Understanding the Impact of Health Care Reform

This manual was originally created for the seminar Understanding the Impact of Health Care Reform in Oakland, California, on October 26, 2010.
Understanding the Impact of Health Care Reform

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The ability to learn faster than your competitors may be the only sustainable competitive advantage.

— Arie de Geus

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"The ability to learn faster than your competitors may be the only sustainable competitive advantage."

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Timeline of Key Health Reform Changes for Employers

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Timeline of Key Health Reform
Changes for Employers
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Overview

Healthcare Reform

- Individual Mandate
- Employer Mandate
- Employer Notification Requirements
- Near-Term Ins. Market Reforms
- Longer-Term Ins. Market Reforms
- Government Assistance
- Other Provisions
- Taxes
Timeline of Key Changes for Employers

- Reimbursement for early retiree coverage (6/23/10 – 1/1/14)
- High risk pools for individuals with preexisting conditions established
- Rebates for exceeding targeted medical loss ratios
- HRA, FSA, HSA OTC drug reimbursement excluded
- Tax on non-qualified HSA distributions increased to 20%
- Tax credit of 35% of employer contributions to health premium for small employers (tax years 2010-2013)
- Value of health benefits included on W-2 (begins with 2011 tax year)
- Annual contributions to FSA limited to $2,500
- 3.8% Medicare Tax on net investment income for individuals with modified adjusted gross income over $200k / $250k
- Employer deduction for Part D drug subsidy eliminated

6/23/10 9/23/10 1/1/11 1/1/12 1/1/13 1/1/14

- Lifetime dollar limits prohibited; annual dollar limits restricted (applies to grandfathered plans)
- Rescissions prohibited (applies to grandfathered plans)
- Coverage of preventive health care required
- Coverage of adult children to 26 (applies to grandfathered plans, but limited to those not eligible for employer coverage)
- Coverage for pre-existing for enrollees up to age 19 required (applies to grandfathered plans)
- IRS 105 (h) nondiscrimination rules extended to fully insured plans
- Claims appeals procedure requirements
- Applies to plan years beginning on/after 9/23/10

- Employer coverage mandates
- Individual coverage mandate (phased in 2014-2016)
- Waiting periods limited to 90 days
- Annual dollar limits prohibited
- Coverage for pre-existing health conditions required for all ages
- Children to age 26 (even if eligible for employer coverage)
- Discrimination based on health status prohibited
- Changes to wellness program requirements

Near-Term Requirements

When: Plan years beginning on or after 9/23/2010

Who: All plans, including grandfathered plans

- Cover adult children to 26
- No annual, lifetime $ limits
- No pre-existing conditions on enrollees under 19
- No rescissions except fraud, intentional misrepresentation

When: Plan years beginning on or after 9/23/2010

Who: All plans, EXCEPT grandfathered plans

- Expansion of nondiscrimination rules to fully-insured plans
- First $ preventive benefits
- Emergency room
- Choice of primary care provider/pediatrician
- OB/GYN care
- Mandatory appeals process

When: Tax years after 12/31/2010

Who: All plans, no grandfathering provisions

- No reimbursement for over-the-counter medications under FSAs, HSAs, HRAs
- Report value of coverage on employee’s Form W-2
2010 It starts!
• Reinsurance for early retiree coverage (6/23/10 – 1/1/14)
• High-risk pools for individuals with preexisting conditions established
• Lifetime dollar limits prohibited; annual dollar limits restricted (applies to grandfathered plans)
• Rescissions prohibited (applies to grandfathered plans)
• Coverage of preventive health care required
• Coverage of adult children to 26 (applies to grandfathered plans, but limited to those not eligible for employer coverage)
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• Applies to plan years beginning on/after 9/23/10

2011 It continues!
• Rebates for exceeding targeted medical loss ratios
• HRA, FSA, HSA OTC drug reimbursement excluded
• Tax on non-qualified HSA distributions increased to 20%
• Tax credit of 35% of employer contributions to health premium for small employers’ (tax years 2010-2013)
• Value of health benefits included on W-2 (begins with 2011 tax year)
2012 An “off” year
2013 – The Hits Keep on Coming

• Rebates for exceeding targeted medical loss ratios
• HRA, FSA, HSA OTC drug reimbursement excluded
• Tax on non-qualified HSA distributions increased to 20%
• Tax credit of 35% of employer contributions to health premium for small employers’ (tax years 2010-2013)
• Value of health benefits included on W-2 (begins with 2011 tax year)

2014 – The Year of the Mandate

• Employer coverage mandates
• Individual coverage mandate (phased in 2014-2016)
• Waiting periods limited to 90 days
• Annual dollar limits prohibited
• Coverage for pre-existing health conditions required for all ages
• Children to age 26 (even if eligible for employer coverage)
• Discrimination based on health status prohibited
• Changes to wellness program requirements
Individual Mandate -2014

- Minimum Essential Coverage
- Premium Assist.
- OR
- Penalty
- OR
- Exception

Employer Mandate – 2014

- Employer with more than 50 full time employees

1. Offer Coverage + NO EEs on assistance
2. Offer Coverage + EE(s) on assistance
3. No Coverage + EE(s) on assistance

- OR
- Limited 90-day waiting period
- $3,000/ee on asst (with a cap)
- $2,000/FTE less 1st 30 ees

Voucher Option for EEs Ineligible for Assistance
Exchanges - 2014

Government Subsidy ➔ Individuals ➔ Small Group ➔ Large Group

Bronze Plan ➔ Silver Plan ➔ Gold Plan ➔ Platinum Plan ➔ Public Plan

Providers

“Cadillac” Tax – 2018

COBRA Rate ≥ $10,200 for individual or $27,500 for family

Excise Tax

≥ 40% of plan value that exceeds threshold

Special Provisions
• High risk professions
• Early retirees
• Age & Gender
Health Care Reform and Consumer Directed Health Care: What now?

Prepared and Presented by:

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Pacific Benefit Consultants, Inc.
Health Care Reform and Consumer Directed Health Care: What now?

I. Consumer Directed Health Care defined

II. Definitions: HSAs, HRAs, FSAs, MERPS and HDHPs

III. Effect of Health Care Reform (HCR) on Benefit costs
   A. Up or Down?
   B. Future costs

IV. Effects on Cafeteria Plans:
   A. 60 day notice requirement for “material changes”
      i. SMMS format
      ii. $1,000 a day penalties
      iii. Can apply to OTC changes in existing plans
   B. Pre-Tax Premium Account
   C. Dependent Care Account
   D. Medical Flexible Spending Account:
      i. Elimination of over-the counter drugs and medicines with out a prescription- starting 01-01-11
      ii. Effect on “grace period” plans
      iii. Change in Dependent Definition
      iv. Cap on Medical Flexible Spending Account-plan years starting in 2013
   E Adoption Assistance Plans
   F Cadillac Tax-2018-all account type plans

V. New “Simple” Cafeteria Plans—effective plan years beginning in 2011
   A. Cafeteria Plans will be treated as meeting the nondiscrimination requirements if they meet certain minimum eligibility, participation and minimum contribution requirements. This “safe harbor” will also apply to certain benefits offered under the Cafeteria Plan umbrella.
   B. Eligible employers: eligible if, during the preceding two years, the business employed 100 or fewer employees on average business days. New businesses eligibility is determined based on the number of employees the business is reasonably expected to employ.
   C. Business once eligible can grow to 200 employees
   D. Usual aggregation rules apply for multiple entities
   E. Some exclusion rules apply
      i. at least 1,000 hrs of service
      ii. under age 21
      iii. less than one year of service
iv. collective bargaining groups
v. nonresident aliens

F. Each eligible employee must be able to elect any benefit available under the plan under the same terms and conditions as all other participants

G. Minimum employer Contribution Requirement: Must be sufficient to provide benefits to non-highly compensated employees (NHCEs) of at least:
   i. A uniform percentage (at least 2%) of compensation, whether or not the employee makes salary reduction contributions to the plan; or
   ii. The lesser of a 200% matching contribution or six percent of the employee’s compensation

Additional contributions may be made but the rate of any matching contribution for HCEs or key employees cannot be greater than the rate of match for NHCEs

H. Nondiscrimination Safe Harbors:
   i. 25% key employee test is met
   ii. Nondiscrimination tests that apply to individual benefits under the plan are also met—Sec. 79(d) rules for group-term life insurance, Sec. 105(h) rules for self-insured medical expense reimbursement plans (MERPs) and dependent care rules under Sec. 129(d)(2),(3) and (8) (DCAPS)

I. Prohibitions for Self-Employed Owners still in Force
   i. Cafeteria Plan participants still must qualify as “employees”

VI. Health Savings Accounts (HSAs): Employer Plans

A. Viewed as true consumer directed health care-coupled with High Deductible Health Plan (HDHP)
B. Typical plan design--$2,000 and $4,000 deductibles
C. Employer premium savings from HDHP plan is partially used to contribute to HSA for participating employees
D. Once monies are contributed they are exclusive property of employee
E. Unused portion rolls over each year and earns interest or is invested
F. HSAs are portable and go with employees when they leave
G. Changes from Health Care Reform
   i. Over-the-counter drugs no longer allowed without a prescription—effective for plan years starting 01-01-11
   ii. Penalty for using monies for non-medical expenses increased from 10% to 20% excise tax
H. Escaped relatively unscathed from HCR
VII. HRAs and MERPS: 105(h) plans

A. Used extensively in Consumer Directed Health Care (CDHC)
B. Are essentially employer self-funded medical plans
C.  
   i. To fund high deductible health plan  
   ii. Alternate to HSAs  
   iii. Used to fund employer funded dental and vision plans
D. Changes  
   i. Over-the-Counter drug exclusion in 2011  
   ii. Effected by CMS regulations beginning 10-01-10  
   iii. COBRA compliance required  
   iv. Annual and Lifetime limits unclear on these plans  
   v. Age 26 extension (grandfathered vs. non-grandfathered)  
   vi. Must cover preventative care with no cost sharing for non-grandfathered plans  
   vii. Waiting periods in excess of 90 days prohibited-1-1-2013  
   viii. Subject to “Cadillac Tax” in 2018
E. In addition to required Summary Plan Description (SPD)  
   i. Must be furnished participants initially and at time of reenrollment  
   ii. Cannot be more than 4 pages in length  
   iii. No print smaller than 12 point font  
F. Summary and Case Studies
Consumer Directed Healthcare Is Not A Product; It’s A Strategy.

The strategy is to create informed and confident consumers capable of making value-based healthcare decisions.

Consumer Directed Healthcare:

- A partnership between the employer and the employee
- A new promise that combines:
  - Premium Savings
  - Education for Healthcare Decisions
  - Wise use of Healthcare Dollars

What Is the targeted result of Consumer Directed Healthcare?

- Lower Trends and Long Term Cost-Containment
- Decisions based on realistic costs associated with healthcare
Some Consumer Directed (Driven) Health Care Definitions

- **Health Savings Accounts (HSAs)**
  - noun: health savings account (hēlth sav·īngz uh-kount )
  - They are combined with a High Deductible Health Plan (HDHP) to give employees money to spend at their discretion on Health Care Expenses. Contributions can be made by both Employers and Employees up to the yearly limits established by IRS. Unused funds roll forward each year and earn interest. All monies belong to employees and go with them upon termination. Money must be spent on eligible medical expenses; if not then the employee pays an excise tax penalty.

- **Health Reimbursement Arrangements (HRAs)**
  - noun: health re·im·burse·ment account (hēlth rē’im-būrs’ment uh-kount )
  - These are similar to HSAs in some respects. Main difference is funding is only by the employer, no employee contributions are allowed. Employer may allow carryovers, of partial carryovers each year. Monies usually stay with the employer upon termination. Require CMS reporting and COBRA administration.

- **Flexible Spending Accounts (FSAs)**
  - noun: flexible spending accounts (flek-suh-buh spēnd-ing uh-kounts)
  - They are usually part of your Cafeteria Plan. The medical FSA is the one that we are concerned with and it shares some characteristics of the HSA with one big difference. That difference is the so-called "use it or lose it provision"; meaning that any funds left in employee accounts at year-end forfeit to the employer and do not roll over like the HSA. These are usually employee funded with pre-tax dollars but employer contributions are allowed as well.

- **Medical Expense Reimbursement Plans (MERPs)**
  - noun: medical expense reimbursement plans (med-i-kuh ik-spens rē’im-būrs’ment plāns)
  - These are the oldest form of CDHC plans. They are always employer funded and resemble an insurance plan. In fact, they have been called self-insured plans when used in place of a base insurance policy. The employer acts like an insurance company up to a certain point and then actual insurance kicks in. Some large companies use these plans in lieu of a traditional insurance company plan. These are also used by smaller companies to self-insure the deductible on a high deductible health plan and sometimes to self-insure dental or vision benefits.
• **High Deductible Health Plan (HDHP)**

  *high de-duct-i-ble health plan* (hahy dih-duhk-i-buh hělth plān) **noun**

  Best described as a Major Medical Plan with a high out of pocket cost (high deductible) before insurance coverage kicks in. Deductibles usually range from $2,000 and $4,000 all the way to $10,000 and $20,000.

