

# HHS Task Force Sunset Review

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## NEIGHBORHOOD CHILD CARE CENTER ACT

*Millions of American families have come to depend on two incomes. With the dependence has come an accompanying reliance on child care services. Businesses that mind children for working parents became a growth industry in the 1970s and they were met with another growth industry of the 1970s, government regulation.*

**Section 1. Short Title.** This act may be cited as the Neighborhood Child Care Center Act.

### **Section 2. Agencies Subject to Regulation; Investigation of Alleged Child Abuse.**

A. A child welfare agency, as defined in **{insert statute}**, shall not be subject to the provisions of **{insert licensing statute for child care centers}** licensing if:

1. It is under the direct management of an administrative department of the state; or
2. If it receives no state or federal funds and complies with standards of fire and safety promulgated by the **{insert name of office of state fire protection}** and standards of health and sanitation promulgated by the **{insert name of office of health services and environmental quality}**. However, any such agency may apply for and be granted licensing if it complies with standards promulgated by the department.

B. Upon receipt of a complaint alleging child abuse, as defined in **{insert statute}** in any child welfare agency, whether they are licensed or not licensed, the secretary of the **{insert name of state department of health and human resources}** shall have the power to investigate the complaint and shall initiate the investigation within one working day after receipt of the complaint. The chairman of the **{insert name of state committee on child protection}** shall immediately notify the administrator of the facility if the complaint and seek further information from the administrator with respect to the allegations. If the administrator refuses to cooperate or if the chairman determines that further investigation is necessary, the chairman shall call a meeting of the committee to consider what further action may be taken. The committee shall have the authority to inspect the premises of the facility, interview witnesses, receive testimony under oath, and examine documents in furtherance of the investigation. At the completion of its investigation, the committee shall issue a report which shall, along with the minority report filed by any member, be filed with the district attorney of the **{insert city or**

**county}** wherein the facility is located, the secretary of the department, and the chairman of the **{insert name of house or senate committee on health and welfare}**.

C. The special committee on child protection shall consist of a chairman, a vice chairman, and three other members. The members of the committee shall consist of the secretary of the department or his designee, a physician, a social worker, a religious representative, and one member from the general public. At least one member of the committee shall be an attorney. The members shall be appointed by the secretary and shall serve at his pleasure.

D. The **{insert name of state department of health and human resources}** may assist the committee. The administrator of any facility under investigation shall have the right to present evidence and call witness before the committee during the hearing.

E. The **{insert name of office of state fire protection}** and the **{insert name of office of health services and environmental quality}** shall report to the secretary of the **{insert name of state department of health and human resources}** within thirty (30) days after inspection all day care centers that have been inspected by said offices and the results of that inspection.

F. All child welfare agencies shall report their existence to **{insert name of state department of health and human resources}** within one hundred and eighty (180) days after the effective date of this act or within sixty (60) days after the agency begins operation. The information to be reported shall be the name of the owner and the name and address of the facility. Any child welfare agency which does not register with the **{insert name of state department of health and human resources}** shall be guilty of a misdemeanor and shall be fined not less than twenty-five dollars (\$25.00) nor more than two hundred dollars (\$200.00). Each day of operation without registration shall constitute a separate offense.

**Section 3. {Severability Clause}**

**Section 4. {Repealer Clause}**

**Section 5. {Effective Date}**

*Approved by the Health and Human Services Task Force in 1985.*

## **Privatization Of Child Support Enforcement Services**

**Section 1. Title.** This Act shall be known and cited as the “Privatization of Child Support Enforcement Services Act.”

**Section 2. Definitions.** As used in this Act:

A. “Child support” or “child support obligation” means a financial obligation to support:

1. the payer’s marital child either in an intact family or as a result of a court order;
2. the payer’s nonmarital child as a result of a court order; or,
3. the payer’s nonmarital child in an intact family as a result of adoption, maternity or an acknowledgement of paternity.

B. “Child support enforcement services” means parent location, collection and payment processing.

C. “Department” means {insert name of appropriate state human services department}.

D. “Competitive contracting” means the department will choose the private providers from which it will purchase related services.

E. “Agency” means the contracted private provider organization to provide the child support enforcement services within the state.

F. “Paternity” means the natural or adoptive parent of child.

*[Drafting note: Some states use the term “parentage,” rather than “paternity.”]*

### **Section 3. Child Support Enforcement Program.**

A. The Department shall contract for the administration, delivery, and management of child support enforcement services.

### **Section 4. Agency Contracts.**

A. The Department may award a {insert time frame} contract, on the basis of a competitive contracting process approved by the {insert appropriate state agency, i.e.

**secretary of administration**}, to any agency for one or more components of the child support enforcement services.

*[Drafting note: Refer to ALEC's Competitive Contracting of Public Services for competitive contracting process.]*

B. The Agency's contract will only be renewed if the Agency has located, collected and provided payment for **{insert percentage}** of the state's child support obligations in **{insert time frame}**. The Department must establish the minimum percentage and the maximum time frame at the beginning of each contract.

C. The Department may finance contracts to Agencies and optional performance bonuses in Section 6 with federal government subsidies specified for child support enforcement.

**Section 5: Agency Requirements.** The Agency must report *[Drafting Note: Refer to Section 6B]* to the Department the following, but is not limited to:

A. Effectiveness of child support enforcement program:

1. Average percent of all child support collected (yearly basis and a total basis);
2. Percent of children with paternity established; and
3. Percent of children with court order for support.

B. Timeliness of enforcement actions:

1. Average time to establish paternity and support for cases requiring establishment of both paternity and support;
2. Average time to establish support for cases requiring the establishment of support only; and
3. Average time from delinquency to initial payment to satisfy delinquency.

**Section 6. Performance Standards.** The Department shall establish performance standards for the administration of child support enforcement programs. If an Agency does not meet the standards, the Department may withhold any or all payment for the Agency.

**Section 7. Performance Incentives for Agencies.** *[Drafting note: This section is optional.]*

A. The Department may award the Agency a {insert percentage} final bonus for each completed case for delinquent obligations, including child support obligation collected and paid the child support payment, beyond the Department's requirement and in a predetermined time frame.

*[Drafting Note: The bonus amount and maximum time frame must be established.]*

B. The Department must submit an annual report regarding quality performances, outcome measure attainment, and cost-effectiveness to the state legislature and Governor.

**Section 8. {Severability Clause}.**

**Section 9. {Repealer Clause}.**

**Section 10. {Effective Date}.**

*Approved by the Health and Human Services Task Force in August 1999.*

## Privatization Of Foster Care And Adoption Services

**Section 1. Title.** This Act shall be known and may be cited as the “Privatization of Foster Care and Adoption Services Act.”

