—prohibits any person, employer, or healthcare provider from being compelled to purchase or provide health insurance; protects the right of a person or employer to pay directly for lawful healthcare services; protects the right of a health care provider to accept direct payment for lawful healthcare services, and protects the existence of a private health insurance market.

ALEC's *Freedom of Choice in Health Care Act*, if passed by statute, can provide a state-level defense against ObamaCare's excessive federal power. Particularly, the measure can provide standing to a state participating in current litigation against the federal individual mandate; allow a state to launch additional, 10th-Amendment-based litigation if the current lawsuits fail; and empower a state attorney general to litigate on behalf of individuals harmed by the mandate once it goes into effect in 2014.

If enacted as a constitutional amendment, ALEC's *Freedom of Choice in Health Care Act* will not only help defend against the federal individual mandate as indicated above, but it will also prohibit a Canadian-style, single-payer system, which legislators in some states have been advocating even before ObamaCare. And if ObamaCare is repealed, it will also prevent a state-level requirement to purchase health insurance.

In the 2010 session, 42 states introduced or announced ALEC's *Freedom of Choice in Health Care Act*. Six states (Virginia, Idaho, Arizona, Georgia, Louisiana, Missouri) passed it statutorily, and two states (Arizona, Oklahoma) passed it as a constitutional amendment.

More importantly, many of these states showed bipartisan opposition to the individual mandate. Virginia was the first state to pass the measure with a Democrat-controlled chamber; Louisiana was the first state to pass the measure with a Democrat-controlled legislature; and in Missouri, one in six Democrat primary voters pulled the lever for Proposition C, Missouri's *Freedom of Choice in Health Care Act* statutory referendum.

Introduce a resolution supporting repeal of ObamaCare to send the repeal message to members of your state's congressional delegation.

In the 2010 session, 23 states filed resolutions opposing the *Patient Protection and Affordable Care Act*, in whole or in part. Sample resolution language may be found in the first ObamaCare repeal bill prefiled for the 2011 session—Kentucky House Joint Resolution 8.

Enact a moratorium on ObamaCare rulemaking which will allow your state to focus its limited regulatory resources on core functions of government.

Last year, North Carolina Gov. Bev Perdue and Washington Gov. Christine Gregoire signed executive orders suspending their states' rulemaking processes in favor of job growth and economic recovery, although the orders did not specifically include the *Patient Protection and Affordable Care Act*. Arizona Gov. Jan Brewer went even further by ordering state officials to abandon ObamaCare-related rulemaking in January 2009. In November 2010, Wisconsin's Gov.-Elect Scott Walker urged incumbent Gov. Jim Doyle to halt implementation of ObamaCare and other state projects that "would put [Wisconsin] in a more challenging spot when it comes to the next budget." The devastating economic consequences resulting from the law should persuade other states to do the same.

Introduce legislation authorizing your state to seek a federal waiver of ObamaCare's medical loss ratio requirement which will help your state delay implementation of this provision until 2014.

The new medical loss ratio requirement—which requires insurers to spend 80-85 percent of health insurance premiums on medical care—will likely leave only large insurance companies in the market, as many small insurers may be ill-equipped to comply with the new rules. This will lead to less consumer choice and higher prices,

and may also force consumers to lose popular coverage options such as high-deductible and "mini med" health insurance policies.

Seven states (Iowa, Maine, Florida, Georgia, Oklahoma, South Carolina, West Virginia) have signaled that they will petition the U.S. Department of Health and Human Services (HHS) for a blanket exemption that includes all insurance carriers within their states, citing a "disruption" or "destabilization" in the individual insurance market if the new provision takes effect before 2014.

Reject ObamaCare discretionary grants that aid in the federal takeover of state health insurance regulation.

Through its grantmaking, the *Patient Protection and Affordable Care Act* conscripts states into enforcement arms of federal policy. While these grants may be attractive to cash-strapped states, federal funding comes with federal strings. It is unlikely that HHS will allow states that accept federal grants to ignore federal mandates.