  With health insurance premiums ever on the rise, employers and employees must cope with higher co-payments, higher deductibles and increased provider restrictions. Many employers are now exploring alternatives to standard medical care that combine insured high-deductible health plans (HDHP) with CDHC Plans to ease this burden.

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**Today’s Health Insurance Landscape**

• Health insurance costs continue to rise each year.

• Employers have experienced double digit rate increases over the last decade.

• For most groups: 2010 increases are running between 12% and 22%

• **What does that mean going forward?**
Immediate Impact of Health Care Reform

- Pre-existing condition coverage for children age 19 and below
- Preventative care coverage with no co-insurance
- No lifetime limits on Benefits
- Coverage of dependents up to age 26

What will this do to your insurance rates next year?

Health Care Reform and Your Cafeteria Plan

60 Day Notice For “Material Change”
- Must be Summary of Material Modifications (SMMS) format
- $1,000 a day penalties
- Can apply to OTC changes in existing plans
- Pre-tax premium account
- Dependent Care Account
- Medical Flexible Spending Account
  - Elimination of OTC drugs and medicines w/out a prescription
  - Effect on “grace period”
  - Change in Dependent definition
  - Cap on Medical FSA-starting 2013
  - Cadillac Tax-all account type plans
New “Simple Cafeteria Plans”—Starting 2011

Cafeteria Plans will be treated as meeting the nondiscrimination requirements if they meet certain minimum eligibility, participation and minimum contribution requirements. This “safe harbor” will also apply to certain benefits offered under the Cafeteria Plan umbrella.

Eligible employers: eligible if, during the preceding two years, the business employed 100 or fewer employees on average business days

• Business once eligible can grow to 200 employees
• Usual aggregation rules apply for multiple entities
• Some exclusion rules apply
• Each eligible employee must be able to elect any benefit available under the plan under the same terms and conditions as all other participants

Simple Cafeteria Plans - continued

Minimum Employer Contribution Rules

• Must be sufficient to provide benefits to non-highly compensated employees (NHCEs) of at least:

  A uniform percentage (at least 2%) of compensation, whether or not the employee makes salary reduction contributions to the plan;

  Or the lesser of a 200% matching contribution or 6% of the employee’s compensation

• Nondiscrimination Safe Harbors:
  ► 25% key employee test is met
  ► Nondiscrimination tests that apply to individual benefits under the plan are also met

• Prohibitions for Self-Employed Owners still in Force
  Cafeteria Plan participants still must qualify as “employees”
Health Savings Accounts (HSAs): Employer Plans

- Viewed as true consumer directed health care-coupled with High Deductible Health Plan (HDHP)
- Typical plan design--$2,000 and $4,000 deductibles
- Employer premium savings from HDHP plan is partially used to contribute to HSA for participating employees
- Once monies are contributed they are exclusive property of employee
- Unused portion roles over each year and earns interest or is invested
- HSAs are portable and go with employees when they leave

Changes from Health Care Reform

- Over-the-counter drugs no longer allowed without a prescription—effective starting 01-01-11
- Penalty for using monies for non-medical expenses increased from 10% to 20% excise tax
- Escaped relatively unscathed from Health Care Reform

HRAs and MERPS: 105(h) plans

- Used extensively in Consumer Directed Health Care (CDHC)
- Are essentially employer self-funded medical plans

Health Reimbursement Arrangements (HRAs)—Uses

- To provide benefits under the high deductible health plan
- Alternate to HSAs
- Used to fund employer funded dental and vision plans
- Can be used to fund specific benefits under any type medical plan

Changes

- Over-the-Counter drug exclusion in 2011
- Effected by CMS regulations beginning 10-01-10
- COBRA compliance required
- Annual and Lifetime limits unclear on these plans
- Age 26 extension for non-grandfathered plans
- Must cover preventative care with no cost sharing for non-grandfathered plans
- Waiting periods in excess of 90 days prohibited-1-1-2013
- Subject to “Cadillac Tax” in 2018
Summary of Benefits and Coverage Explanation:

Applies to all plans

- Must be furnished participants initially and at time of reenrollment
- Cannot be more than 4 pages in length
- No print smaller than 12 point font
- Timeline-within 2 yrs of enactment: March 23, 2012

Summary and Case Studies

Case 1: 203 Benefited Employees:
Current Plan: HMO Plan w/$10 co-pay for Doctor office visits; $40 Brand Drugs, $30 Generic, $20 mail order.
Switch to CDHC plan w/$40 co-pay for Doctor office visits and $250 deductible for Brand Drugs—HRA to cover $20 of Doctor visit co-pay and $200 of Brand Drugs Deductible; Employee now pays total of $20 for office visit and $50 for Brand Drugs
Result: First year savings of $127,000 after claims and administration costs-3 year cost savings over $330,00

Case 2: 23 Benefited Employees:
Current Plan: PPO w/$250 deductible and 80/20 to $5,000, then 100%
Switch to CCDHC plan w/$1,000 deductible and 80/20 to $5,000, then 100% MERP to fund 80% of $1,000 after $250 deductible
Result: First year savings of $4,704 after claims and administration costs-after avoiding a 16% rate increase
Questions
Patient Protection and Affordable Care Act – Legal Challenges and Legislative Updates

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Patient Protection and Affordable Care Act - LEGAL CHALLENGES AND LEGISLATIVE UPDATES

By Susan E. Kirkgaard

LEGISLATIVE HISTORY

- Public Law 111-148.
- Passed by the House: 10-8-09.
- Passed by the Senate, with amendment: 12-24-09.
- House agreed to Senate amendment: 3-21-10.
- Signed into law by President Obama: 3-23-10.
OVERVIEW

The federal healthcare reform law (“Patient Protection and Affordable Care Act” or “PPACA”) requires state legislative and/or administrative action in order to become fully effective.

State infrastructure is needed to implement, but not all states are cooperative.

• States already regulate much of health insurance.
• 2009: 33 states had bills to address access to health care.
• 2006 to 2008: 26 states approved Medicaid income eligibility expansion.
• 2009: 30+ states had expanded family health insurance coverage to include young dependants.

• NCSL Reports online: www.ncsl.org/?tabid=14516
OVERVIEW

- States may wish to set up infrastructure to implement the act, in the event that constitutional challenges by various states are not successful.
- CA is doing both – through A.B. 1602 and SCA 29.

Overview

- In response to federal health reform legislation, some members of at least 40 state legislatures have proposed legislation to limit, alter or oppose selected state or federal actions, including single-payer provisions and mandates that would require purchase of insurance. In general most of the measures, in both 2009 and 2010:
Overview

• Contradict, some would say challenge, some features of the new federal law.
• Focus on not permitting or enforcing mandates (federal or state) that would require purchase of insurance by individuals or by employers and impose fines or penalties for those who fail to do so.
• Seek to keep in-state health insurance optional, and instead allow people to purchase any type of health services or coverage they may choose.
• The language varies from state to state, often using provisions from Arizona, as discussed later in the program.
CA and A.B. 1602

• In early June CA State Assembly passed A.B. 1602 to enact CA’s response to healthcare reform.

• Bill is currently **enrolled, sent to the governor, 8/31/2010.**

• If enacted as it now reads, the bill has five principal parts:

1. Prohibit individual insurance companies or plans from establishing lifetime limits on the dollar value of health insurance benefits paid to an insured;

2. Prohibit the limiting age of dependant health care coverage sold in CA to be less than 26 years of age;
CA and A.B. 1602

3. Effective 9-23-10, require health insurers to provide coverage for certain preventive procedures, such as approved immunizations and periodic health screenings for minors;

4. Prohibit the imposition of coverage limitations for pre-existing health conditions; and

5. Create the “CA Health Benefits Exchange”
   • to be governed by a board of appointees by the Governor, the Assembly Speaker and the Senate Rules Committee,
   • to arrange for, administer and supervise the sale of qualified health insurance policies pursuant to rules established by the federal Secretary of Health and Human Services.
WHAT ARE THE GROUNDS FOR STATE CHALLENGES TO FEDERAL LAW?

SUMMARY

• In response to PPACA, 39 State legislatures have proposed legislation to limit, alter or oppose selected state or federal actions, including single-payer provisions and mandates that would require purchase of insurance.

• This is done through:
  – State constitutional amendments (CA);
  – Federal constitutional amendments (Idaho);
  – Changing state law (Virginia, Idaho and Utah);

For an up to date look at this legislative challenge process, please go to National Conference of State Legislatures website, www.ncsl.org.
CHALLENGES TO PPACA

• Some states are filing challenges to the new law under various theories, the most typical of which are:

• Unconstitutional exercise of federal power (need ¾ of the states vote to amend the federal constitution);

• Violation of the Tenth Amendment: The Tenth Amendment restates the Constitution's principle of federalism by providing that powers not granted to the national government nor prohibited by the states by the Constitution of the United States are reserved to the states or the people, so no mandated healthcare.
Federalism

• The term federalism is also used to describe a system of the government in which sovereignty is constitutionally divided between a central governing authority and constituent political units (like states or provinces). Federalism is a system in which the power to govern is shared between national and provincial/state governments, creating what is often called a federation. Proponents are often called federalists.

Federalism

• Opponents to the new law argue that because duties are shared, through the concept of Federalism, the federal government cannot act unilaterally to impose mandated healthcare on the states.
Necessary and Proper Clause

• The Necessary and Proper Clause is the provision in Article One of the United States Constitution, section 8, clause 18:

  “The Congress shall have Power - To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof”.

• It is thus used to enforce interpretations of other constitutional provisions as being “necessary and proper”.

Necessary and Proper Clause

• Whether various federal laws are “necessary and proper” exercises of Constitutional power or violations of Constitutional limits on federal power and whether the Supreme Court has ruled properly in cases where this question is at issue seems a constant matter of deep controversy.
CHALLENGES TO PPACA

• Violates the Commerce Clause: Federal power to regulate commerce between the states.
• Violates the Taxing and Spending Power: can’t tax persons for being uninsured.
• Constitution prohibits unapportioned direct tax: needs to be apportioned among the states re: populations

Commerce Clause

• The Commerce Clause is an enumerated power listed in the United States Constitution (Article I, Section 8, Clause 3). The clause states that the United States Congress shall have power "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes". Courts and commentators have tended to discuss each of these three areas of commerce as a separate power granted to Congress.
• It is common to see the Commerce Clause referred to as "the Interstate Commerce Clause," which refers to states rights application of the same sentence in the Constitution.
**Taxing and Spending Clause.**

- **Article I, Section 8, Clause 1** of the United States Constitution, is known as the **Taxing and Spending Clause**. It is the clause that gives the federal government of the United States its power of taxation. Component parts of this clause are known as the **General Welfare Clause** and the **Uniformity Clause**.

**CHALLENGES TO PPACA**

- Violates the principles of Federalism and State Sovereignty.
  - Florida is using this theory – prior to PPACA, states were given discretion to implement and operate Medicaid.
  - New Medicaid requirements under PPACA will increase costs to the states.
State Sovereignty

- The current notion of state sovereignty was laid down in the Treaty of Westphalia (1648), which, in relation to states, codified the basic principles of territorial integrity, border inviolability, and supremacy of the state (rather than the Church). A sovereign is a supreme lawmaking authority.

LIMITATIONS ON STATES

- States cannot simply nullify federal law;
- The Supremacy Clause provides that the federal laws supersede states laws to the contrary;
- Political posturing and threats to nullify a federal law may have Congressmen violating their oath of office.
PREEMPTION AND STATES RIGHTS

- State constitutions clearly can restrict state law, and federal law can clearly preempt state action.
- When states reform health care, they must deal with federal laws;
- When Congress reforms health care, it can change federal laws;
- But Congress must comply with constitutional constraints.

WHICH STATES HAVE FILED CHALLENGES TO THE HEALTH CARE LAW?
OTHER STATES

• California is unique in moving quickly to implement the new federal law. The legislatures and/or administrations of at least 18 other states have taken action to “study”, oppose or to implement PPACA.

SOME STATES ARE FIGHTING IMPLEMENTATION

• Arizona has a proposed amendment to its state constitution scheduled for vote in November 2010 which states that a person may not be required by law to participate in any health care system nor pay fines or penalties for failing to do so.
CHALLENGES TO PPACA

• Idaho has called for the adoption of a new “28th Amendment” to the U.S. Constitution to provide that Congress may not make any law requiring a citizen to have health insurance.

• Virginia challenged the section mandating through statute that qualifying healthcare coverage is in conflict with the Virginia Code, which prohibits mandatory insurance purchases for Virginia residents. Utah and Idaho soon followed suit by passing similar statutes prohibiting mandated healthcare.