**Section 2. Definitions.** As used in this Act:

- A. “Privatize” means to contract with qualified community-based providers.
- B. “Qualified” means community-based providers which meet the eligibility requirements listed in Section 3.
- C. “Community-based provider” means the for-profit or non-profit private agency with which the Department shall contract for the provision of child protective services in a district.
- D. “District” means a community that is no smaller than a county.

*[Drafting Note: Define maximum size of community.]*

- E. “Child protective services” mean family preservation, independent living, emergency shelter, residential group care, foster care, therapeutic foster care, intensive residential treatment, foster care supervision, case management, postplacement supervision, long-term, adoption and family reunification.
- F. “Child protective investigations” mean inquiries carried out by the Department or local law enforcement agencies regarding the well being of the child(ren) involved.
- G. “Department” means the appropriate state child and family services Department.
- H. “Competitive contracting” means the state Department chooses the private providers from which it will purchase services. The Department must decide to renew or not renew a contract on a **{insert time frame, e.g., 1 year}**. Chosen private contractors must demonstrate a guarantee of confidentiality in the change of provider.

**Section 3. Eligibility of Community-Based Provider.** The community-based provider must have:

- A. To provide directly, or contract for, through the most appropriate provider identified in a timely manner, all necessary child protective services, as listed in Section 2 (E);



B. To ensure continuity of care from entry to exit for all children referred from the protective investigation and court systems; *{Drafting note: The community-based provider cannot turn down a child or eject a child from its care if that child is part of the group of children in the geographical location for which the community-based provider has earned a provider contract.}*

C. To be accountable by meeting the outcomes and performance standards related to child protective services established by the state legislature and the Federal Government; *{Drafting note: This provision does not preclude new or non-related organizations from submitting proposals.}*

D. To serve all children referred to it from the protective investigation and courts systems, regardless of the level of funding allocated to the community by the state, provided all related funding is transferred; *{Drafting note: The community-based provider cannot turn down a child or eject a child from its care if that child is part of the group of children in the geographical location for which the community-based provider has earned a provider contract.}*

E. To ensure that each individual or organization who provides child protective services complete the training required of child protective services by the Department at the very least; and

#### **Section 4. License Requirement.**

Each foster home, therapeutic foster home, emergency shelter, or other placement facility operating by the qualified community-based agency must be licensed by the Department.

For-profit and non-profit private providers are encouraged to set and utilize additional standards, such as: marital status, income, and religious beliefs. *{Drafting note: Private providers in various states are already employing standards higher than those used by states.}*

#### **Section 5. Department Plan.**

A. The Department must submit a plan to accomplish privatization statewide through a competitive contracting process in keeping with the norms of the state procurement process, and the plan must be phased in over a *{insert timeframe, e.g. minimum of one year}*.

B. Included in the plan must be:

- 1) Qualified community-based providers and current local participants in developing the plan; and
- 2) Methodology for determining and transferring all available funds appropriated and



budgeted for all services that have been incorporated into the project which are necessary to accomplish the objectives outlined in this legislation, including all management, capital office overhead, and administrative funds. Providers must assess anticipated costs of payments to subcontractors.

### **Section 6. Private Contracting.**

A. The Department shall issue request for proposals for the delivery, administration, or management of child protective services specified in Sections 2 (E).

B. Contracts with organizations responsible for services must include the management and administration of all privatized child protective services as listed in Section 2 (E).

C. The Department may use funds for contract management only after obtaining written approval from the Governor's office. The request must include a statement of the proposed amount of such funds and a description of the manner in which such funds will be used. *{Drafting note: If state has existing contract management language, then do not include this language.}*

### **Section 7. Performance Incentives.**

A. The Department must submit an annual report regarding quality performances, outcome measure attainment, and cost-effectiveness to the state legislature and Governor.

B. This report shall include:

1. The percentage of children in foster care placed in adoptive homes in a {insert timeframe, e.g. 12 months} period. The Department must furnish the community-based provider with a percentage rate range to which the community-based provider contract will be renewed.

2. The payments made by the Department to the community-based provider must be on a decreasing sliding scale basis over a {insert specific time frame, e.g. 24 months} time period for each foster care child remaining not placed in a permanent home. After the established time frame {e.g. 24 months}, the Department must make payments of which must be calculated to not provide any financial return above costs.

3. The Department must award the community-based provider a bonus for each child in foster care placed in an adoptive home or reunification with the original family. The bonus amount must be calculated to provide financial incentives in placing children in foster care into adoptive homes at the earliest period possible. The bonus amount must reflect, through a rate to be determined by the state, the timeframe in which the foster child is adopted *{i.e. within two months, the bonus is 100 percent, within four months, the bonus is 75 percent, within six months, the bonus is 50 percent, etc}*. The amount of the financial bonus must be greater than the expected financial return from keeping children in foster care, including any future bonus award.

**Section 8. Liability.**

The Department shall retain responsibility for the quality of contracted services, and shall ensure that services are delivered in accordance with applicable federal and state statutes and regulations.

**Section 9. [Severability clause]**

**Section 10. [Repealer clause]**

**Section 11. [Effective date]**

*Approved by the Health and Human Services Task Force in August 1998.*

## **Acknowledgement Of Paternity Act**

### ***Summary***

This act would provide a newborn's mother and natural father with an opportunity to complete an affidavit acknowledging paternity. It also provides the mother with written information explaining the benefits of having her child's paternity established, the availability of paternity establishment services, and the availability of child support enforcement agencies.

### ***Model Legislation***

#### **Section 1. {Title.}**

#### **Section 2. {Definitions.}**

**Section 3. {Acknowledgment upon birth.}** Upon the birth of a child to an unmarried woman, the attending physician or midwife, an agent of either, or an agent of the hospital where the birth occurred shall:

(A) Provide the newborn's mother and natural father with an opportunity to complete an affidavit acknowledging paternity. The completed, signed affidavit shall be filed in triplicate with the {insert appropriate local office.} The (appropriate local office) shall send one copy to the (appropriate state office) and one copy to the (state's department responsible for public welfare) and shall retain one copy. A fourth and fifth copy shall be given to the mother and natural father separately. This affidavit shall contain:

- (1) a sworn, signed statement by the mother consenting to the assertion of paternity and stating that this is the only possible father;
- (2) a signed statement by the father that he is the child's natural father;
- (3) a written explanation of the implications of and the parental duties and parental rights that arise from signing such a statement;
- (4) the Social Security numbers, driver's license numbers and addresses of both parents.

(B) Provide written information, furnished by the (state's department responsible for public welfare) to the mother, which explains the benefits of having her child's paternity established, the availability of paternity establishment services and the availability of child support enforcement agencies.