Many states have already refused federal grants designed by Congress to enforce or implement ObamaCare. In 2010, then-Minnesota Gov. Tim Pawlenty signed an executive order prohibiting state agencies from applying for ObamaCare-related discretionary grants. Two states (Alaska, Minnesota) declined federal funding to help set up health insurance exchanges. Five states (Alaska, Wyoming, Iowa, Georgia, Minnesota) rejected federal "rate review" grants that would have required state insurance officials to enforce new federal rules against "unreasonable premium increases." And only one state (Connecticut) has accepted federal dollars to expand its Medicaid population in advance of the 2014 deadline.

The *Patient Protection and Affordable Care Act* also offered states "free" federal money if they set up new, temporary high-risk insurance pools. (Many states had already enacted a high-risk pool on their own, but in an odd twist, Congress wanted those states to set up a second pool to undercut the ones already in place.) Twenty-three states rejected these "free" funds, citing inadequate funding and other concerns. Instead, these states have let the federal government set up the new pools for their citizens.

Decline to enforce ObamaCare's "consumer protections" if such enforcement authority does not already exist in your state.

The New York Times reports that insurance commissioners in half the states lack clear statutory authority to enforce new federal mandates on insurers, including the ban on pre-existing conditions for child-only coverage and the requirement that "children" may stay on

their parents' insurance policies up to age 26.

A state will not be able to lessen the impact of the *Patient Protection and Affordable Care Act* simply because it chooses to enforce the law. In reality, states will only be able to tinker at its edges, or seek minor concessions from Washington. And so ObamaCare presents the following choice for legislators: expend limited state resources to enforce the law, or step back and let the federal government enforce the law on its own.

The choice is clear. States should let federal bureaucrats spend their own time, money, and political capital to enforce the *Patient Protection and Affordable Care Act*. Georgia Senate Bill 399, filed in the 2010 session, is one possible way to act accordingly. It provides model language that requires specific legislative authority before the state chooses to enforce any federal health reform provision.

Use Oversight Powers As Appropriate

Commission independent research to track and measure ObamaCare's effects at the state level.

This research should include increases in premiums as a result of new regulations; Medicaid/SCHIP enrollment growth and related state spending; the number of individuals and employers forced to drop coverage they currently have; the reduction of choice and competition in the private insurance market; and the amount of state funds allocated to enforcement. The information gives state leaders two key pieces of information: a state's fiscal and health condition prior to full enactment of the *Patient Protection and Affordable Care Act*, and the precise, state-level effects of the new law as it is implemented. Grassroots activists and citizens, meanwhile, will be able to use this information to ensure that ObamaCare supporters are keeping their promises.

Hold public hearings and establish standing legislative committees to examine ObamaCare's implementation and impact.

Since the *Patient Protection and Affordable Care Act* was enacted, Congress has exercised little oversight over HHS Secretary Kathleen Sebelius and her implementation of the new law. State legislators can fill this void by holding regular, public hearings and inviting

HHS officials and members of their state's congressional delegation to explain the law and its implementation. Standing legislative committees can invite small businesses, doctors, seniors, and others to discuss the law's impact at the local level.

Participate in the ObamaCare rulemaking and comment process to the extent possible.

As with all federal laws, the *Patient Protection and Affordable Care Act* gives the public a certain window to comment on proposed regulations. State legislators, charged with overseeing the implementation of many features of ObamaCare, should continually make on-the-record statements of how the law burdens their states.

In October 2010, the state of Utah submitted its own response to the federal request for comments (RFC) on implementing health insurance exchanges. In the RFC, Utah—which had already established a loosely-regulated exchange on its own—petitioned the federal government to allow states maximum flexibility as it certifies state-designed exchanges.

You can engage in the ObamaCare rulemaking process first by using the Kaiser Family Foundation's online implementation timeline at http://healthreform.kaiser.org/timeline. Find the provisions that will affect your state the most, and then search for them at www.regulations.gov for comment deadlines and related information. Organizations like ALEC and The Heritage Foundation may also keep state legislators apprised of upcoming RFCs.