• *Thomas More Law Center v. Obama*: The Thomas More Center joined 4 individuals to file a complaint in Michigan alleging that PPACA imposes government mandates that restrict personal and economic freedom on citizens in violation of the Constitution.
CHALLENGES TO PPACA

• Florida lawsuit: Attorney General of Florida has been joined by counterparts of 18 other states - South Carolina, Nebraska, Texas, Utah, Louisiana, Alabama, Michigan, Colorado, Pennsylvania, Arizona, Indiana, Mississippi, Nevada, North Dakota, Washington, Idaho and South Dakota, seeking declaratory and injunctive relief on the basis that the legislation exceeds Congress’ enumerated powers under Art 1.

Among the “enumerated powers” given Congress in Article I Section 8, is the following:

• To lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts and excises shall be uniform throughout the United States;
CHALLENGES TO PPACA

• Florida lawsuit:
  • Article 1 of the Constitution allows Congress to tax and spend to “provide for the common defense and general welfare of the United States”.
  • However, deals were cut for certain states making the argument available that it is not in the general welfare to treat states differently.

• Florida lawsuit alleges:
  • “The Constitution nowhere authorizes the United States to mandate, either directly or indirectly or under threat of penalty, that all citizens and legal residents have qualifying health care coverage” and that the law puts an unfair financial burden on state governments.
CHALLENGES TO PPACA

• Florida lawsuit alleges:
• “Regulation of non-economic activity under the Commerce Clause is possible only through the Necessary and Proper Clause. This clause confers supplemental authority only when the means adopted to accomplish an enumerated power are ‘appropriate’ and are ‘plainly adapted to that end’ and are ‘consistent with the letter and spirit of the constitution’.”

ENUMERATED POWERS FOR CONGRESS

• Congress has the power to tax and spend for the general welfare;
• The power to regulate commerce – the “individual mandate” extends the power to economic inactivity;
• The power to regulate insurance;
• It can incentivize states to do its will.
MAY STATES ENACT LEGISLATION TO CURTAIL THE HEALTH CARE LAW?

YES!

WILL THE LEGISLATIVE CHALLENGES TO CURTAIL THE HEALTH CARE LAW SUCCEED?

PROBABLY NOT.
What Do the Experts Say?

• Professor Robert Sedler at Wayne State University states the States’ lawsuits are “pure political posturing”. Constitutional law professor Bruce Jacob at Stetson University disparages the lawsuits’ chances and commented that the “federal government certainly can compel people to pay taxes.”

• Edwin Chemerinsky, dean and constitutional law professor of the University of California, Irvine called the bill “clearly” constitutional, explaining that “everyone at some point is going to need health care, whether it is for an auto accident or a communicable disease, and Congress can make sure everyone pays for the system they’re likely to benefit from”. Providence Journal, March 25, 2010.

What Do the Experts Say?

• Most legal scholars seem to be opining that these legal challenges will not succeed. “States may not opt out of federal laws that they might find distasteful. “There is no way this challenge will succeed in court” according to Mark A. Hall, professor of law and public health at Wake Forest University.

• “States may no more nullify a federal law like this than they could nullify the civil rights laws by adopting (state) constitutional amendments, States cannot nullify federal law. The principle is simply beyond debate, and state legislators, many of them lawyers, know that” says Timothy Stoltzfus Jost, professor of health law at Washington and Lee University School of Law states in the New England Journal of Medicine.
What the Obama Administration Says

• The administration officials, emphasized the wide latitude Congress has been granted under the U.S. Constitution’s commerce clause. One precedent they cited: U.S. v. Southeastern Underwriters Association, a 1944 Supreme Court decision that allowed congressional regulation of insurance.

• The officials also cited Gonzales v. Raich, a 2005 decision in which the Court ruled that Congress can regulate intrastate activity when failure to do so could “undercut” its regulation of interstate commerce. “The requirement that everyone have insurance,” one official said, “is essential to making those other requirements work,” such as non-discrimination based on pre-existing conditions.

The End
State Legislation Challenging Certain Health Reforms, 2010 (State Activity)

Updated: September 15, 2010 - subject to additions

by: Richard Cauchi, Program Director, NCSL Health Program

States have an extensive and complicated shared power relationship with the federal government in regulating various aspects of the health insurance market and in enacting health reforms.

In response to federal health reform legislation, some members of at least 40 state legislatures have proposed legislation to limit, alter or oppose selected state or federal actions, including single-payer provisions and mandates that would require purchase of insurance. In general most of the measures, in both 2009 and 2010:

- Contradict, some would say challenge, some features of the new federal law.
- Focus on not permitting or enforcing mandates (federal or state) that would require purchase of insurance by individuals or by employers and impose fines or penalties for those who fail to do so.
- Seek to keep in-state health insurance optional, and instead allow people to purchase any type of health services or coverage they may choose.
- The language varies from state to state, often using provisions from Arizona, as cited below.

State constitutional amendments: In 30 of the states, the filed measures included a proposed constitutional amendment by ballot question. In a majority of these states, their constitution includes an additional hurdle for passage - requiring either a "supermajority" of 60% or 67% for passage, or requiring two affirmative votes in two separate years, such as 2010 and 2011.

Federal constitutional amendment: Idaho called for adding a U.S. Twenty-eighth Amendment to provide that Congress shall make no law requiring citizens of the United States to enroll in, participate in or secure health care insurance or to penalize any citizen who declines to purchase or participate in any health care insurance. This was adopted by both Senate and House on March 29, 2010.

Changing state law: In at least 16 states proposed bills would amend state law, not the state constitution. These require a simple majority vote and action by the governor; they also can be re-amended or repealed by a future state law. So far in 2010, Virginia became the first in the nation to enact a new statute section titled, "Health insurance coverage not required." It became law on March 10, 2010. Georgia, Idaho, Louisiana, Missouri, Utah and Arizona also each enacted a similar statute.

Based on actions initially in Arizona in 2009, 29 other states considered proposed state constitutional amendments, using language such as:

"To preserve the freedom of all residents of the state to provide for their own health care... A

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State Legislation Challenging Certain Health Reforms, 2010 (State Activity)

law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system ... A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services..."

B. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule*

[See full text in Appendix 1]

Arizona voters are scheduled to cast ballots on this constitutional amendment on November 2, 2010.

According to The New York Times, "Conservatives and libertarians, mostly, have been advancing the theory lately that the individual mandate, in which the government would compel everyone to buy insurance or pay a penalty, is unconstitutional." (NY Times, 9/26/09)

** 40 States with 2009-2010 Legislation Opposing Certain Health Reforms **

NOTES: FLORIDA's proposed ballot question was removed from the ballot by the state court on August 31. COLORADO will have a citizen initiative on the ballot.

As of mid-September, formal resolutions or bills had been considered in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. Additional states were reported in media or association articles to have discussed future action or intentions; examples are listed below.

New Laws: Seven states have signed or enacted statutes in 2010, based on final actions as of August 27, 2010:

- A Virginia law passed both Senate and House, was amended by the Governor and both branches of the legislature and became law as Chapter 106 on March 18, becoming the first such statute in the nation.*
- Idaho enacted a similar statute, signed as Chapter 46 on March 17.
- A Utah statute, signed March 22, prohibits any state agency from implementing health reform unless state agencies recommend action or the legislature passes a provision.
- A Georgia statute addition was substituted during a conference committee and passed by Senate and House on the

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last day; it was signed into law by the governor on June 2.

- **Louisiana** enacted a statute, declaring that residents "shall be free from governmental intrusion in choosing or declining to choose" health coverage; signed July 2.
- **Arizona** enacted a separate statute, similar to their constitutional ballot question for November 2010. (Explained below)

**Statute Ballot Question approved in Missouri**

- **Missouri**'s Legislature passed a proposed statute, but required that it be put to voters for approval or disapproval on their primary election day, Tuesday August 3, 2010. It was approved by a 71.1% yes vote. 

**Constitutional Ballot Questions in three states:**

- **Arizona**'s resolution of June 2009 was the first constitutional ballot question measure to have passed the legislative process, for a decision by voters on November 2, 2010. (Also see statute, listed above).

- **Florida**'s legislature was the second state to approve a constitutional amendment ballot question, on 4/22/10, for a decision by voters on November 2, 2010. However, in late July a Florida District court ruled the question wording as inappropriate; on August 31 their State Supreme Court agreed that the question must be removed from the ballot.

- **Oklahoma**'s constitutional amendment ballot question was approved by the Senate and House in May 2010, and will appear on the November 2, 2010 ballot.

- **Colorado**: Although the legislature rejected a resolution on the topic, a citizen initiative proposed constitutional amendment has placed a question on the November 2, 2010 ballot.

**Non-binding measures:**

**South Dakota** passed a resolution opposing "government take-over" of health care. **South Carolina** adopted a resolution opposing health mandates and directing the attorney general to challenge such provisions in federal health reform. A **Michigan** Senate resolution urging removal of financial obligations passed in January 2010. **Idaho** called for adding a U.S. Constitutional Amendment to provide that Congress shall make no law requiring citizens of the United States to enroll in, participate in or secure health care insurance or to penalize any citizen who declines to purchase or participate in any health care insurance.

**Measures that "Did Not Pass:"

For the 2009-2010 legislative sessions, so far **26 states** have not passed or have rejected bills and resolutions (25 states in 2010, one in 2009).

For 2010 sessions, the states are: **Alabama**, **Alaska**, **Arkansas**, **California**, **Colorado**, **Indiana**, **Iowa**, **Kansas**, **Kentucky**, **Maryland**, **Michigan**, **Minnesota**, **Mississippi**, **Nebraska**, **New Hampshire**, **New Mexico**, **North Carolina**, **Rhode Island**, **South Carolina**, **South Dakota**, **Tennessee**, **Washington**, **West Virginia**, **Wisconsin** and **Wyoming**. A 2009 **North Dakota** constitutional proposal did not pass by the end of their session. 2010 Delaware measures did not pass in regular session but may be considered in a special session. If additional special sessions, reintroductions or reconsideration motions are filed, they will be added to this report.

An "interim study proposal" resolution was not acted on in Arkansas; in Indiana a resolution passed the Senate but did not pass the House. States with discussions but no known legislation are listed separately; information in the examples list below is based on media statements by individual legislators or legislative associations.[1]

**Attorneys General** in at least 20 individual states have also taken some actions related to constitutional challenges to health reform, listed below. In addition individual governors in 3-4 states have urged such legal challenges.

The issue has garnered state legislative interest in 2009-2010 in part due to the American Legislative Exchange Council's (ALEC) model "Freedom of Choice in Health Care Act," which the organization described as "How Your State Can Block Single-Payer and Protect Patients' Rights." The ALEC-endorsed language mirrors Arizona Proposition 101, which was narrowly defeated in 2008.

Legal experts have expressed widely varying pro and con opinions on the validity of this approach. [See **Appendix 2** for commentary and quotes.]

**Table 1:**

**Filed Bills and Resolutions for 2009-2010**

Table 1 indicates 1) Activity and status for measures filed;

**The State Constitutional process:**

In 35 states, the legislature can enact a proposed

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2) the percentage of affirmative votes in the legislature required for approval;
3) the earliest date that a proposed constitutional amendment can appear on the statewide ballot. Timing and parliamentary steps vary among states.

constitutional amendment during a single session. [Appendix 3] This would allow passed measures to appear on the state ballot in 2010 or later. In 12 states the legislature must enact a proposed constitutional amendment during two sessions, which would make 2012 the earliest date for voter decisions.