#### **Section 4. {Severability clause.}**

**Section 5. {Repealer clause.}**

**Section 6. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1995.*

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## **Child Relocation Notification Act**

### *Summary*

This act required that, in any custody or visitation proceeding, advance written notice be given to either the court, the other party, or both by any party intending to relocate the permanent residence of the child at least 60 days prior to the intended relocation.

### *Model Legislation*

**{Title, enacting clause, etc.}**

**Section 1.** In any custody or visitation proceeding, the court shall include as a condition of any custody or visitation order a requirement that advance written notice be made to either the court, the other party, or both by any party intending to relocate the permanent residence of a child. Such notice must be given at least 60 days prior to the intended relocation. The court may require that such notice be in such form and contain such information as the court may deem proper and necessary under the circumstances of the case.

**Section 2. {Repealer clause}.**

**Section 3. {Severity clause}.**

**Section 4. {Effective date}.**

*Approved by the Health and Human Services Task Force in 1995.*

## **Child Visitation Dispute Mediation Act**

### ***Summary***

While divorce cannot be avoided, the emotional, psychological, and social needs of children must receive greater attention. Legislation must ensure that custody decisions truly reflect the best interests of children. The following legislation encourages the promotion of mediation as an alternate to litigation to resolve visitation.

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** The legislature hereby finds and declares that the divorce rate in this state has reached alarming proportions and the number of children affected by divorce has grown accordingly. The legislature also finds and declares that the denial and interference with visitation rights of noncustodial parents is a serious problem for which there is presently no adequate remedy other than litigation between the parties involved, a process that is often lengthy, expensive, and harmful to the best interests of the child involved. Therefore, the legislature declares that it is the public policy of (insert state) to promote the uses of mediation as an alternate to litigation to resolve visitation disputes.

**Section 2.** As used in this Act the following terms have the following meaning:

- (A) "Office" means the Child Visitation Office as established by this Act.
- (B) "Local Department" means the local department of social services for a county.

**Section 3.** (A) In each local department of social services for a county there is established a Child Visitation Office. The purpose of such office shall be to develop and implement a visitation dispute mediation program to investigate and mediate complaints arising out of visitation orders issued by a court of competent jurisdiction.

(B) The establishment and operation of such office shall be directed by the (insert appropriate department). The (insert appropriate department) shall:

- (1) adopt rules, regulations, and guidelines for the program;
- (2) monitor and evaluate the effectiveness of the program; and
- (3) establish in each local Office an adequate staff to implement the program.

(C) The legislature appropriates the sum of (insert dollar amount of appropriation) for the establishment and operation of this program.

**Section 4.** The Child Visitation Office shall:

(A) investigate visitation complaints filed by any party to a visitation order issued by a court of competent jurisdiction. The Office may investigate complaints by persons other than parents who have visitation rights pursuant to an order by a court of competent jurisdiction.

(B) attempt to mediate and informally resolve any dispute concerning visitation that may arise between the parties.

(C) maintain such records as may be necessary, including:

- (1) the number of complaints;
- (2) the number of complaints investigated;
- (3) the amount of time spent on each complaint;
- (4) the result of the investigation and/or mediation of each complaint; and
- (5) the number of complaints resolved.

(D) Upon a request by a court of competent jurisdiction, the office shall make available to the court any records of any visitation complaint investigated by the Office, including the final report.

**Section 5.** The function of the Office shall be only to investigate and mediate visitation disputes. The office shall not exercise any enforcement powers.

**Section 6.** {Repealer clause.}

**Section 7.** {Severability clause.}

**Section 8.** {Effective date.}

*Approved by the Health and Human Services Task Force in 1995.*



## **Marriage Contract Act**

### ***Summary***

The institution of marriage is one of the fundamental building blocks of our society, embodying the values of commitment, loyalty, trust, and mutual support. Currently, every state except South Dakota provides some form of no-fault divorce, while several states provide no-fault as the only means for nullifying marital contracts. The following legislation provides that the dissolution of a marriage will only take place by showing a preponderance of the evidence by one party of the fault of the other party which constitutes grounds for the end of a marriage.

### ***Model Legislation***

**{Title, enacting clause, etc.}**

**Section 1.** Two persons of the opposite sex may, either prior to after a marriage is lawful and duly solemnized, enter into a written marriage contract providing that the marital relationship will not be dissolved except on a showing by a preponderance of the evidence by one party of the fault of the other party which constitutes grounds for the dissolution of the marriage, as specified in the marriage contract.

**Section 2.** If the requirements for enforceability as defined in this Act are met, a marriage contract shall be enforced by a court of competent jurisdiction and the marriage of the parties shall not be dissolved or modified except under the terms of the marriage contract.

**Section 3.** A party to the marriage who believes that the marriage contract has been violated and that the grounds specified in the contract exist for dissolution of the marriage may institute a legal proceeding to dissolve the marriage, and if the grounds as specified in the contract are proven, that party shall be awarded a decree of dissolution of marriage.

**Section 4.** The written marriage contract, to be enforceable, must contain the following agreements between the parties:

(A) The written marriage contract contains the exclusive understanding and agreement between the parties regarding the terms of continuance of their legal marital relationship.

(B) (1) The marriage of the parties shall not be dissolved or otherwise modified except by mutual consent of the parties or upon a showing by a preponderance of the evidence by one of the fault of the other party which constitutes grounds for the dissolution of the marriage, as specified in the marriage contract, in a court of competent jurisdiction.

Those acts that constitute fault must be set out in the marriage contract and must not be contrary to public in order to justify the dissolution of the marriage of the parties.

(2) Those acts that constitute fault may include:

(a) when consent to the marriage of the party to the petition for dissolution, legal separation, or declaration concerning validity was obtained by force or duress or fraud of the other party;

(b) when the party filing the petition for dissolution, legal separation, or declaration concerning validity was incapable of consenting to the marriage because of physical or mental incompetence;

(c) when a party commits adultery;

(d) when a party is impotent and the party filing the petition for dissolution, legal separation, or declaration concerning validity was unaware at the time of the marriage that the other party was or was likely to become impotent;

(e) when a party is infected with a sexually transmitted disease and the party filing the petition for dissolution, legal separation, or declaration concerning validity was unaware at the time of the marriage that the other party was so infected;

(f) when a party has abandoned the relationship or has disappeared for one or more years;

(g) when a party has an habitual and ongoing addiction to alcohol or drugs;

(h) when the husband continually neglects or refuses to make reasonable provisions for the basic needs of the family;

(i) when a party has been imprisoned in a state, federal, or foreign prison for at least two years;

(j) when a party is continually treating the other party, or any minor natural, adopted, step or foster child residing in the home of a party, with physical abuse or extreme mental cruelty, or any such child with sexual abuse;

(k) when a party is determined to be legally insane; and

(l) any such other actions or circumstances as shall be agreed by both parties at the time the marriage contract is signed.