Serve as a legislative check on agency and executive branch implementation of ObamaCare.

In October 2010, Florida House Speaker Dean Cannon sent then-Florida Gov. Charlie Crist a cease-and-desist letter calling for a halt to executive and agency implementation of federal health reform.

In the order, Cannon alleged that Crist had commandeered state insurance regulatory resources in support of the *Patient Protection and Affordable Care Act*. He also wrote that Florida's "executive branch agencies implementing the law are doing so without waiting for clear and comprehensive guidance from the [l]egislature, the entity solely responsible for policymaking under Florida's constitution."

Legislators should be empowered to investigate how much their state is spending on implementation, and ensure that ObamaCare-compliant governors gain legislative approval before taking any further action.

Reframe the Debate on ObamaCare

Introduce study bills or make public calls for Medicaid "opt out" in 2014 as a way to shift the debate to the unintended consequences of ObamaCare's Medicaid mandates.

As a voluntary federal-state partnership, the Medicaid program is jointly funded and administered by the federal government and the states. All states have elected to join the Medicaid program, and the last state to do so was Arizona in 1982.

However, the *Patient Protection and Affordable Care Act* presents states with good reason to opt out of Medicaid altogether. First, the law requires that cash-strapped states extend their Medicaid programs to persons making up to 133 percent of the federal poverty level by 2014. In some states that will result in a near doubling of the Medicaid population. Until 2014, states are also required to maintain current rules for Medicaid eligibility because of ObamaCare's "maintenance of effort" requirement. Lawmakers looking to balance budgets will be forced to raise taxes or cut other state funding priorities, such as K-12 education or transportation. Finally, many conservative analysts predict that the law will further undermine state Medicaid authority once rulemaking begins.

The Heritage Foundation estimates that states could save nearly $1 trillion by opting out of the Medicaid program, and that nearly every state would come out ahead even if it retains a state-only program for people needing long-term care services, currently the most expensive part of Medicaid in many states. People in Medicaid who are not in long-term care would likely qualify for more generous subsidies in the new health insurance exchanges. Doctors—who are paid at paltry Medicaid rates—would also get more generous, Medicare-level reimbursements through the exchanges.

State officials are increasingly calling for termination of the Medicaid program if ObamaCare's Medicaid mandates are not delayed or repealed in favor of more innovative approaches, like block grants or medical savings accounts. The state of Texas—which has the third-largest Medicaid program in the country and also faces a $21 billion budget shortfall—is leading the opt-out charge, as it stands to save more than $60 billion by transitioning Medicaid beneficiaries into the exchanges. And in Washington, Alabama, South Carolina, Wyoming, and Nevada, state officials have said that the option is on the table.

Introduce study bills or make public calls for "public employee opt out" to focus attention on the unintended consequences of ObamaCare's employer mandate.

The states collectively employ more than 3.8 million workers, and in 2014 would be subject to the mandate along with businesses that employ more than 50 full-time workers. Employers that do not comply with the mandate, or who do not offer health coverage approved by the federal government, must pay a penalty of $2,000-$3,000 per full-time worker.

In October 2010, then-Tennessee Gov. Phil Bredesen announced in The Wall Street Journal that his state could save $146 million per year by terminating state employee health coverage in 2014 and shifting those workers into the new health insurance exchanges. Bredesen's calculations even took into account the $2,000 per-worker penalty and giving state workers extra money so they would not have to pay additional out-of-pocket costs when purchasing coverage in the exchanges. Bredesen concluded with an ominous warning for ObamaCare supporters:

> "The consequence of these generous subsidies will be that America's health reform may well drive many more people than projected out of employer-sponsored insurance and into the heavily subsidized federal system. Perhaps this is a miscalculation by the Congress, perhaps not. One principle of game theory is to think like your opponent; another is that there's always a larger game."