<table>
<thead>
<tr>
<th>State</th>
<th>Activity/Legislation</th>
<th>Required for passage</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>HB 42 by Rep. Bentley; HB 47 by Rep. Gipson; HB 498 by Rep. Galliher; SB 233 by Sen. Seaborn. Would propose a constitutional amendment to prohibit any person, employer, or health care provider from being compelled to participate in any health care system. (HB 42 prefilled 11/5/09 for 2010 session; sent to Health Committee 1/12/10; did not pass by end of session 4/22/10) (SB 233 filed 1/13/10; Passed Senate, sent to House 4/1/10; did not pass by end of session 4/22/10)</td>
<td>60% both legislative chambers + 2010 ballot vote</td>
</tr>
<tr>
<td>Alaska</td>
<td>HR 35 by Rep. Kelly filed for 2010 session Would propose a state constitutional amendment prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system. (Filed 1/19/10; favorable House committee reports 3/12/10; failed passage 22y-18n 4/15/10)</td>
<td>2/3rds both legislative chambers + 2010 ballot vote</td>
</tr>
<tr>
<td>HR 14 by Rep. Chenault Would urge the United States Congress to oppose federal health care reform bills. (Filed 2/17; re-referred to House Comm. 3/19/10)</td>
<td>Non-binding resolution; majority vote</td>
<td></td>
</tr>
<tr>
<td>Arizona (2009)</td>
<td>Resolution HCR 2014 of 2009 by Rep. Barto Refers to the November 2010 ballot a proposed amendment to the State Constitution &quot;which provides that no law or rule shall compel any person or employer to participate in any health care system, a person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for doing so, a health care provider may provide directly purchased lawful health care services; prohibits the terms or conditions of a health care system from imposing certain mandates or limitations.&quot; [full text in Appendix 1 below] (Filed 1/15/09; passed House 6/11/09; passed Senate 6/22/09; will appear on Nov. 2, 2010 ballot for voter approval or disapproval) Also see 2009 ballot question history, below.</td>
<td>50% both legislative chambers (Passed) 2010 ballot vote</td>
</tr>
</tbody>
</table>
| Arizona (2010) | SB 1001 by Sen. Added by state statute the "public policy that every person in this state... may choose or decline to choose any mode of securing lawful health care services without penalty or threat of penalty." Also protects "any right of contract related to the provision of lawful health care services to any person or group". "A public official or an employee or agent of this state or any political subdivision of this state shall not act to impede, collect, enforce or effectuate any penalty in this state that violates the public policy prescribed in this section."
(Substituted by committee; Signed into law by governor as chapter 1, 4/1/2010) | Proposed statute: majority both legislative chambers                                                                                |
| HB 2443 by Rep. Burges Would add by state statute the Health Care Freedom of Choice Act requiring Arizona to exercise its option to decline the public health care plan if authorized by the federal government. (Filed and sent to committees 1/26/10; did not pass by end of session) | Proposed statute: majority both legislative chambers                                                                                |
| Arkansas    | ISP 2009-204 by Rep. Glidewell (Interim Study Proposal for 2010 Fiscal Session) Would add a state statute to "ensure freedom of choice in health care" for state residents; "to prevent involuntary enrollments in health care insurance programs" and providing that an "individual or an employer may make direct payment for lawful health care services and shall not be required to pay penalties or fines" for making direct payment for health services. | Proposed statute: majority both legislative chambers                                                                                |

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<table>
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<tr>
<th>State</th>
<th>Description</th>
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<tbody>
<tr>
<td>California</td>
<td>SCA 29 by Sen. Strickland. Would propose a state constitutional amendment prohibiting the effectiveness or enforcement of a state or federal program that (1) requires individuals to obtain health care coverage, (2) requires health care service plans or health insurers to guarantee issue contracts and policies to all applicants, (3) requires employers to either provide health care coverage to their employees or pay a fee or tax to the state or the federal government in lieu thereof, (4) allows an entity created, operated, or subsidized by the government to compete with health care service plans and health insurers in the private sector, or (5) creates a single-payer health care system, unless the program is approved by the electorate by ballot measure. <em>(Filed 2/19/10; did not pass Senate Comm. 3y-6n, 5/5/10)</em></td>
</tr>
<tr>
<td>Colorado</td>
<td>HJR 10-1009 by Rep. Acree. Resolution stating the intent of the General Assembly, to “Reserve the opportunity and ability of the State of Colorado and its citizens, under the state’s and the people’s Tenth Amendment rights, to opt out of any obligations due or participation required in any new federal health care legislation.” <em>(Filed 2/5/10; Judiciary Comm. did not pass -postponed indefinitely 3/11/10)</em></td>
</tr>
<tr>
<td>Delaware (2010)</td>
<td>HB 353 by Rep. Hudson. &quot;The people of Delaware have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The United States Congress may not require any person to participate in any health care system or plan, nor may it impose a penalty, fine, tax, or fee of any type for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan. Only the State of Delaware has the legal authority to regulate private health care insurance, systems, plans, and services for the people of Delaware within its borders.&quot; <em>(Filed 3/30/10; held in House Administration Comm.; did not pass by end of regular session 6/30/10; may be considered in special session)</em></td>
</tr>
<tr>
<td>Florida</td>
<td>HJR 32 (Joint Resolutions filed for 2010) by Rep. Plakon; 39 co-sponsors; SJR 72 by Sen. Baker. Joint resolutions proposes a State Constitutional amendment to prohibit laws or rules from compelling any person, employer, or health care provider to participate in any health care system; permits person or employer to purchase lawful health care services directly from health care provider; and permits health care providers to accept direct payment from a person or employer for lawful health care services. <em>(Filed 3/18/10; no action; held in committee; did not pass by end of regular session 6/30/10; may be considered in special session)</em></td>
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(HJR 37 prefiled 7/27/2009 for 2010 session; substituted; passed House; passed Senate; enrolled; 4/22/10; was directed to appear on the November 2, 2010 state ballot for voter approval or disapproval) This ballot question, Amendment 9, was ordered removed from the ballot by the Florida District Court in late July; on August 31 the Florida State Supreme Court agreed and ordered that the question wording was inappropriate and must be removed from the ballot. [text of court ruling No. SC10-1527] [Article by AP 9/1/10] (SJR 72 prefected 10/5/09; favorable comm. report 3/4/10 substituted by HRJ 37 above)

NOTE: SB 10 separately calls for a United States Constitutional Convention to address various matters related to a balanced Federal Budget, including health care expenditure requirements. (Passed Senate and House; enrolled and signed, 5/5/10)

Georgia


Would propose an amendment to the Constitution so as to provide that no law or regulation shall compel any person, employer, or health care provider to participate in any health care system and to authorize persons and employers to pay directly for lawful health care services without penalties or fines; would provide for submission of the amendment for ratification or rejection. SR 795 would provide that residents would not be subject to penalties or fines for not having health insurance.

(Prefiled 11/23/09 for 2010 session; HR 1086 favorable report 3/11/10; did not pass House 3rd Reading 111y-61n-3nv, 3/18/10; motion to reconsider vote granted 110y-58n-6nv, 3/24/10) 2/3rd affirmative vote required; did not pass by end of session 4/29/10)

SR 795 favorable report by Senate Judiciary 2/2/10; did not pass by end of session 4/29/10) [SR 794 did not pass Senate 3rd reading 31y-19n, 3/18/10]

SB 317 by Sen. Hill

Would establish by statute that "no law or rule or regulation shall compel any person, employer, or health care provider to participate in any health care system; to authorize persons and employers to pay directly for lawful health care services without penalties or fines."

(SB 317 filed 1/25/10; favorable Comm. report 2/10/10; passed Senate 31y-16n; did not pass by end of session 4/29/10)

SB 411 with amendment 37-1032S by Sen. Hill

Wellness discounts bill; amended, inserting similar language from SB 317 by Sen. Judson Hill.

Establishes by statute that "no law or rule or regulation shall compel any person, employer, or health care provider to participate in any health care system;" to authorize persons and employers to pay directly for lawful health care services without penalties or fines. The intent is that state residents would not be forced to comply with the mandates in the federal health care reform law.

(House amendment, added and passed 4/27/10; 4/29/10 (AM21-3736) passed Senate 4/29/10; signed into law by governor 6/2/10) [Bill history]

SR 829 and SR 830 by Sen. Hill. (Substituted and approved by conference committee)

Resolutions would direct the Attorney General to "initiate a formal investigation into the constitutionality of the special exemption set forth in the United States Senate's version of this national health care legislation and explore the availability of all other legal challenges.

(Filed 1/15/10; Senate 2nd reading 2/11/10; did not pass by end of session 4/29/10)

HB 391 by State Affairs Comm.

Amend and add to existing law to establish the Idaho Health Freedom Act, stating in part, "that every person within the state of Idaho is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty."

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Idaho

SIM 106 by State Affairs Committee
Non-binding memorial stating findings of the Legislature urging Congress to take action to amend the United States Constitution to provide that "Congress shall make no law requiring citizens of the United States to enroll in, participate in or secure health care insurance or to penalize any citizen who declines to purchase or participate in any health care insurance program."
(Filed 3/26/10; passed Senate and House 3/29/10)

Illinois (2010)

H 6842 by Rep. Mitchell
Would provide by statute that no resident of the State, regardless of whether he has or is eligible for health insurance coverage, shall be required to obtain or maintain individual insurance except as required by a court or a State agency
(Filed and sent to committee 3/26/10; pending; held in Rules Comm. as of 9/7/10)

HR 1074 by Rep. Bellock
Would request that the IL Commission on Government Forecasting and Accountability examine the provisions of the federal health care reform law to determine the fiscal impact of the provisions on the budget of the State.
(Filed and sent to Rules Committee, 3/26/10; placed on calendar 4/28; held in Rules Comm. as of 9/7/10)

HR 1075 by Rep. Bellock
Would urge the IL Attorney General to take steps necessary to file a suit challenging the constitutionality of the federal Patient Protection Affordable Care Act.
(Filed and sent to Rules Committee, 3/26/10; pending; held in Rules Comm. as of 9/7/10)

Indiana (2009)

SJR 65 by Sen. Waltz; SJR 91 by Sen. Waltz; SJR 111 by Sen. Waltz (Advisory resolutions for 2009)

SJR 91: Resolved, "That the Indiana General Assembly must ensure that all residents of Indiana may enter into private contracts with health care providers for health care services and may purchase private coverage for health care services. That the Indiana General Assembly should not require an individual to participate in a health care system or plan or impose on an individual a penalty or fine of any type for choosing to obtain or decline coverage for health care services or participating in a particular health care system or plan."
(SJR 65 - filed 4/7/09 - did not pass by end of session; SR 91 - filed 4/27/09 - did not pass by end of session; SR 111 - filed 4/28/09 - did not pass by end of session; Indiana does not carry over bills or resolutions to 2010)

Indiana (2010)

SJR 14 by Sen. Knaute, HR 5 by Rep. Noe; HR 8 by Rep. Turner; also non binding resolution SCR 10

Would propose a state constitutional amendment stating, "A person, an employer, or a health care provider shall not be compelled, directly or indirectly, to participate in any health care system. A person or an employer may pay directly for lawful health care services and shall not be subject to penalties or fines for paying directly for lawful health care services. A health care provider may receive direct payment for health care services from a person or an employer and shall not be subject to penalties or fines for accepting direct payment from a person or an employer."
(SCR 10 - nonbinding resolution passed Senate 2/1/10; did not pass House Committee)
(Filed 1/11/10; did not pass by end of regular session deadline 3/3/10)

HR 2007 by Rep. Upmeyer
Would propose a state constitutional amendment prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system.
(Filed 1/26/10; did not pass by end of session 4/12/10)