(C) Any legal proceeding involving the marriage contract shall be brought in the Superior Court of (insert state.) The practice of civil actions in (insert state) shall govern all proceedings. (Insert state) shall retain jurisdiction over all actions involving the marriage and the laws of this state shall apply. A dissolution of marriage, divorce, legal

separation, or declaration concerning the validity of the marriage that is not in conformity with the marriage contract and the law of (insert state) shall have no force or effect in (insert state.)

(D) The parties must acknowledge that each recognizes that, in the absence of a written marriage contract, either party may petition the court for a dissolution of marriage on the grounds that the marriage is irretrievably broken, and the petition shall be granted in accordance with (insert appropriate statute). The parties must state in the written marriage contract that each, by executing the document, gives up the right and agrees to be bound solely by the terms of the written marriage contract to determine the grounds that will enable a party to successfully petition for dissolution of the marriage.

(E) The written marriage contract shall not be enforced until the marriage is duly and lawfully solemnized.

**Section 5.** (A) When violation of a written marriage contract is alleged and the responding party contests the petition or denies the allegations of fault, the court shall submit the issue of whether the marriage contract has been violated to a jury at the request of either party.

(B) If the jury finds that a violation of the written marriage contract has occurred, the court shall enter a decree of dissolution of marriage. The court shall determine issues of property division, child custody, child visitation, and maintenance requests by either party without submission of those items to the jury.

**Section 6.** *{Repealer clause.}*

**Section 7.** *{Severability clause.}*

**Section 8.** *{Effective date.}*

*Approved by the Health and Human Services Task Force in 1995.*

## Newborn Infant Protection Act

### *Summary*

In April 1982, “Baby Doe” was starved to death in a hospital in Bloomington, Indiana. The death was sanctioned by the infant’s parents, his physician, and the state judicial system. Despite offers to adopt the child, “Baby Doe” was purposely allowed to die by those who normally would be his protectors. His crime? He was not perfect. He was born with Down’s syndrome, a handicap that in most cases results in mild or moderate retardation.

A month later, the Maryland Board of Veterinary Examiners fined a veterinarian \$3000 dollars, suspended his license 60 days, and placed him on probation for six months. The Board ruled that the doctor had starved a dog to death. Unlike “Baby Doe’s,” the dog’s life was properly deemed to have had value.

While highly publicized, the Bloomington case is part of a practice of infant starvation that is neither new nor isolated. The October 23, 1973, issue of the New England Journal of Medicine contains an article addressing the issue of babies who are believed to have, in the words of the authors, “little or no hope of achieving meaningful ‘humanhood.’” The article, “Moral and Ethical Dilemmas in the Special-Care Nursery” by Raymond S. Duff, M.D., and A.G.M. Campbell, M.B., F.R.C.P., refers to early death for handicapped infants as a “management choice,” with the usual “treatment” in such cases being “nothing by mouth.” Furthermore, the authors note that over a two-year period, 14% of the deaths in the hospital special-care nursery that studied were “permitted to happen because parents and doctors had decided the children should not be allowed to live.”

In the Bloomington case, “meaningful humanhood” apparently did not include retardation. Those entrusted with the life of “Baby Doe” prescribed starvation because of death was seen as preferable to life with a handicap; death was a “management choice”. The person with the greatest stake in this “choice,” however, was too young to offer an opinion, much less defend himself.

The Newborn Infant Protection Act secures the rights of newborn children by prohibiting their intentional starvation, dehydration, or asphyxiation. Louisiana is the first state to enact this Legislation which declares that no infant born alive shall be denied food, nutrients, water and oxygen “by any person whomsoever with the intent to cause or allow the death of the child for any reason.”

The legislation generally prohibits the deprivation of necessary medical or surgical care by parent, physician, or any other person when such medical attention is essentially to save the life of the child. The Act does not uniformly mandate costly

medical care, however. A child's parents or physician are not prevented from ending the use of artificial life-support systems for a child in a continual comatose condition when the physician determines there is no hope for recovery. Moreover, the Act does not require extra lifesaving medical or surgical care for a child when the risks far outweigh the advantages of such methods. Both hospitals and physicians are protected against liability by the measure when medical or surgical treatment is administered without the parent's consent.

With the practice of selective care for newborn children a reality in our hospitals, the rights of our most defenseless citizens must be clearly stated. The Newborn Infant Protection Act is such a statement, as well as an affirmation of the inherent of every human life.

### ***Model Legislation***

(Title, enacting clause, etc.)

**Section 1.** *[Short title]* This act may be cited as the **Newborn Infant Protection Act**.

**Section 2.** *[Statement of Purpose]* The Legislature of [name of state] hereby enacts this statute relative to nutritional or medical deprivation of infants, to provide with respect to infants denied or deprived of food, water, or medical care with the intent to cause or allow the death of the child, to provide for procedures when parental consent for necessary care and treatment is refused, to provide with respect to judicial proceedings to enforce the provisions of this Part, and otherwise to provide with respect thereto.

**Section 3.** Infants born alive and other children; nutritional and medical deprivation prohibited.

(A) No infant born alive shall be denied or deprived of food or nutrients, water, or oxygen by any person whomsoever with the intent to cause or allow the death of the child for any reason, including but not limited to the following:

- (1) The child was born with physical or mental handicapping conditions which, in the opinion of the parent or parents of the child, the physician, or other persons, diminishes the quality of the child's life.
- (2) The child is not wanted by the parent or parents.
- (3) The child is born alive in the course of an attempted abortion.

No infant child shall be intentionally killed by any other means by any person for any reason.



(B) No minor child, from the moment of live birth, shall be intentionally denied or deprived of any medical or surgical care by his or her parent, physician, or any other person when such medical or surgical care is necessary to attempt to save the life of the child, in the opinion of a physician exercising competent medical judgment, despite the opinion of the child's parent or parents, the physician, or others that the quality of the child's life would be deficient should the child live.

(C) Nothing in this Section shall be interpreted to prevent a child's parents and physician from discontinuing the use of life support systems or non-palliative treatment for a child who is terminally ill where, in the opinion of the child's physician exercising competent medical judgment, the child has no reasonable chance of recovery from said terminal illness despite every appropriate medical treatment to correct such condition.

(D) This Section shall not be interpreted to require the provision of potentially lifesaving medical or surgical care to a child when in the opinion of the child's parent or parents and their physician exercising competent medical judgment, the potential risks to the child's life inherent in the treatment or surgery are equal to or exceed the risks to the child's life arising from the condition that the surgery or treatment would cure or palliate.