Recruit unlikely allies and demonstrate broad-based opposition to the individual mandate.

Jane Hamsher, founder of the progressive blog FireDogLake.com, argued in The Huffington Post that the individual mandate "forces you to pay 8 percent of your income to private insurance corporations—whether you want to or not." Former Democratic National Committee Chair Howard Dean criticized the individual mandate on MSNBC, saying "Academically you want a mandate. The American people aren't going to put up with a mandate."

Liberty-minded legislators may have serious disagreements with progressive-minded legislators on the area of health care, but they should look for opportunities to reach across the aisle in opposing the individual mandate. Bipartisan efforts have already begun at the federal level, where U.S. Sens. Scott Brown (R-MA) and Ron Wyden (D-OR) have sponsored legislation that would allow states to opt out

of the individual mandate beginning in 2014. The Brown-Wyden proposal is not likely to be effective, as it allows an opt-out only to states that meet coverage goals set up by ObamaCare. In short, it accepts that the federal government can dictate the "right" amount of coverage—hardly a position that state legislators can agree with. Still, Brown-Wyden is a useful reminder that it is important to forge alliances across the ideological spectrum.

Engage key stakeholders in an "adult conversation" about ObamaCare's impact on state funding priorities.

When asked by a Politico reporter about the issues Republicans should run on, New Jersey Gov. Chris Christie famously replied, "They should be talking about treating people like adults and telling them the truth: we're in huge trouble. And it's going to mean cutting back on a lot of things that folks either have become used to or in a perfect world would like to have."

Indeed, according to the National Association of State Budget Officers, in 2010, 21 states made spending cuts in transportation, 37 states cut law enforcement spending, and 35 states cut K-12 education spending. And these cuts were made prior to "health reform."

The same lesson applies to state legislators faced with the *Patient Protection and Affordable Care Act*. The law not only requires states to expand their Medicaid programs, but its "maintenance of effort" provision prevents states from cutting Medicaid eligibility in order to balance the budget. This—coupled with declining tax revenues and a stagnant economy—will require states to make some tough choices.

Now is the time for state lawmakers to initiate an "adult conversation" in the public square about the impact of ObamaCare on K-12 education, transportation, law enforcement, and other state spending obligations. In August 2010, Nebraska Gov. Dave Heineman sent a letter to the state's teacher unions urging them to support ObamaCare's repeal in order to protect state education funding:

> "As you know, the three largest components of the [s]tate's budget are state aid to education, the University of Nebraska and higher education, and Medicaid. Increased Medicaid funding is likely to result in less funding for education.
>
> "I am writing today to encourage you and your board to support the repeal of this federal health care law. If you sit silently by, I am going to assume that your lack of action is tacit support for increased Medicaid funding and the likely reduction in funding for education."

Promote Health Care Freedom Using ALEC Model Legislation

Playing defense against the *Patient Protection and Affordable Care Act* is essential in taming excessive federal power. But true reform means that state legislators cannot "just say no" to the designs of Congress. The 10th Amendment affirms that states have a big role to play in policy matters "not delegated to the United States by the Constitution, nor prohibited by it to the States." Health care is no exception—and state legislators must move forward with a pro-patient, market-driven health reform agenda.

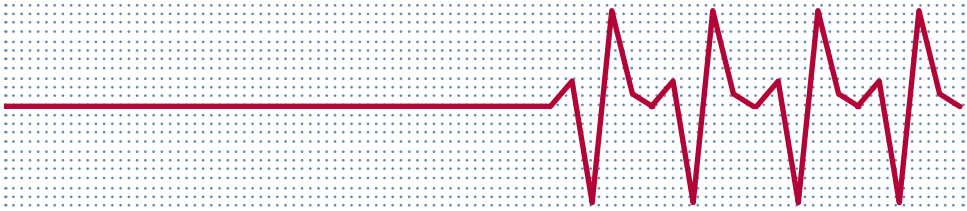
During the health reform debate, ObamaCare supporters consistently talked about three themes: security, affordability, and access. But the "solutions" put forth in the *Patient Protection and Affordable Care Act* will do little to fix the underlying problems with our health-care sector—and are likely to make them even worse.