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<tr>
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<th>Law</th>
<th>Description</th>
<th>Proposed Statute</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>HCR 5032 by Rep. Landwehr; SCR 1626 by Sen. Pilcher-Cook</td>
<td>Would propose a state constitutional amendment providing that 1) &quot;A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system or purchase health insurance. &quot;A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services.&quot;</td>
<td>Majority both legislative chambers</td>
<td>2/3rd majority both legislative chambers; 2010 ballot vote</td>
</tr>
<tr>
<td>Kansas</td>
<td>HB 307 by Rep. Moore</td>
<td>Would prohibit by statute any other law &quot;from requiring any individual to participate in any health care system or plan, or to impose a penalty or fine regarding participation; permit an individual or an employer to pay directly for health care services and a health care provider to accept direct payment without penalties or fines. Also would prohibit the state executive branch from &quot;participating in or complying with any federal law, regulation, or policy that would compromise the freedom of choice in the health care.&quot;</td>
<td>Majority both legislative chambers</td>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
<tr>
<td>Kentucky</td>
<td>HB 1474 by Rep. Talbot</td>
<td>Prohibits by statute any resident from being required to purchase health insurance coverage; provides that it is a declared public policy of the State that every person within the state is and shall be free from governmental intrusion in choosing or declining to choose any mode of security health insurance coverage without a penalty or threat of penalty.</td>
<td>Majority both legislative chambers</td>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
<tr>
<td>Louisiana</td>
<td>SB 26 by Sen. Crowe</td>
<td>Would prohibit by statute any other law requiring a &quot;person, employer, health care provider to participate&quot; in a health system or insurance system; also would prohibit compelling participation in any health care system or health insurance plan. Would establish a misdemeanor offense and penalty ($500 or five-day in prison) for any state or local official who &quot;attempts to coerce any individual to purchase health insurance.&quot;</td>
<td>Majority both legislative chambers</td>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
<tr>
<td>Louisiana</td>
<td>HB 94 by Rep. Talbot</td>
<td>Would propose a state constitutional amendment to prohibit laws or rules that would compel &quot;any person, employer, or health care provider to participate in any health care system&quot;; would allow the direct payment of health care services; also such persons, employers or providers would &quot;not be required to pay penalties or fines&quot; for buying or selling health services.</td>
<td>Majority both legislative chambers</td>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
<tr>
<td>Louisiana</td>
<td>HB 603 by Rep. Shenk; SB 397 by Sen. Pipkin</td>
<td>Would propose a state constitutional amendment limiting the regulation of health care in the state; prohibiting a law from compelling residents to participate in any health care system; prohibiting residents from being required to pay penalties or fines for not participating in health insurance; specifying that the purchase of specified health insurance may not be prohibited by law; authorizing residents to pay directly or accept direct payment for specified health care services.</td>
<td>Majority both legislative chambers</td>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Maryland</td>
</tr>
<tr>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
<tr>
<td>HB 1563 by Rep. Dwyer</td>
</tr>
<tr>
<td>Would provide by statute any other law requiring a &quot;person, employer, health care provider to participate&quot; in a health system or insurance system; a person has the right to choose to participate in a private health insurance system or plan; establishes that, notwithstanding specified provisions of law and subject to a specified exception, a person has the right to pay for lawful medical services without interference and a penalty, tax, fee, or fine may not be imposed on a person who declines to contract for health insurance coverage.</td>
</tr>
<tr>
<td>(Filed and sent to committee 3/21/10; did not pass by end of session 4/20/10)</td>
</tr>
<tr>
<td>Michigan</td>
</tr>
<tr>
<td>2/3 both legislative chambers + 2010 ballot vote</td>
</tr>
<tr>
<td>Would propose a state constitutional amendment &quot;to affirm the right to independent health care.&quot; Includes a statement that &quot;a person or employer shall not be required to pay penalties or fines for paying directly for lawful health care services.</td>
</tr>
<tr>
<td>(Filed 8/1/9/09, 8/29/09 and 9/9/09; pending in Committee on Health Policy; no floor vote in 2009; carried over to 2010) SJR K 2nd Reading and committee substituted; failed to pass 3rd Reading; reconsidered 3/16/10; no further actions as of 5/21/10)</td>
</tr>
<tr>
<td>Minnesota</td>
</tr>
<tr>
<td>50% both legislative chambers + 2010 ballot vote</td>
</tr>
</tbody>
</table>
| Would propose an amendment to the Minnesota Constitution stating that "no law shall be passed that restricts a person's freedom of choice of private health care systems or private health plans of any type. No law shall interfere with a person's or entity's right to pay directly for lawful medical services, nor shall any law impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or health plan."
| (Filed 1/22/09, 3/9/09; did not pass committee by end of 2009 session; did not pass committees by end of 2010 session 5/17/10) |
| Executive Order 10-12: In an action unrelated to the legislature "Governor Pawlenty signed an Executive Order "Directing State Agencies to Decline All Discretionary Participation in Federal health reform" - 8/31/2010. |
| Mississippi |
| 2/3 both legislative chambers + 2010 ballot vote |
| Resolution, would propose a constitutional amendment to prohibit laws compelling any person, employer or health care provider to participate in any health care plan. Would provide that a "person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly."
| (Filed; sent to Committee on Constitution 1/7/10; HCR 17 and SCR 562 died in committee 2/2/10) |
| Missouri |
| 50% both legislative chambers + 2010 ballot vote |
| Joint resolutions, would propose a constitutional amendment which would prohibit compelling a person to participate in any health care system. "Upon voter approval, this proposed constitutional amendment prohibits any person, employer, or health care provider from being compelled to participate in any health care system. Individuals and employers may pay directly for lawful health care services, and health care providers can accept payment for health care services from individuals or employers without being subject to fines or penalties. The purchase or sale of health insurance in private health care systems cannot be prohibited by law or rule. Committee substitute added definitions
| (Prefiled 1/6/10 for 2010 session; HJR 48 House resolutions combined & passed House 109y-46n, 3/16/10; pending in Senate 5/12/10)
| (SJR 25 substituted; favorable comm. report 3/16/10; session adjourned 5/25/10 without further action) |
| HB 1764 by Sen. Cunningham [final full text] |
| Proposed state insurance statute amendment to prohibit "any person, employer, or health care provider from being compelled to participate in any health care system. |

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<table>
<thead>
<tr>
<th>State Legislation Challenging Certain Health Reforms, 2010 (State Activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nebraska</strong></td>
</tr>
<tr>
<td>LR 289CA by Sen. McCoy - Proposed constitutional amendment stating &quot;no law shall be passed that: (1) Restricts a person’s freedom of choice of private health care systems or private health plans of any type; (2) Interferes with a person’s or an entity’s right to pay directly for lawful medical services; or (3) Imposes a penalty or fine of any type for choosing to obtain or decline health care coverage.&quot; (Filed 1/13/10; postponed indefinitely; did not pass by end of session 4/14/10)</td>
</tr>
<tr>
<td><strong>New Hampshire</strong></td>
</tr>
<tr>
<td>CACR 30 of 2010 by Rep. Renzullo - Would propose a state constitutional amendment to establish a right stating, &quot;People may enter into private contracts with health care providers for health care services and to purchase health care coverage.&quot; Also would prohibit the state legislature from requiring health insurance or imposing any fine or penalty for not having coverage. (Filed 1/6/10; did not pass as &quot;unexpedient to legislate&quot; 2/3/10)</td>
</tr>
<tr>
<td>Also see Financing category below</td>
</tr>
<tr>
<td><strong>New Jersey</strong></td>
</tr>
<tr>
<td>ACR 109 by Assembly member Mchose; SCR 81 by Sen. Doherty - Would propose a state constitutional amendment to prohibit state or federal law or regulation from compelling a person to obtain, provide, or participate in health care coverage. (New Jersey's constitution requires a three-fifths vote in each chamber at one session [2010], or majority vote in each chamber for two successive sessions [for 2012]) (ACR 109: Filed 2/25/10; held in commerce committee as of 7/20/10) (SCR 81: Filed 2/25/10; held in health and human services committee 7/20/10)</td>
</tr>
<tr>
<td><strong>New Mexico (2009)</strong></td>
</tr>
<tr>
<td>SIR 1 of 2009 by Sen. Sharer; HB 10 of 2009 by Rep. Gardner - Proposed constitutional amendment stating, &quot;No law shall be enacted that: A. restricts a person’s freedom of choice of a private health care system or plan; B. interferes with a person’s right to pay directly for lawful medical services; or C. imposes a penalty or fine of any type on a person for choosing to obtain or to decline health care coverage or for participation in a particular health care system or plan.&quot;</td>
</tr>
<tr>
<td><strong>New Mexico (2010)</strong></td>
</tr>
<tr>
<td>HB 18.5 by Rep. Gardner; SIR 2 by Sen. Sharer - Proposed constitutional amendment stating, &quot;No law shall be enacted that: A. restricts a person’s freedom of choice of a private health care system or plan; B. interferes with a person’s right to pay directly for lawful medical services; or C. imposes a penalty or fine of any type on a person for choosing to obtain or to decline health care coverage or for participation in a particular health care system or plan.&quot; (Filed 1/20/10; failed to pass by end of regular session 2/10)</td>
</tr>
<tr>
<td><strong>State Statute placed on voter ballot for approval in August 2010.</strong></td>
</tr>
<tr>
<td><strong>60% both legislative chambers + 2010 ballot vote</strong></td>
</tr>
<tr>
<td><strong>60% both legislative chambers + 2010 ballot vote with 2/3rd popular vote</strong></td>
</tr>
<tr>
<td><strong>50% both legislative chambers + 2010 ballot vote</strong></td>
</tr>
<tr>
<td><strong>Proposed bill, majority vote</strong></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>State</th>
<th>Bill Details</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>SB 1157 by Sen. Forrester. Proposed constitutional amendment stating, &quot;A law or rule shall not compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system. (b) A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services.&quot; (Filed 5/17/10; Did not pass by end of 2010 session)</td>
<td>50% both legislative chambers + 2010 ballot vote</td>
</tr>
<tr>
<td>North Dakota</td>
<td>HCR 3010 by Rep. Kasper (Joint Resolution), a proposed 2010 constitutional amendment based on Arizona language. Would propose an amendment to the State Constitution; relates to freedom of choice in health care; prohibits laws that restrict an individual's choice of private health care systems or private plans, interfere with a person's right to pay for lawful medical services, or impose a penalty or fine for choosing to obtain or decline health care coverage or for participation in any health care system or plan. (Filed 1/14/09, failed to pass House 3/4/09 by end of 2009 session; no regular session in 2010)</td>
<td>50% both legislative chambers + Future year ballot vote</td>
</tr>
<tr>
<td>Ohio</td>
<td>SJR 2 of 2009 by Sen. Coughlin; SJR 7 by Sen. Grendell; HJR 3 by Rep. Maag. Joint resolutions for a proposed constitutional amendment to state, &quot;The people of Ohio have the right to enter into contracts with health care providers ... and to purchase private health care coverage. Would prohibit state laws requiring coverage or imposing fines. For &quot;obtaining or declining&quot; coverage. (SJ 2 filed 2/24/09; held in Senate committee as of 7/20/10) (SJ 7 filed 9/25/09; held in Senate Insurance &amp; Commerce Comm. as of 7/20/10) (HJR 3 filed 8/26/09; sent to Insurance Comm. 9/15/09; carried over to 2010; held in comm. as of 7/20/10)</td>
<td>60% both legislative chambers + 2010 ballot vote</td>
</tr>
<tr>
<td></td>
<td>HB 489; SB 244. Would prohibit requiring an individual to obtain or maintain a policy of health insurance. (Filed 4/14/10; pending; held in original comm. as of 7/20/10)</td>
<td>Proposed statute: majority both legislative chambers</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>HJR 1054 by Rep. Ritz; SJR 56; SJR 59 by Sen. Newberry. Joint resolution for a proposed constitutional amendment stating, &quot;A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system; and A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines&quot; for lack of insurance. HJR 1054 was amended by conference committee; it would enact a statute instead of a constitutional amendment. Also directs the state Attorney General to file a lawsuit against the federal government to prevent legislation regarding federal health insurance; (HJR 1054 filed 12/22/09; passed House 77y-10n, 3/11/10; enacting clause stricken, which nullified effect of the resolution; passed Senate 36y-11n, 3/23/10; Statute version favorable conference committee report, 4/19/10; approved by House 4/28/10; approved by Senate 4/29/10; vetoed by governor; veto overridden by House 5/18/10; veto override did not pass in Senate, 5/21/10) (SJ 59 Conference Comm. report for a separate 2010 constitutional amendment ballot question approved by Senate 5/5/10; approved by House and sent to Secretary of State 5/26/10; will appear on the November 2, 2010 ballot as Question #756)</td>
<td>50% both legislative chambers + 2010 ballot vote</td>
</tr>
<tr>
<td></td>
<td>SJR 58 by Sen. Coffee. Petitions the federal government to opt-out of certain mandates; and for certain waivers and block grants. (Filed 2/1/10; passed Senate 35y-11n, 2/22/10; did not pass by end of session 5/28/10)</td>
<td>Non-binding resolutions</td>
</tr>
<tr>
<td></td>
<td>SJR 64. Directs the Attorney General to file a lawsuit against the federal government to prevent legislation regarding federal health insurance; directs distribution. (Filed 2/1/10; passed Senate 29y-16n, 2/24/10; did not pass by end of session</td>
<td></td>
</tr>
<tr>
<td>State Legislation Challenging Certain Health Reforms, 2010 (State Activity)</td>
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<tr>
<td><strong>5/28/10</strong></td>
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<tr>
<td>Pennsylvania HB 2052 by Rep. Baker Proposed statute &quot;providing for the rights of individuals to purchase private health care insurance and prohibiting certain governmental action.&quot; States, &quot;The people shall have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The legislature may not require any individual to participate in any health care system or plan, nor may it impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.&quot; (Filed and sent to Insurance Committee, 10/21/09; no floor vote in 2009; pending; held in committee with no action as of 7/20/10) Proposed statute: majority both legislative chambers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhode Island S 2544 and S 2242 by Sen. Blais Would provide that no law would restrict a person's ability to contract with, pay for, and/or otherwise select a private health care system or private plan of that person's choosing; would take effect upon passage. (Filed and sent to committee 2/11/10; committee &quot;held for further study&quot;; did not pass by end of 2010 session 4/28/10) Proposed statute: majority both legislative chambers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Carolina HJR 4181 by Rep. Scott; HJR 4240 by Rep. Duncan; HJR 4602 by Rep. Viers; SIR 980 by Sen. Bright; SIR 1010 by Sen. Rose. Resolution for a proposed constitutional amendment, &quot;prohibiting any law, regulation, or rule to compel an individual, employer, or health care provider to participate in a health care system, by allowing individuals and employers to pay directly for lawful health care services without penalties or fines for these direct payments, by providing that the purchase or sale of health insurance in private health care systems must not be prohibited by law, regulation, or rule.&quot; The resolution title states, &quot;... to preempt any federal law or rule that restricts a person's choice of private health care providers or the right to pay for medical services.&quot; (HJR 4181 filed for 2010 session; sent to Committee on Labor, Commerce and Industry, 11/17/09; held/pending 5/31/10; session adjourned without further action 6/3/10; state wide session to be held 6/15/10) (SJR 980 and SIR 1010 filed; sent to Senate Judiciary Committee 1/12/10; favorable report 3/30/10; session adjourned without further action 6/3/10; state wide session to be held 6/15/10) SB 987 by Sen. Rose. By statute would provide that citizens &quot;have right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The General Assembly may not require a person to participate in any health care system or plan and may not impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.&quot; (Favorable Senate Judiciary Committee report 3/31/10; held/pending 5/31/10; session adjourned without further action 6/3/10; state wide session to be held 6/15/10) Proposed statute: majority both legislative chambers + 2012 ballot vote</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCR 424 by Sen. Bright Senate concurrent resolution referencing state sovereignty under 9th and 10th Amendments. Resolves &quot;that it is the policy of the State&quot; that &quot;no law shall interfere with the right of a person to be treated by or receive services from a health care provider of that person's choice; no law shall restrict a person's freedom of choice of private health care systems or private health care plans of any type; no law shall interfere with a person's or an entity's right to pay directly for lawful medical services; and no law shall impose a tax, penalty, or fine, of any type, for choosing a health care provider.&quot; States that &quot;the Attorney General will challenge constitutionality of any provision adopted by U.S. Congress&quot; that violates these policies; also &quot;no state agency, agent, department, instrumentality, or subdivision shall cooperate or participate in any way with any mandate passed by U.S. Congress&quot; if a court challenge is filed. (Adopted by Senate and House with amendments, 3/9/10) Proposed statute: resolution; majority vote; no signature needed</td>
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<table>
<thead>
<tr>
<th>State</th>
<th>Proposal</th>
<th>Description</th>
<th>Outcome</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>South Dakota</strong></td>
<td>HJR 1001 by Rep. Jensen</td>
<td>Resolution for a proposed constitutional amendment, stating &quot;The Legislature may not enact a law that restricts an individual's freedom of choice of private health care systems or private plans of any type; a law that interferes with a person's right to pay directly for lawful medical services; or a law that imposes a penalty or fine of any type for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.&quot; (Filed 1/28/10; sent to committees 2/10/10; did not pass committee &quot;deferred&quot; past end of session, 2/18/10)</td>
<td>50% both legislative chambers + 2010 ballot vote</td>
<td>Non-binding resolution</td>
</tr>
<tr>
<td><strong>Utah</strong></td>
<td>H 67 for 2010 session by Rep. Wimmer</td>
<td>Amends statute provisions related to the state's strategic plan for health system reform to respond to federal reform efforts; prohibits a state agency or department from implementing any provision of the federal health care reform without first reporting to the Legislature: 1) whether the federal act compels the state to adopt the particular federal provision; 2) consequences to the state if the state refuses to adopt the particular federal provision; and 3) impact to the citizens of the state if reform efforts are implemented or not implemented; 4) would require any agency of the state not to implement any part of federal health care reform passed by the US Congress after March 1, 2010, unless the department or agency reports to the Legislature and the Legislature passes legislation &quot;specifically authorizing the state's compliance or participation in, federal health care reform.&quot; (Passed House amended; 53y-20n, 2/11/10; passed Senate 22y-7n; signed into law by governor 3/23/10) News articles 4, 7</td>
<td>Statute: majority both legislative chambers</td>
<td></td>
</tr>
<tr>
<td><strong>South Dakota</strong></td>
<td>HCR 8 by Rep. Clark</td>
<td>Urges Congress to refuse to pass any health care legislation that contains certain provisions, urges Congress to pass health care legislation with specific provisions, and urges Congress, should it pass health reform legislation that further restricts states, to grandfather certain state laws, regulations, and practices. (Filed 1/25/10; signed into law by governor, 3/22/10)</td>
<td>Non-binding resolution</td>
<td></td>
</tr>
<tr>
<td><strong>South Dakota</strong></td>
<td>HR 11 by Rep. Morley</td>
<td>Urges the United States Congress to refrain from passing certain federal health insurance reforms.</td>
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### Virginia