(E) No child who is being provided treatment in accordance with the tenets of a well-recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected under the provisions of this Part, unless the life of the child is substantially and seriously threatened due to the lack of traditional medical care. Provided however that the parents of a child whose life the [name of State department] alleges is substantially and seriously threatened due to lack of traditional medical or surgical care shall have the right to petition a district court of competent jurisdiction for a temporary restraining order or injunction prohibiting the [name of State department] from intervening in the matter. The court shall give preference to such hearings, and such matters shall be tried summarily.

**Section 4. Parental consent to care and treatment; refusal**

(A) Whenever the parent or parents of a child refuse to consent to the care and treatment of the child protected by this Act they shall at all times be free to execute a voluntary act of surrender of the child pursuant to [State Adoption code section], placing the child in custody of the [name of State department] or other licensed adoption agency. All medical expenses incurred by the [name of State department] on behalf of the child shall be reimbursed by the parent or parents of the child, provided they have not been declared financially needy. No medical insurer of the parent or parents of a child who would have otherwise been liable for such medical expenses may deny liability to their insured solely because of the parent or parents desire to withhold medical or surgical treatment from the child. The agency shall immediately provide the treatment for the child and shall make every effort to find an adoptive home for the child.

(B) Whenever the parents of a child protected by this Act refuses to consent to the necessary care and treatment for the child, but refuses to surrender the child for adoption, the physician, or other persons included in the provisions of [code section] shall report

the child as a neglected child or child in need of care to the local child protection agency or to the police.

(C) No physician, hospital, or other person authorized by law to provide medical or surgical care shall be held liable for providing medical or surgical care for a child protected by this Act without the consent of the child's parent or the agency having custody of the child, when in the opinion of the physician, hospital, or other person authorized by law to provide medical or surgical care, exercising competent medical judgment, the child's life would be threatened by delaying the provision of the care or treatment.

**Section 5.**

(A) Judicial proceedings to enforce the provisions of this Part may be instituted by any agency, institution, or person interested in the child's welfare in the juvenile court in the jurisdiction where the child is found. All such proceedings shall be heard in confidence without delay, including the holding of special sessions of court. Any appeal or application for writs in any appellate court in cases arising from this Section shall be heard and decided in the shortest possible time. An attorney shall be appointed to represent the child in all trial and appellate proceedings.

(B) Nothing in this Part shall diminish the application of the [State criminal code] where appropriate.

**Section 6.** If any provision or item of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions, items, or applications of this Act which can be given effect without the invalid provisions, items, or applications, and to this end the provisions of this Act are hereby declared severable.

**Section 7.** All laws or parts of laws in conflict herewith are hereby repealed.

*Approved by the Health and Human Services Task Force in 1983.*



## **Parental Consent for Abortion Act**

### *Summary*

Rather than end the debate on abortion, the Supreme Court's 1973 decision of *Roe v. Wade* has only ignited a firestorm of controversy. The consequences of the Court's actions include an annual 1.5 million deaths by abortion and the attendant emotional and physical turmoil suffered by once expectant mothers, their families, and loved ones. The Parental Consent for Abortion Act, which is based on a 1984 Indiana law, establishes a mechanism by which some of the burdens involved in this most serious of decisions can be shared by a young girl's most caring support group, her family. The measure also includes a provision that reflects the great advances in medical care of the last decade. As premature babies are surviving at earlier and earlier ages, and as more late-term abortions actually result in live births, the bill requires that abortions performed on babies after the age of viability be done in hospitals with premature birth intensive care units and in the presence of a second physician whose specific duty is to care for a child born alive.

While the Supreme Court has taken the right to decide the legality of abortion from the states, it has repeatedly recognized that in view of the unique status of children under the law, the states have a significant interest in certain abortion regulations aimed at protecting children "that is not present in the case of an adult." (See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75). While the right of privacy includes "independence in making certain kinds of important decisions," (*Whalen v. Roe*, 429, U.S. 589, 599-600). The Supreme Court has recognized that many minors are less capable than adults in making those decisions, and has held that states have a legitimate interest in encouraging parental involvement in their minor children's decision to have an abortion (*H.L. v. Matheson*, 450 U.S. 389). In *Bellotti v. Baird* (443 U.S. 622), the Court concluded that a state which encourages parental involvement must provide an alternative procedure through which a minor may demonstrate that she is mature enough to make her own decision or that the abortion is in her "best interest."

Clearly, then, the Supreme Court will uphold parental consent laws dealing with abortion if those laws dealing with abortion if those laws conform to its requirements. Basically, a state must provide a consent procedure in its law whereby a pregnant minor may demonstrate that she is sufficiently mature to make the abortion decision herself or that, despite her immaturity, an abortion would be in her best interests. There must be an "opportunity for case-by-case evaluations of the maturity of pregnant minors." (*Bellotti*, 643, n.23).

The Parental Consent for Abortion Act is designed to meet the constitutional tests established by Supreme Court decisions. The Act includes procedural safeguards that correct deficiencies found in Indiana's 1982 parental notification law. It would allow a

minor who objects to obtaining the written consent of her parent or legal guardian, or whose parent or guardian refuses or consent of an abortion, to petition the juvenile court to waive the requirement, or a judge would be permitted to waive the requirement if he determined the minor was mature enough to make the decision on her own, or that an abortion would be in the best interest of the minor. The Act would require the judge to appoint an attorney to represent the minor in a waiver proceeding or appeal unless she had already engaged an attorney. The county would have to pay the cost of the attorney's fees.

Additional procedural safeguards include: permitting non-resident minors to petition the juvenile court in the county in which the abortion is to be performed; expedited appeal; confidential records; appointment of counsel; and exemption of filing fees.

A state certainly has legitimate, perhaps compelling interest in protecting the most basic social unit, the family. By involving families in the life changing decision of parenthood/adoption/abortion, it advances family integrity and parental authority. It also recognizes that there is no "mediating structure" better equipped to help a child than her family.

As mentioned, the proposed legislation also would necessitate that post-viability abortions be performed in hospitals with premature birth intensive units and in the presence of a second physician whose duty would be to care for a child born alive.

This section of the bill conforms to the Supreme Court's decision in *Planned Parenthood v. Ashcroft*, which upheld Missouri's second-physician law. This Act declares that a child born alive is a person under the law and, therefore, such a child would be issued a birth certificate, and in the event that the child dies, it would be issued a death certificate. Failure to take reasonable steps to preserve the child's life and health would be actionable under applicable criminal, wrongful death, and malpractice laws.

### ***Model Legislation***

**(Title, enacting clause, etc.)**

**Section 1.** [Short title] This act may be cited as the **Parental Consent for Abortion Act**.

### **Section 2.** [Definitions]

(A) "Hospital" as used in this act means any institution, place, building, or agency represented and held out to the general public as a ready, willing and able to furnish care, accommodations, facilities, and equipment for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment.