ObamaCare supporters rightly pointed out that too many Americans lose or are denied health coverage, or fear not having health insurance when they need it. Instead of fixing that problem, they enacted an individual mandate that penalizes the insured for not purchasing a government-defined benefits package; an employer mandate that incentivizes businesses to drop coverage for their workers; and "guaranteed issue" requirements on insurers that drive up the cost of coverage and cripple the private health insurance market.

ObamaCare supporters rightly pointed out that the cost of health insurance is too high and is spiraling out of control. Instead of fixing that problem, they enacted a host of policies that will lead to skyrocketing health insurance premiums, increased spending and public debt, and higher taxes on insurance plans, medical devices, and prescription drugs.

ObamaCare supporters rightly pointed out that poor and uninsured Americans often lack access to care that meets their health needs. Instead of fixing that problem, they enacted a Medicaid expansion that puts pressure on already-overburdened state budgets and taxpayers, and leaves the "newly-insured" with a Medicaid program that restricts access to care and results in poor health outcomes.

State legislators can, and should, do better. ALEC's model legislation can bring about reform that, unlike ObamaCare, will address the challenges that Americans face. This legislation promotes three separate but related goals: bringing health security, making health insurance and health care affordable, and increasing access to health care for the poor.



ALEC Model Legislation That Secures Health Coverage

ALEC's ***High Risk Health Insurance Pool Act*** protects people with pre-existing conditions, as well as the medically-uninsurable, by allowing them to purchase more affordable health insurance through a state- and industry-funded high-risk pool. Thirty-five states have already created high-risk pools, which guarantee access to health insurance for everyone—without mandates or price controls that distort the market for those who have health insurance.

ALEC's ***Rescission External Review Act*** safeguards against excessive health insurance company rescissions and provides for an independent, external review when health coverage is rescinded.

ALEC's ***Health Care Sharing Ministries Freedom to Share Act*** protects health care sharing ministries—voluntary, health care cost-sharing arrangements among those with similar beliefs—by exempting them from regulation in the state insurance code. Ten states have specific regulatory exemptions for health care sharing ministries, through which more than 100,000 Americans share more than $60 million per year for one another's health costs.

ALEC's ***Health Care Sharing Ministries Tax Parity Act*** supports those who pay for medical bills through health care sharing ministries. It gives them a state income tax deduction or credit for health care sharing expenses when such a deduction or credit is allowed for traditional health insurance.

ALEC's ***Cancer Drug Donation Program Act*** establishes a voluntary program through which cancer patients can donate their unused prescription drugs to uninsured or underinsured patients. Seven states have established repositories to secure prescription drug access for cancer patients.

ALEC's ***Organ Donation Tax Deduction Act*** provides a $10,000 state income tax deduction for qualified expenses related to living organ donation. Sixteen states have enacted this model legislation, which helps cover the costs of organ-donation expenses not covered by traditional insurance.

ALEC Model Legislation That Makes Health Coverage Affordable

ALEC's ***Health Care Choice Act for States*** allows people to purchase quality, affordable health insurance across state lines. Currently, individuals can only purchase coverage sold within their state's borders—a policy that prohibits millions of Americans from gaining meaningful coverage that may be available in other states. In 2010, 19 states introduced—and Wyoming enacted—this legislation that expands coverage choices and lowers costs.