**HJ 7 by Del. Marshall**

Resolution for a proposed constitutional amendment, to protect "an individual's right and power to participate or to decline to participate in a health care system or plan; prohibiting any law that will infringe on an individual's right to pay for lawful medical services and prohibiting the adoption of any law that imposes a penalty, tax, or fine upon an individual who declines to enter into a contract for health care coverage or to participate in a health care system or plan."

*(Filed for 2010 and sent to committee 12/9/09; did not pass)* [Also see bills below]


Amends state law by adding a section, "Health insurance coverage not required. No resident of this Commonwealth, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the Commonwealth or the federal government, shall be required to obtain or maintain a policy of individual insurance coverage. No provision of this title shall render a resident of this Commonwealth liable for any penalty, assessment, fee, or fine as a result of his failure to procure or obtain health insurance coverage." It does not apply to Medicaid and CHIP coverage.

*(Filed for 2010 session 1/13/10; SB 283, SB 311 and SB 417 passed Senate 23y-17n, 2/1/10; passed House 67y-29n, 2/12/10; sent to governor; amended and repassed Senate 3/4/10; repassed House; became law 3/10/10)*

*Under Virginia law, the Governor exercised his option to return the bill to the legislature with a formal recommended amendment. Both branches of the legislature voted to accept the Governor’s recommendation, at which point the bills became law without requiring the Governor’s signature.*


### Washington

**HB 2669 by Rep. Hinkle; SB 6535 by Sen. Holmquist**

Would amend state law by adding a provision that the state "shall not directly or indirectly compel any person, employer, or health care provider to participate in any health care system." and that "A person or employer may pay directly for lawful health care services and shall not be required to pay any penalty, fine, or other sanction for paying directly for lawful health care services.

*(Filed & sent to Health & Wellness Comm. 1/12/2010; did not pass by end of regular session; reintroduced in 1st Special Session 3/15/10; final day 4/13/10)*

### West Virginia (2009)

**H 3002 by Rep. J. Miller**

The "Health Care Freedom Act" states, "The people have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The Legislature may not require any person to participate in any health care system or plan, nor may it impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan."

*(Filed 3/9/09; failed to pass by end of session; cannot carry over to 2010)*

### West Virginia (2010)

**HJR 103 by Rep. J. Miller**

A proposed 2010 Constitutional amendment prohibiting compulsory purchases in healthcare and providing choice and in payment for health services.

*(Filed 2/5/10; motion to discharge postponed 2/25/10; did not pass committee by deadline - end of session. 3/19/10)*

2/3rds Vote in both legislative chambers

*2010 ballot vote*
State Legislation Challenging Certain Health Reforms, 2010 (State Activity)

Wisconsin

SJR 62 by Sen. Leibham; AJR 138
A proposed 2012 Constitutional amendment; would establish the "right of the people to contract privately for health care services and health care coverage, and prohibiting requiring a person to obtain or maintain" health coverage.
(Filed 2/22/10; did not pass committee by 2010 session deadline 4/28/10)

50% both legislative chambers
+ 2012 ballot vote

2/3 both legislative chambers
+ 2010 ballot vote

Wyoming (2009)

SJR 3, by Sen. Pres. Hines
A proposed 2010 Constitutional amendment based on Arizona language, "that protects individuals, employers and health care providers from having to participate in any health care system." Provides for "freedom of choice in health care; prohibits laws interfering with freedom of choice in health care"
(Filed 1/20/09; died in Senate committee 3/3/09; no carryover)

Wyoming (2010)

Resolution for a proposed 2010 constitutional amendment for "Health freedom of choice," stating, "the federal government shall not interfere with an individual's health care decisions." Also would call for "prohibiting any penalty, fine or tax imposed because of a decision to participate in or decline health insurance, or to pay directly or receive payment directly for health care services."
(Filed 1/26/10; did not pass Introduction 18y-12n, 2/9/10; HJ 12 did not pass introduction 38y-19n, 2/10/2010) [news article]

SB 49 by Sen. Jennings
Resolution would direct the attorney general to investigate the state and federal constitutional effects of federal health care or health insurance reform legislation; requiring a report within 60 days of any future federal enactment; providing for the attorney general to seek legal remedies.
(Filed 2/3/10; did not pass introduction requirement, 18y-12n, 2/9/10)

States Opposing Health Reform Financing and Unfunded Mandates

<table>
<thead>
<tr>
<th>State</th>
<th>Activity/Legislation</th>
<th>Required for Passage</th>
</tr>
</thead>
</table>
| Arizona | HCM 2002; SCM 1001
Relates to Medicaid; urges Congress to ensure that any federal health care reform legislation has a minimal fiscal impact on the states. (Filed 1/15/10; favorable report 3/17/10; did not pass by end of session) | Non-binding resolutions |
| Illinois | HR 107 by Rep. Bellock
Would request that the IL Commission on Government Forecasting and Accountability examine the provisions of the federal health care reform law to determine the fiscal impact of the provisions on the state budget, with a report due July 1, 2010 for use with the FY1011 budget. (Filed and sent to Rules Committee, 3/26/10; held in comm. as of 9/7/10) | Non-binding resolutions |
| Iowa    | SB 2097
Would affirm the intent of the General Assembly to exercise those powers reserved to the states; includes but not limited to providing state-based regulation of the health insurance market; provides aggressive oversight of this market; enforces consumer protection and a local, responsive presence for consumers. (Filed; sent to Senate Committee on Judiciary 1/27/10; did not pass by end of session 4/10) | |
| Michigan| SR 106 by Sen. George
Memorializes the President, the Congress, and the Secretary of HHS to remove provisions from the final version of the federal health care reform legislation that would increase financial obligations for states, whether through expanded Medicaid requirements or other mandates. (Filed; Adopted by Senate 1/16/10) | Non-binding resolutions |
| New     | SB 417 by Sen. Bradley
Would amend state law to prohibit the expansion of the Medicaid program if Congress passes a national health insurance plan unless the expansion is approved by the NH | Proposed statute: majority both |

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61
Can Congress compel Americans to engage in specific commercial transactions?

In early April 13 state attorneys general filed a lawsuit seeking to repeal health care reform in federal court in Florida; by June a total of at least 20 states had some role in support of this legal challenge. Virginia Attorney General Ken Cuccinelli is pursuing a similar suit in his home state. The cases center on health care reform's mandate that Americans, starting in 2014, purchase insurance. If they don't, they will stand to pay a fine of $750, or 2 percent of their income, whichever is greater.

On April 6th, the Thomas More Law Center asked the U.S. District Court for the Eastern District of Michigan (Case No. 2:10-cv-11156-GCS-RSW) for a preliminary injunction preventing the implementation of the health care reform provision that would require all Americans to purchase health insurance.

The Center, in its motion for preliminary injunction, claimed that health care reform, particularly the individual mandate, "represents an unprecedented encroachment on the liberty of all Americans, including plaintiffs, by imposing unprecedented governmental mandates that restrict their personal and economic freedoms in violation of the Constitution." Read more:


As of mid-August 2010 there are three distinct federal court challenges:


[Additional links and resources provided]

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Constitutional Issues and the Patient Protection and Affordable Care Act Session

NCSL's Legislative Summit 2010, July 27, 2010 — Louisville, Kentucky

Since passage of the federal health reform laws in March, questions have been raised about the constitutionality of some key provisions, including the requirement that most people have health insurance and the expansion of who is entitled to Medicaid. Explore and discuss these key constitutional questions and review pending challenges to the new laws.

Speaker: James Blumstein, Vanderbilt University School of Law, Tennessee - State Challenges to Health Reform: A Look At The Constitutional Issues (©18-page PDF File)
Table 3
Examples of states with reported interest or pre-legislative steps toward a proposed constitutional amendment or statute.

<table>
<thead>
<tr>
<th>State</th>
<th>Action and Context</th>
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</thead>
<tbody>
<tr>
<td>Montana</td>
<td>5 (next regular session in 2011)</td>
</tr>
<tr>
<td>Texas</td>
<td>SOURCE (next regular session in 2011)</td>
</tr>
</tbody>
</table>

Recent News and Articles

- "Another Health-Care Obstacle Awaits in States" - article; includes NC SL citation. Wall Street Journal, 1/20/2010.
- Virginia "Bill stating that no one can be forced to buy health insurance advanced." The Roanoke Times, 1/26/2010.
- "States Look to Forstall Hypothetical Mandate" - article; includes NC SL citation. NY Times, 2/8/2010.
- "Bill to tell feds to back off health care fails in Wyo Senate" - Cowboy State Free Press (WY), 2/9/2010.
- MO: Missouri House sends to Senate plan for voiding federal requirement to buy health insurance - Kansas City Star.
- The Missouri House on Tuesday gave final approval to a proposed state constitutional amendment that would attempt to nullify a possible federal mandate to purchase health insurance, 3/16/2010.
- Legal Challenges to Health Reform - An Alliance for Health Reform Toolkit by Kevin Arts. March 29, 2010 - [www.allhealth.org](http://www.allhealth.org)
- Health Reform Challenges Continue from Many States - PBS VIDEO 4/1/10 (13 1/2 minutes).
- Efforts to Halt Health Reform: Playing Politics with Our Health "counters the misinformation that is being spread by opponents of reform, particularly regarding the individual responsibility requirement". Families USA, 4/10.
- Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis - Report by the Congressional Research Service (CRS), 5/7/10.
- Florida: Suit on Health Care Bill Appears Likely to Advance - federal judge says he will rule on challenge to the new health care law within a month - 9/15/2010.

APPENDIX 1 - The Arizona Proposed Constitutional Amendment

Engrossed (Full Text)

HOUSE CONCURRENT RESOLUTION 2014

A CONCURRENT RESOLUTION
PROPOSING AN AMENDMENT TO THE CONSTITUTION OF ARIZONA; AMENDING ARTICLE XXVII, BY ADDING SECTION 2, CONSTITUTION OF ARIZONA; RELATING TO HEALTH CARE SERVICES.