The term does not include convalescent homes, boarding homes, or homes for the aged; nor does it include any hospital or institution specially intended for use in the diagnosis, care and treatment of those suffering from mental illness, mental retardation, convulsive disorders, or other abnormal mental conditions; nor does it include offices of physicians where patients are not regularly kept as bed patients.

The [appropriate state office] shall have the authority to determine whether or not any institution or agency comes within the scope of this act and its decisions in that regard shall be subject only to such rights of review as the courts exercise with respect to administrative actions. It shall be unlawful for institution, place, building, or agency to be called a hospital which is not a hospital as defined in this section.

(B) "Trimester" means any one of three (3) equal periods of time of normal gestation period of the pregnant woman in question derived by dividing such period of gestation into three (3) equal parts of three (3) months each and to be designated as the first trimester, second trimester, and third trimester, respectively.

(C) "Abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

(D) "Physician" means a person an unlimited license to practice medicine, surgery, or obstetrics in this state.

(E) "Viability" means the ability of a fetus to live outside the mothers womb.

(F) "Consent" means a written agreement to submit to an abortion after consenting party has had full explanation of the abortion procedure to be preformed as evidenced by the signature of the consenting party on a form of explanation and written consent promulgated by the state board of health.

(G) "Parental consent" means the written consent of the parent or legal guardian of an unemancipated pregnant woman under age of eighteen (18) years to the performance of an abortion on the minor pregnant woman.

**Section 3. [Parental consent for abortions preformed on minors]**

(A) No physician shall perform an abortion upon an unemancipated pregnant woman under the age of eighteen (18) years without fist having obtained the written consent of one (1) of the parents or the legal guardian of the minor pregnant woman.

(B) A minor who objects to having to obtain the written consent of her parent or legal guardian under this section, or whose parent or legal guardian refuses to consent to an abortion, may petition, on her own behalf to by next friend, the juvenile court for a waiver of the parental consent requirement under Section 3(A).

(C) A physician who feels that compliance with the parental consent requirement in Section 3(A) would have an adverse effect on the welfare of the pregnant minor or on her

pregnancy may petition the juvenile court in the county in which the minor resides (or the juvenile court in the county in which the abortion is to be performed if the minor is a nonresident) within twenty-four (24) hours of the abortion request, for a waiver of the parental consent requirement under Section 3(A).

(D) The juvenile court must rule on a petition filed by a pregnant minor under Section 3(B) or by her physician under Section 3(C) within forty-eight (48) hours of the filing of the petition. Before ruling on such petition, the court shall consider the concerns expressed by the pregnant minor and her physician. The requirement of parental consent under this section shall be waived by the juvenile court if the court finds that the minor is mature enough to make the abortion decision independently or that abortion would be in the minor's best interest.

(E) Unless the juvenile court finds that the pregnant minor is already represented by an attorney, the juvenile court shall appoint an attorney to represent the pregnant minor in a waiver proceeding brought by the minor under Section 3(B) or on any appeals. The cost of legal representation appointed for the minor under this section shall be paid by the county.

(F) A minor (or her physician) who desires to appeal an adverse judgment of the juvenile court in a waiver proceeding under Section 3(B) or Section 3(C) is entitled to an expedited appeal, under rules to be adopted by the [state] Supreme Court.

(G) All records of the juvenile court and any appellate court that are made as a result of proceedings conducted under this section are confidential.

(H) A minor who initiates legal proceedings under this section is exempt from the payment of filing fees.

(I) This section shall not apply where there is an emergency need for a medical procedure to be performed such that continuation of pregnancy provides an immediate threat and grave risk to the life or health of the pregnant woman and the attending physician so certifies in writing.

**Section 4.** It shall be the responsibility of the attending physician to determine in accordance with the accepted medical standards which trimester the pregnant woman receiving the abortion is in, to determine whether the fetus is viable, and to certify that determination as part of any written reports required of him by the state board of health or the facility in which the abortion is performed.

**Section 5.** [Penalty] A physician who performs an abortion intentionally or knowingly in violation of Section 3 of this Act commits a [class of misdemeanor].

**Section 6.** [Abortions performed on viable fetuses]

(A) All abortions performed after a fetus is viable shall be:

(1) preformed in a hospital having premature birth intensive care units, unless compliance with the requirement would result in an increased risk to the life or health of the mother; and

(2) performed in the presence of a second physician as provided in Section 6(B).

(B) An abortion may be preformed after a fetus is viable only if there is in attendance a physician, other than the physician performing the abortion who shall take control of and provide immediate care for a child born alive as a result of the abortion. During the performance of the abortion, the physician performing it, after the abortion, the physician required by this subsection to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child. However, this subsection does not apply if compliance would result in an increased risk to the life or health of the mother.

(C) Any fetus born alive shall be treated as a person under the law, and a birth certificate shall be issued certifying the child's birth even though the child may subsequently die, in which event a death certificate shall be issued. Failure to take all reasonable steps, in keeping with good medical practice, to preserve the life and health of the live born person shall subject the responsible persons to [state] laws governing homicide, manslaughter, and civil liability for wrongful death and medical malpractice.

(D) If, prior to the abortion, the mother and if married, her husband, has or have stated in writing that she does or they do not wish to keep the child in the event that the abortion results in a live birth, and this writing is not retracted prior to the abortion, the child, if born alive, shall immediately upon birth become a ward of the county department of public welfare.

*Approved by the Health and Human Services Task Force in 1985.*

## Parental Rights Amendment

### *Summary*

The Parental Rights Amendment grants parents the right to direct the upbringing and education of their children.

### *Model Legislation*

**Section 1. {Short Title}** "This Act may be cited as the Parental Rights Amendment"

**Section 2. {Legislative Declarations}**

**Section 3. {Main provisions}**

Be it resolved that the State Constitution be amended to read as follows:

The right of parents to direct the upbringing and education of their children shall not be infringed. The legislature shall have power to enforce, by appropriate legislation, the provisions of this section.