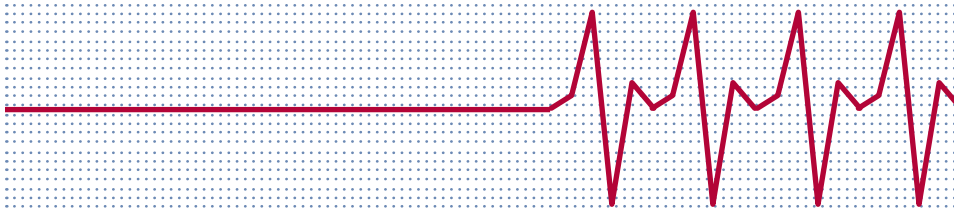
ALEC's ***Mandated Benefits Review Act*** provides an institutional check on mandated health insurance benefits—often steamrolled into existence by politcally-active interest groups—which individuals are required to "purchase" if they want to buy health coverage at all. Twenty-nine states have enacted some kind of mandated benefits review, which helps curb high-cost mandates that keep health coverage unaffordable.

ALEC's ***Affordable Health Insurance Act*** gives tax breaks to individuals, employers, and insurers who buy or sell affordable, high-deductible health plans (HDHPs) compatible with Health Savings Accounts (HSAs). According to America's Health Insurance Plans, in 2010 more than 10 million Americans were covered by an HDHP or an HSA.

ALEC's ***Health Care Tax Relief Equity Act*** eliminates discriminatory treatment of individuals who purchase insurance on their own. The act allows state tax credits for both the purchase of individual health insurance policies and out-of-pocket medical expenses. Currently, only businesses receive tax breaks when they purchase health insurance for their workers; individuals purchasing health insurance must do so with "after tax" dollars. Among its faults, current tax policy discourages people from buying insurance that they can take from job to job.

ALEC's ***Patient's Right to Know Act*** requires medical providers and insurers to provide cost estimates to patients upon request. Medical price transparency allows patients to better plan for the cost of major medical expenses, and introduces elements of competition to the healthcare marketplace.

ALEC's ***Taking the Best: ALEC's Comprehensive Medical Liability Reform Act*** promotes medical liability reform with legislative language from states that have already enacted successful reforms. Medical liability reform will help address the rising cost of medical malpractice insurance that threatens access to medical care and keeps health costs high for providers and patients.



ALEC Model Legislation That Ensures Health Coverage Access for the Poor

ALEC's ***Patients First Medicaid Reform Act*** establishes Medical Savings Accounts for Medicaid beneficiaries, and allows them to use their accounts to purchase a high-deductible health policy and pay for out-of-pocket medical expenses. Many Medicaid patients are now unable to see a doctor due to Medicaid's low reimbursement rates—providers, on average, receive about 60 cents for every dollar of Medicaid care they provide. If these patients have private insurance, which pays doctors more than Medicaid, doctors will have more of a financial reason to see them. As a result, they will have better access to the care they need.

ALEC's ***Medicaid Consumer-Directed Care Act*** establishes a "cash and counseling" program for aged and disabled Medicaid beneficiaries, which will provide them with more independence, flexibility, and choice in arranging their care. A "cash and counseling" model gives Medicaid beneficiaries a cash allowance so that they can purchase the long-term care services of their own choosing, and also provides a case manager to assist them in making health and financial decisions.

ALEC's ***SCHIP Anti-Crowd Out Act*** encourages the use of private insurance by offering premium assistance to people who are eligible for SCHIP, but also have access to employer-sponsored coverage.

ALEC's ***Long Term Care Tax Credit Act*** allows a state income tax credit for up to 20 percent of the premium cost for long-term care insurance. Many middle- and upper-class seniors artificially impoverish themselves with questionable "estate planning" techniques in order to gain Medicaid long-term care benefits. Encouraging those seniors to purchase private, long-term care insurance will help preserve the Medicaid safety net for the truly needy.

ALEC's ***Medicaid Optional Benefits Evaluation Act*** requires a legislative evaluation of proposed, "optional" Medicaid benefits before they are enacted. This institutional check on optional Medicaid benefits will help keep Medicaid costs low and preserve the financial viability of existing Medicaid benefits.

ALEC's ***Medical School Loan Repayment Act*** encourages physicians to practice in underserved areas by requiring the state to repay up to $50,000 in medical school loans, if the physician agrees to practice primary care in a "medical shortage" area of the state.

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