Be it resolved by the House of Representatives of the State of Arizona, the Senate concurring:

http://www.ncsl.org/?tabid=18906
1. Article XXVII, Constitution of Arizona, is proposed to be amended by adding section 2 as follows if approved by the voters and on proclamation of the Governor:

2. Health care; definitions

section 2. A. To preserve the freedom of Arizonans to provide for their health care:

1. A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system.
2. A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.

B. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

C. This section does not:

1. Affect which health care services a health care provider or hospital is required to perform or provide.
2. Affect which health care services are permitted by law.
3. Prohibit care provided pursuant to article XVIII, section 3 of this constitution or any statutes enacted by the legislature relating to worker's compensation.
5. Affect the terms or conditions of any health care system to the extent that those terms and conditions do not have the effect of punishing a person or employer for paying directly for lawful health care services or a health care provider or hospital for accepting direct payment from a person or employer for lawful health care services.

D. For the purposes of this section:

1. "compel" includes penalties or fines.
2. "direct payment or 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.
3. "health care system" means any public or private entity whose function or purpose is the management of, processing of, enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants.
4. "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 that may be provided by persons or businesses otherwise permitted to offer such services.
5. "penalties or fines" means any civil or criminal penalty or 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 section.

2. The article heading of article XXVII, Constitution of Arizona, is proposed to be changed as follows if approved by the voters and on proclamation of the Governor:

The article heading of article XXVII, Constitution of Arizona, is changed from "REGULATION OF PUBLIC HEALTH, SAFETY AND WELFARE" to "REGULATION OF HEALTH, SAFETY AND WELFARE".

3. The Secretary of State shall submit this proposition to the voters at the next general election as provided by article XXI, Constitution of Arizona.

Arizona 2008 History/Action: In 2008, Arizona Proposition 101 appeared on the ballot, referred to by proponents as the "Freedom of Choice in Health Care Act." If it had passed, it would have added the following language to the Arizona Constitution: "Because all people should have the right to make decisions about their health care, no law shall be passed that restricts a person's freedom of choice of private health care systems or private plans of any type. No law shall interfere with a person's or entity's right to pay directly for lawful medical services, nor shall any law impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan." Proposition 101 failed to pass by a vote of 1,048,512 in favor and 1,057,199 opposed, a difference of 8,687 votes. Arizona's Proposition 101 language from 2008 has served as the basis for 2009 legislative language drafted by the American Legislative Exchange Council (ALEC).

Arizona Opinions: ALEC article: "Arizona Poised to Block Single-Payer Health Care"
http://www.alec.org/am/pdf/Inside+July+09+pdf

The 2009 legislative resolution was approved "along party lines." "I certainly would expect it would go to the courts as a states' rights issue," says Bert Coleman, manager of the Arizona campaign. Coleman adds that proponents of the efforts

http://www.ncsl.org/?tabid=18906

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chose to go through the legislative route rather than a much slower citizen petition (as in 2008) process in order to be part of the ongoing discussion over health reform. "We wanted to be part of the debate now," Coleman stated to Inside Health Policy. "Will it influence the debate? I certainly hope so."

APPENDIX 2:
Some Legal and Legislative Opinions on Anti-Reform State Actions

- Rep. Nancy Barto, chairwoman of the Arizona House's Health and Human Services Committee, sponsored the bill that led to the ballot referendum. Her basic argument is that "there is no place for government between someone and their doctor," said Becky Blackburn, communications director for the Republican Caucus of the Arizona House of Representatives.

- Rep. Linda Upmeyer, Iowa State Representative and the chair of ALEC's Health and Human Services Task Force stated, "Federal health care reform efforts may include a requirement that individuals purchase health insurance, and a so-called 'public option' could result in fewer choices for consumers and new government mandates."

- Thomas Miller, resident fellow at the American Enterprise Institute, stated that lawsuits are likely to challenge the mandate as an unprecedented violation of inherent individual rights under the U.S. Constitution in enforcing the purchase of a product "with no other reason other than the fact that you are just living in the country. "There's no clear Supreme Court precedent suggesting that this is going to be overturned constitutionally," he said. However, "give me the right to justice and anything's possible. Enforce it in a particularly onerous, all-encompassing, unfair manner and then it's more politically viable for judges to have problems with the way it comes out."

The New York Times cited several legal experts who said "they saw little room for such a challenge:"  
- Mark A. Hall, professor of law and public health at Wake Forest University, says states don’t have the power to override or "opt out" of, or not participate in the mandate. The debate is "a flash in a pan" set off by libertarians who say "Washington, D.C. shouldn't be telling us what to do," he said. "There is no way this challenge will succeed in court," adding that the state measures seem more "an act of defiance, a form of civil disobedience if you will." He has studied the constitutionality of mandates that people buy health insurance, for The O'Neill Institute at Georgetown University.

- Timothy Stoltzfus Jost, a health law expert at Washington and Lee University School of Law, concludes that "States can no more nullify a federal law like this than they could nullify the civil rights laws by adopting constitutional amendments." In March 2010, he added, "State law cannot nullify federal law. This principle is simply beyond debate, and state legislators, many of them lawyers, know that," writes Jost in the New England Journal of Medicine. "The purpose of these laws, therefore, is not legal but rather political. Should health reform pass, the state bills "can thus be seen as invitations to civil disobedience that counsel state citizens to 'violate the federal law, wave this statute in their face, and dare them to come after you,'" says Jost.

- Randy E. Barnett, a Georgetown law school professor who has written about what he views as legitimate constitutional questions about health insurance mandates, seemed doubtful. "While using federal power to force individuals to buy private insurance raises serious constitutional questions," Professor Barnett said, "I just don't see what these state resolutions add to the constitutional objections to this expansion of federal power."

- Stuart Taylor Jr. wrote, in "Health Law Not A Sure Bet In Court," ... But A Decision In Its Favor Is Still The Best Bet. What chances of success await the lawsuits challenging the constitutionality of the new health insurance reform law filed by 14 state attorneys general this week, with more lawsuits by states, individuals, and companies in the pipeline?

Not much, according to most of the academic experts who have weighed in. They confidently predict that the Supreme Court will (if the case gets that far) uphold the new law's major provisions. These include the much-debated mandate for individuals to buy comprehensive health insurance unless they're already covered by employer-based plans, and also the requirement that states spend billions of dollars expanding their Medicaid programs (unless they withdraw) and administering the complex new law. These experts cite the justices' very broad reading since the New Deal of Congress' powers to regulate interstate commerce and to tax and spend. -National Journal, 3/26/2010

- Wendy K. Mariner, J.D., M.P.H., and George J. Annas, J.D., M.P.H., Boston Univ. School of Public Health published the following, Health Insurance Policy in Federal Court in NEDM, August 25, 2010 (c) 2010 NEDM. Excerpts--

"Having been outmaneuvered in Congress with the passage of the Patient Protection and Affordable Care Act ("Affordable Care Act," or ACA), Republicans have taken their case to federal court, arguing that the law's key provision, the individual mandate to purchase health insurance, is unconstitutional. This argument has been made most prominently by attorneys general from 20 states in a Florida federal court and by the Commonwealth of Virginia in a Virginia federal court. In early August, federal district court judge Henry Hudson decided that the Virginia challenge deserves a hearing, thereby giving the constitutional argument an aura of respectability and ensuring that we'll hear more about the meaning of states' rights in the context of the Constitution's Commerce Clause (which grants Congress the authority to regulate interstate commerce), both in court and on the campaign trail.

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The states have inherent (police) powers authorizing them to regulate residents' inactivity — to require residents, for example, to get vaccinations and even to purchase health insurance, as Massachusetts does. The federal government's powers are limited to those listed in the Constitution, but the reach of the Commerce Clause has necessarily expanded with the national economy. Virginia argues that if Congress can regulate inactivity that affects interstate commerce like insurance and health care, then there is no practical limit to federal regulation and Congress will usurp the state's police powers.

The fundamental legal problem is whether, if the federal government can penalize individuals for refusing to purchase health insurance, there is any principle that would limit the power of the federal government to penalize the failure to purchase other products, such as a daily newspaper to save the newspaper business from extinction. The federal government's answer is that people simply cannot choose "to avoid participation in the health care market." Rather, "it is inevitable ... that every person — today or in the future — healthy or otherwise — will require medical care," and the ACA provides a dependable, affordable mechanism to pay for such care.

This answer may offer a limiting principle that distinguishes the ACA from a hypothetical penalty for not buying newspapers. There are few nondiscretionary national markets in which virtually all Americans inevitably participate. Congress could not require all Americans to buy cars from Detroit in order to shore up the automobile industry; not everyone needs a car. On the other hand, perhaps the federal government could justify penalizing individuals for not buying an apple a day or for not buying a gym membership or multivitamins, at least if these purchases are seen as integral parts of containing costs in a national health insurance market, because people who don't make these purchases increase health care costs for all of us.

We think that the federal government has the more realistic view of how the national economy functions and how the Constitution should function today. Nonetheless, the outcome in the federal courts is far from certain and will ultimately be decided by the Supreme Court, which is just as ideologically fractured as the Congress that passed this law. Other clearly constitutional approaches were available, including Medicare for All, or simply raising the income or payroll tax to pay for health benefits, but these would have been even more objectionable to those who are raising Commerce Clause problems with the ACA.

Judge Hudson's next decision, this fall, will be on the merits of the case, and as he recognizes, his decision will be appealed no matter how he rules. But health care politics will not be put on hold while we await judicial resolution, which could take years. Without mentioning the Commerce Clause or health care, many politicians will campaign on the argument that the federal government is too big, is too intrusive into our individual lives, and spends too much money. In this debate, the ACA will be exhibit number one. (10.1056/NEJMp1009054) was published on August 25, 2010, at NEJM.org.

Ruth Marcus, a legal analyst writing for the Washington Post (November 26, 2009), "Constitution no bar to health reform," seeks to make a detailed case that the latest federal proposals are constitutional. She stated,

"Is Congress going through the ordeal of trying to enact health-care reform only to have one of the main pillars — requiring individuals to obtain insurance — declared unconstitutional? An interesting debate for a constitutional law seminar. In the real world, not a big worry. ... it's worth explaining where the Constitution grants Congress the authority to impose an individual mandate. There are two short answers: the power to regulate interstate commerce and the power to tax. The (Commerce) clause empowers Congress "to regulate commerce ... among the several states," which may not sound terribly far-reaching. But since the New Deal, the Supreme Court has interpreted this authority to cover local activities with national implications.

... But the individual mandate is central to the larger effort to reform the insurance market. Congress may not be empowered to order everyone to go shopping to boost the economy. Yet health insurance is so central to health care, and the individual mandate so entwined with the effort to reform the system, that this seems like a different, perhaps unique, case. Congress clearly has authority to, in effect, require employees to purchase health Insurance for their old age by imposing a payroll tax to fund Medicare.

The individual mandate is to be administered through the tax code: On their forms, taxpayers will have to submit evidence of adequate insurance or, unless they qualify for a hardship exemption, pay a penalty. See full text online.

Sources: NCSL provides links or references to third-party articles and information as a convenience. NCSL is not responsible for the accuracy or completeness of such material.

[1] American Legislative Exchange Council (ALEC) as quoted in article of August 12, 2009 and NCSL interview with Christie Herrera, ALEC Health Director, August 17, 2009.


http://www.ncsl.org/?tabid=18906
State Legislation Challenging Certain Health Reforms, 2010 (State Activity)


APPENDIX 3:
Number of Sessions During Which Legislative Enactment Is Required

In the following 35 states, the legislature enacts a proposed constitutional amendment during only one session.

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In the following 12 states, the legislature must enact a proposed constitutional amendment during two sessions.

| Delaware ** | Nevada | Tennessee |
| Delaware | New York | Vermont |
| Iowa | Pennsylvania | Virginia |
| Massachusetts | South Carolina | Wisconsin |

** Delaware does not require a public vote once a proposed amendment passes two consecutive sessions by a 2/3 vote.

In the following three states, the vote total determines the number of sessions during which a proposed constitutional amendment must be enacted.

| Connecticut | New Jersey | Hawaii |

Source for Appendix 3: Brenda Erickson, NCSL Legislative Management memorandum, 2009.
BILL ANALYSIS

AB 1602

Date of Hearing: April 22, 2010

ASSEMBLY COMMITTEE ON HEALTH
William W. Monning, Chair
AB 1602 (John A. Pérez) - As Amended: April 15, 2010

SUMMARY: Amends the California Patient Protection and Affordable Care Act to implement reforms under the federal Patient Protection and Affordable Care Act (Affordable Care Act) in California. As such, prohibits group or individual health care service plans or health insurers (collectively carriers) from establishing lifetime or unreasonable annual limits on the dollar value of benefits. Requires carriers to provide minimum coverage for specified preventive services. Prohibits carriers from imposing preexisting condition exclusions for enrollees or insureds under 19 years of age. Prohibits the limiting age for dependent health care coverage to be less than 26 years of age. Creates the California Health Benefit Exchange (Exchange) for the purchase of health care coverage. Specifically, this bill:

Lifetime limits

1) Prohibits carriers, effective September 23, 2010, from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary, with respect to plan years prior to January 1, 2014, pursuant to a group or individual health care service plan contract, after September 23, 2010, to only establish a restricted annual limit for the scope of benefits that are “essential health benefits” under the Affordable Care Act, with prior approval from the United States Secretary of Health and Human Services.