**Section 4. {Severability Clause}**

**Section 5. {Repealer Clause}**

**Section 6. {Effective Date}**

*Approved by the Health and Human Services Task Force.*



**Resolution On Reform Of Federal Foster Care Financing:  
Families For All**

**WHEREAS**, Every child needs to be protected from abuse and neglect and deserves to be reared in a loving, safe, stable environment with families that nurture, protect, and guide them; and

**WHEREAS**, Foster care should be a temporary, short-term placement for children until they can achieve permanency through family reunification, adoption, or guardianship. However, the 513,000 children in foster care in the United States have been in foster care for an average of 2 years, 5 months, and the 114,000 children waiting to be adopted have been in foster care for an average of 3 years, 6 months—while a record 24,000 children aged out of the foster care system during the last year for which statistics are available without being placed with a loving, permanent family; and

**WHEREAS**, The federal government shares the responsibility with states to protect children from abuse and neglect and to secure safe, permanent homes for them. However, the current federal financing structure for foster care encourages an over-reliance on placement and maintenance of children in foster care with insufficient resources for other services that keep families together or move such children quickly into a new adoptive family or guardianship when reunification is not possible; and

**WHEREAS**, Sixty-one percent of all federal financing allocated to states for child welfare purposes is mandated according to Title IV-E of the Social Security Act to be used for maintaining children in foster care, and for related administrative and training costs, thereby limiting states' resources for other important services, such as prevention and rehabilitation services, adoptive and foster parent recruitment, and post-placement services for adoptive and foster families; and

**WHEREAS**, The current rigid federal financial structure for foster care harms children by causing them to be maintained in foster care, when greater flexibility would enable states to provide permanency for them more quickly through reunification, adoption, or guardianship; and

**WHEREAS**, A recent survey shows that 61 percent of respondents agree that “federal policy should allow states the flexibility to spend more of their federal foster care dollars on adoptive and foster parent recruitment and on post-placement services for adoptive and foster families;” and



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AMERICAN LEGISLATIVE EXCHANGE COUNCIL

**WHEREAS,** The same survey also shows that 61 percent of respondents agree that “federal policy should allow states the flexibility to spend more of their federal foster care dollars on prevention and rehabilitation services;” and

**WHEREAS,** The federal government mandates that states protect all children from abuse and neglect and provide assistance for such children while they are in the care of the state, regardless of income. However, the federal government only provides assistance to states for children whose birthparents meet the 1996 income eligibility requirements for Aid to Families with Dependent Children (AFDC); and

**WHEREAS,** The outdated income eligibility requirements means 5,100 fewer children are eligible for federal financial assistance each year, shifting the burden to the states and limiting states’ resources for other important child welfare services; and

**WHEREAS,** The same survey shows that 65 percent of respondents agree that “all children who are victims of abuse or neglect should be eligible for federal foster care funding, regardless of income.” However, in 2004, only 47 percent of neglected and abused children in foster care were eligible to receive federal support, causing the states to miss out on an estimated \$1.9 billion dollars in federal reimbursements for foster care support; and

**WHEREAS,** The United States Congress plays a vital role and has a unique opportunity to reform the federal financial system for foster care giving states more flexibility to use their federal dollars towards other important services, such as prevention and rehabilitation services, adoptive and foster parent recruitment, and post-placement services for adoptive and foster families.

**THEREFORE BE IT RESOLVED THAT** the {insert state legislative body} urges the United States Congress to act quickly to reform the current federal financial structure for foster care (most particularly, Title IV-E of the Social Security Act) to allow states the flexibility to use more of their federal financing for other effective child welfare services besides foster care maintenance; and to provide federal foster care funding for all children, who are victims of neglect or abuse, regardless of income.

*Approved by the Health and Human Services Task Force on April 28, 2007.*

## **Resolution To End State-Enabled Newborn Testing Monopolies**

### *Summary:*

This resolution urges state legislators to rescind the laws and regulatory authority that have made state agencies the exclusive providers of clinical laboratory services to detect treatable disorders in newborns. This resolution proposes that newborns, their families, and society would be better served if qualified private organizations were permitted to offer these laboratory services within the marketplace.

**WHEREAS**, improving the health of children is a national goal, and

**WHEREAS**, newborn screening identifies treatable inherited and other disorders in newborn babies by testing a blood sample shortly after birth, and

**WHEREAS**, newborn screening and early clinical intervention can prevent or detect irreversible and serious health problems that could lead to mental retardation or death in children, and

**WHEREAS**, the screening of all babies for treatable newborn disorders has been an accepted medical practice in the United States for more than 30 years, and

**WHEREAS**, advances in technology and clinical interventions by private organizations have made it practical to screen and successfully treat an expanding number of debilitating disorders in newborns, and

**WHEREAS**, state officials have used their regulatory authority and access to state legislatures to establish regulations and laws that exclude private laboratories from performing newborn screening, and

**WHEREAS**, agencies in many states have established fees for newborn screening services while requiring private hospitals and physicians to obtain newborn screening services only from state agencies, and

**WHEREAS**, these monopolistic practices exist primarily to prevent competition from private organizations and assure cash flow to state agencies, and

**WHEREAS**, these monopolistic practices have eliminated the normal market forces that encourage technological innovation, competition, and cost control, and

**WHEREAS**, these monopolistic practice provides no documented medical or public health benefit, and

**WHEREAS**, this is a wide disparity in newborn screening services between states, and

**WHEREAS**, the newest technologies in newborn screening are not available to newborns through most state agencies that provide newborn screening services, and

**WHEREAS**, newborns are not receiving the best services and information on screening because private laboratories are excluded from the marketplace.

**NOW THEREFORE BE IT RESOLVED**, that {insert state and legislative body; i.e. General Assembly} strongly urges the {insert appropriate department} and Governor to end the state monopoly on newborn screening services by revising or rescinding the regulations or laws that exclude qualified private laboratories from providing newborn screening services to hospitals and physicians, and

**BE IT FURTHER RESOLVED**, that hospitals and physicians should be permitted to choose among qualified providers of newborn screening services as they currently do for all other clinical laboratory services.

**BE IT FURTHER RESOLVED**, that the {insert appropriate department} should continue to gather results of newborn screening to ensure appropriate follow up, efficacy, and quality of private screening.

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to {insert the appropriate department} and Governor.

*Approved by the Health and Human Services Task Force.*

## **Extended Care for Mental Health Patients Act**

### ***Summary***

Hospitals releasing mental health patients often fail to secure follow-up-out-patient treatment for them from community mental health centers. Without proper follow-up treatment, many mental health patients are compelled to return to the restrictive environment of mental hospitals. Worse still, a large number of discharged mental health patients have “disappeared through the cracks” of the mental health treatment system, and now comprise a large number of the “street people” in our metropolitan areas.

The **Extended Care for Mental Health Patients Act** requires that the hospital team which discharges a mental health patient arrange an initial appointment for that patient at a local mental health center. The hospital team also is required to contact professional resource people within the community and advise them of the patient’s discharge from the hospital. This allows a professional community resource person to monitor the patient’s treatment at the local mental health center and to encourage the patient’s appropriate use of prescribed medication.

The Oklahoma legislature has enacted similar legislation which has significantly enhanced continued treatment programs for released mental health patients. These programs facilitate the transition for the mental health patient from a highly supervised, institutional environment to a less restrictive setting and eventually back into his community.