Minimum Coverage for Preventive Services

2) Requires carriers, effective September 23, 2010 and subject to the minimum interval established by DHHS Secretary pursuant to the federal Affordable Care Act, to provide coverage, without any cost-sharing requirements, for:
   a) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.
   b) Evidence-informed preventive care and screenings for infants, children, adolescents, and women provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration and other services that meet federal standards, as specified.

Prohibition against Pre-existing Conditions

3) Prohibits anything in this bill from being construed to prohibit a plan from excluding coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended.

Dependent Coverage

4) Prohibits health plans, effective September 23, 2010, from imposing any preexisting condition exclusion with respect to coverage under the plan of any enrollee under 19 years of age.

5) Exempts health plan contracts or health insurance policies that are not required to provide essential health benefits, as defined, from this provision.

http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_cfa_20100419_093...
employment contracts subject to collective bargaining that are effective prior to September 23, 2010 from this provision.

The Exchange

9) Creates the Exchange, governed by an executive board consisting of an unspecified number of members, to be appointed by the Governor, the Senate Committee on Rules, and

the Speaker of the Assembly. Requires the board to be responsible for using the funds awarded by sum for the planning and establishment of the Exchange.

10) Requires the board to, at a minimum:

a) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by DHCS, of health plans as qualified health plans;

b) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

c) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

d) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary;

e) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under the Federal Patient Protection and Affordable Care Act;

f) Inform individuals of eligibility requirements for the Medi-Cal Program, the Healthy Families Program, or any applicable state or local public program, and if through screening of the application, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

g) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost sharing reduction, as specified.

b) Grant a certification attesting that, for purposes of the individual responsibility penalty under existing federal law, an individual is exempt from the individual requirement or from the penalty imposed because:

1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

2) The individual meets the requirements for any other such exception from the individual responsibility requirement or penalty;

3) Transfer specified information to the Secretary of the Treasury; and

4) Provide to each employer the name of each employee who ceased coverage under a qualified health plan during a plan year (and the effective date of such cessation);

11) Permits the board, consistent with the standards, regulations, and rules promulgated by DHCS, to:

a) Determine eligibility, enrollment, and disenrollment criteria and procedures for enrollees and potential enrollees in the Exchange;

b) Determine participation requirements, standards, and selection criteria for qualified health plans, including reasonable limits on a plan's administrative costs;

c) Determine when an enrollee's coverage commences and the
extent and scope of coverage;

d) Determine premium schedules, collect the premiums, and
administer subsidies to eligible enrollees and rates paid
to participating plans;

e) Determine rates paid to qualified health plans;

f) Provide for the processing of applications and the
enrollment and disenrollment of enrollees;

g) Determine and approve the cost-sharing provisions for
qualified health plans;

h) Conduct various administrative functions;

i) Maintain enrollment and expenditures to ensure that
expenditures do not exceed the amount of revenues in the
fund, and if sufficient revenue is not available to pay
estimated expenditures, institute appropriate measures to
ensure fiscal solvency; and,

j) Share information with the Employment Development
Department for the purpose of the administration and
enforcement of the Exchange.

10) Requires the Exchange to facilitate the purchase of qualified

California Health Trust Fund

13) Creates the California Health Trust Fund (Fund) in the State
Treasury for the purpose of this bill. Requires all moneys in
the Fund to be continuously appropriated without regard to
fiscal year and permits any unexpended or unencumbered moneys
in the Fund to be carried forward.

14) Requires the board to establish and maintain a prudent
reserve in the Fund.

Fiscal Effect: This bill has not been analyzed by a fiscal
committee.

Purpose of this Bill. According to the author, given the
recent passage of the Affordable Care Act, California must
begin the important task of implementing federal law. Several
of the federal health reform provisions take effect this year,
including the change in the limiting age, the ban on lifetime
limits, and the end of pre-existing condition exclusions for
children. This bill is a necessary first step towards
enacting these important insurance market reforms.

Additionally, federal health reform makes the states with
establishing the new, organized marketplaces where individuals
and small businesses can more readily identify and compare
coverage choices, purchase value based coverage, and access
premum credits and cost sharing subsidies. This bill
establishes the California Health Benefit Exchange to make
these key changes, and sets in motion the necessary duties to
ensure California can quickly use the federal planning dollars
and commence operations by January 1, 2014.

2) FEDERAL HEALTH CARE REFORM . On March 23, 2010, President
Obama signed the Affordable Care Act, P. L. 111-148, as
amended by the Health Care and Education Reconciliation Act of
2010, P. L. 111-152. Among other provisions, the new law
makes statutory changes affecting the regulation of and
payment for certain types of private health insurance. There
are a number of health insurance provisions that will take
effect in 2010, including those related to this bill:

Young Adults on Parents’ Health Plans. Young adults may stay
on their parents’ health plans to age 26, effective September
2010. The provision applies to all health plans, and does not
exclude young adults who are married.

Prohibition on Preexisting Condition Exclusions for Children.
Insurers are prohibited from excluding coverage of preexisting
conditions for children in the individual market, effective
six months after enactment. According to a March 28, 2010 New
York Times news article, just days after the President signed
the Affordable Care Act, there was a dispute over the language
in the law regarding the pre-existing conditions coverage
provisions. The New York Times article stated that while
insurers agreed that health insurance carriers offering
individual or group coverage were unable to impose preexisting
condition exclusions beginning in September, insurers
initially disagreed that the law required them to write
insurance at all for the child or family, providing what they
call in the insurance world “guaranteed issue” until 2014.

The Secretary of DHHS issued clarification in a letter to the
president of America’s Health Insurance Plans (AHIP) stating
that, “To ensure that there is no ambiguity on this point, I
am preparing to issue regulations in weeks ahead ensuring that
the pre-existing condition exclusion applies to both a child’s
access to a plan and his or her benefits once he or she is in
the plan.” The Secretary further noted that regulations would
make clear that by September, “children with pre-existing
conditions may not be denied access to their parent’s health
insurance plans.” In response, AHIP’s president wrote to
the Secretary that AHIP would accept the clarification of the new
law and fully comply with it.

Prohibitions Against Lifetime Benefit Caps. Group health
plans or insurance companies providing group or individual
market coverage are prohibited from setting lifetime limits on
the dollar value of benefits and from setting unreasonable
annual limits on the dollar value of benefits, effective six
months after enactment. Annual limits will be based
completely in 2014.

3) STATE INSURANCE EXCHANGES - Each state is required to establish
an American Health Benefit Exchange and a Small Business
Health Options Program Exchange by 2014 for individuals
and small employers with 50 to 100 employees; after 2017, states
have the option of opening the small business exchange to
employers with more than 100 employees. States can opt to
provide a single exchange for individuals and small employers.
Groups of states can form regional exchanges or states can
form more than one in-state exchange, but the exchanges must
serve a geographically distinct area. While the individual
and small-group markets will not be replaced by the exchanges,
the same market rules will apply inside and outside the
exchanges. Premium subsidies can be used only for plans
purchased through the exchanges. If DHHS determines in 2013
that a state will not have an exchange operational by 2014,
DHHS is required to establish and operate an exchange in the
state. In 2018, states will have the opportunity to opt out
of the federal requirements to establish insurance exchanges
through a five-year waiver, if they are able to demonstrate
that they can offer all residents coverage at least as
comprehensive and affordable as that required by this bill.

http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_cfa_20100419_093...
Federal responsibilities. HHSC responsibilities with respect to the exchanges include: establishing certification criteria for "qualified health plans" that will be sold through the exchanges; requiring such plans to provide the essential benefits package, requiring that the licensed insurance carriers issuing plans offer at least one qualified health plan at the silver and gold levels and meet marketing requirements; ensuring a sufficient choice of providers; and, ensuring that essential community providers are included in networks, are accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures. In addition, the Secretary will develop a rating system for qualified health plans and a model template for an exchange’s Internet portal, and determine an initial and open enrollment period as well as special enrollment periods for people under varying circumstances. The Secretary is also required to establish procedures under which states may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for subsidies. Such procedures may include the establishment of rate schedules for broker commissions paid by health plans offered through the exchange.

State responsibilities. The state exchanges will be required to certify qualified health plans, operate a toll-free hotline and web site, rate qualified health plans, present plan options in a standard format, inform individuals of the eligibility requirements for Medicaid and the Children’s Health Insurance Program, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual requirement to have health insurance. Exchanges will be required to be self-sustaining by 2015 and will be allowed to charge assessments or user fees to participating health insurance issuers or otherwise generate funding to support their operations. The exchanges also will award grants to "navigators" who will educate the public about qualified health plans, distribute information on enrollment and subsidies, facilitate enrollment, and provide referrals or referrals. Navigators may include trade and professional organizations, farming and commercial fishing organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, or licensed insurance agents or brokers.

Qualified employers purchasing through the exchange. Employers that are qualified to offer coverage to their employees through the exchange may provide premium support for a level of coverage (bronze, silver, gold, platinum) and employers may choose a plan within the designated level.

HEALTHY LIVING - There are a number of bills related to the implementation of federal health care reform in California:

AB 1595 (Jones) commencing January 1, 2014, to the extent required by the Affordable Care Act, requires persons who meets all other applicable eligibility requirements to be eligible for benefits under the Medi-Cal program if his or her income does not exceed 150% of the federal poverty level. AB 1595 is set for hearing on April 30, 2013 in the Assembly Health Committee.

AB 1887 (Villines) establishes the state temporary high risk pool program in order to be eligible for high risk pool funds under the Affordable Care Act. AB 1887 is set for hearing on April 10, 2013 in the Assembly Health Committee.

AD 3445 (De la Torre) requires carriers, after January 1, 2013, to meet the requirements of specified provisions of the federal Public Health Service Act, related to federal health care reform. AD 3445 is set for hearing on April 29, 2013 in the Assembly Health Committee.

AD 2244 (Fuentes) among other things, prohibits carriers from denying coverage on the basis of an actual or expected health condition effective January 1, 2011 for children and effective January 1, 2014 for adults. AD 2244 is set for hearing on April 19, 2013 in the Assembly Health Committee.

AD 2477 (Jones) deletes the provision that requires Mid-Year Status Reports for children from January 1, 2011 to July 1, 2012, therefore establishes continuous eligibility for children in the Medi-Cal Program. AD 2477 is pending in the Assembly Appropriations Committee.

AB 990 (Alquist) establishes the California Health Benefits Exchange within the California Health and Human Services Agency and would require the Exchange to, among other things,
implement specified functions imposed by the Affordable Care Act. SB 100 is set for hearing in the Senate Health Committee on April 21, 2016.

SB 1008 (Valade) prohibits, with a specified exception, the limiting age for dependent children from being less than 27 years of age. SB 1008 is set for hearing in the Senate Health Committee on April 21, 2016.

5) PREVIOUS LEGISLATION . AB 8 (Nunez) of 2007 and AB 1 XI (Mullin) of 2007, would have established a comprehensive package of health care reforms, including creating a statewide health care purchasing program (California Health Insurance Purchasing Program, or CalHIPP), modifying rules governing private (individual) and group health insurance, initiating and expending health care quality and cost measurement activities; and establishing administrative and funding mechanisms to support the reforms. AB 8 (Nunez) was vetoed by Governor Schwarzenegger and AB 1 XI failed passage in the Senate Health Committee.

6) SUPPORT . The California Retired Teachers Association, writing in response to a previous version of this bill, writes that this bill will provide clarity and structure for implementing the new federal health care reform legislation.

7) SUPPORT IF AMENDED . The California Chiropractic Association requests and amendsment to include chiropractic care as a coverage option.

8) CONCERNS . Health Net, writing in response to a previous version of this bill, states that they will work collaborative with the Legislature and regulators to implement federal health care reform, including the creation of an exchange. Health Net further states that their preliminary review of this bill found that there are some provisions that do not follow the authority as set forth in federal health care reform. The California Association of Health Plans (CAHP), also writing in response to a previous version of this bill, states that this bill includes a number of provisions that point towards an Exchange that is intended to be at its core, a purchaser of services. CAHP states that they are still formulating their opinions on this concept and many other aspects of the bill.

9) OPPOSITION . Anthem Blue Cross, writing in response to a previous version of this bill, states that this bill will limit consumer choice and set up onerous rate setting requirements. Anthem further states that this bill would not establish an Exchange that meets the requirements of the insurance market place and ensuring consumer choice.