### ***Model Legislation***

(Title, enacting clause, etc.)

**Section 1.** This Act may be cited as the **Extended Care for Mental Health Patients Act**.

**Section 2. Statement of purpose.** The purpose of this Act is to provide extended care to persons released from mental health institutions through assistance by community agents and support by private industry officials.

**Section 3. Definitions.** As used in this Act:

(A) “Commissioner” refers to the appropriate government official who is charged with the administration of the laws relating to mental health patients.

(B) “Convalescent leave” means leave granted to a patient, rather than a discharge, when that patient’s complete recovery can be determined by permitting him to leave the facility.

(C) “Department” means the principal public welfare-related administrative unit within the executive branch of stat government.

(D) “Facility” refers to the mental health treatment center or hospital from which the mental health patient is released.

(E) “Head of department” means the individual or board in charge of the department.

(F) “Health facility administrator” refers to the administrator of the mental health facility from which the patient is released.

(G) “Released patient” refers to an individual who has been released from a mental health facility.

(H) “Resource person” refers to a trained community agent, local to the release patient’s post-facility place of residence, who will serve as a contact for the patient during the interim period after release from the mental health facility.

**Section 4. Discharge regulations.** Any person detained or committed for treatment pursuant to the provision of *[appropriate state statute]* shall be provided with discharge planning and assistance by the facility where detained or treated. Discharge planning and assistance shall include, but is not limited to, the following:

(A) return of all personal possessions to the person except contraband;

(B) transportation assistance;

(C) planning of further outpatient treatment, including an initial appointment for outpatient services and a treatment plan, if indicated;

(D) housing information and referral; and

(E) the name and telephone number of a resource person in the community.

**Section 5. Responsibilities – Head of department.** The head of the department may discharge a patient or permit him to leave the facility as provided herein:

(A) who, in the judgment of the health facility’s administrator is recovered;

(B) who is not recovered but, in the judgment of the health facility’s administrator, is stabilized and will not benefit by further treatment and who may be appropriately treated or maintained in a program o facility other than a hospital; or

(C) who has not returned to the facility within 12 months from the time a convalescent leave was granted.

**Section 6. Responsibility – Health facility administrator.** The health facility's administrator may grant a convalescent leave status to a patient in accordance with rules prescribed by the Commissioner. The facility granting a convalescent leave status to a patient has no responsibility in returning the patient to the facility should such become necessary. A convalescent leave is granted rather than a discharge when a patient's complete recovery can be determined only by permitting him to leave the facility.

**Section 7. Procedures for the transfer of mental health patients.** In accordance with the rules prescribed by the commissioner, a health facility administrator may transfer a patient to an outpatient or other nonhospital status when, in the opinion of the health facility administrator, such transfer will not be detrimental to the public welfare or injurious to the patient and the necessary treatment may be continued on that basis; provided, however, that before transferring the patient, the health facility administrator shall satisfy himself that appropriate financial resources and appropriate services are available to receive and care for such patient after his transfer.

**Section 8. Visitation procedures for mental health patients.** A visiting status may be granted for a matter of a few hours or days to any patient considered by the health facility's administrator to be suitable for such privileges.

**Section 9. Discharge procedures for mental health patients.** The health facility administrator shall notify the court responsible for committing the patient that the patient has been granted a discharge. Such notification shall be not less than 48 hours prior to the actual discharge.

**Section 10. Financial responsibilities for release of mental health patients.** The expense of returning a patient from convalescent leave, outpatient status or visiting status shall be that of:

- (A) the party removing the patient from the facility; or
- (B) The Department.

When it becomes necessary for the patient to be returned from the county where he happened to be, the Department shall reimburse the county pursuant to the state Travel Reimbursement Act [or similar statute]. In the event authorization is necessary to accomplish the return of the patient to the facility, such authority is hereby vested in the judge of the district court in the county where the patient is located. Upon receipt of notice that the patient needs to be returned to the facility, the judge shall cause the patient to be brought before him by issuance of a citation directed to the patient to appear and show cause why he should not be returned to the facility. The judge shall, if clear and convincing evidence is presented by testimony under oath that the patient should be



returned to the facility, enter an order returning him. If there is a lack of clear and convincing evidence showing the necessity of such return, the patient shall immediately be released. Law enforcement officers are authorized to take into custody, detain and transport a patient pursuant to a citizen or an order of the judge of the district court.

**Section 11. Discharge procedures for mental health patients.** An attending physician of any patient admitted to a private facility may discharge a patient or permit him to leave the facility subject to the same provision applicable to the discharge or release of a patient by the administrator of a state facility.

**Section 12. {Severability Clause.}**

**Section 13. {Repealer Clause.}**

**Section 14. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1987.*

## Vulnerable Adults Act

### *Summary*

**Vulnerable Adults Act** addresses the issue of abuse and neglect of patients. This bill requires any person who knows or suspects that a patient has been abused or neglected to inform the appropriate health care officials. This legislation also fosters prompt investigation and fair disposition of such reports.

### *Model Legislation*

(Title, enacting clause, etc.)

**Section 1. Short title.** This Act may be cited as the **Vulnerable Adults Act**.

**Section 2. Purpose.** The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to abuse or neglect; to provide safe institutional or residential services or living environments for vulnerable adults who have been abused or neglected; and to assist persons charged with the care of vulnerable adults to provide safe environments.

In addition, it is the policy of this state to require the reporting of suspected abuse or neglect of vulnerable adults, to provide for the voluntary reporting of abuse or neglect of a vulnerable adult, to require investigation of the reports, and to provide protective and counseling services in appropriate cases.

**Section 3. Definitions.** As used in this Act:

(A) "Abuse" means:

- (1) any act which constitutes a violation under [cite appropriate chapter relating to criminal conduct];
- (2) nontherapeutic conduct which produces or could be expected to produce severe/additional pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce severe/additional mental or emotional distress;
- (3) any sexual contact between a faculty staff person and a resident or client of that facility;

(4) the illegal use of a vulnerable adult's person or property for another person's profit or advantage, or the breach of a fiduciary relationship through the use of a person or a person's property for any purpose not in the proper and lawful execution of trust. Including, but not limited to, situations where a person obtains money, property, or services from a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud;

(5) counseling or aiding and abetting a suicide, or procuring any lethal instrument or substance when a person knows or has reason to know that a vulnerable intends to commit suicide.

(B) "Attending physician" means the physician with the primary responsibility for the care and treatment of the patient. If there is more than one physician caring for the patient, these physicians, among themselves, shall designate the "attending physician" for purposes of this Act.

(C) "Caretaker" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of family relationship, or who has assumed the responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

(D) "Facility" means a hospital or other entity required to be licensed pursuant to *[cite appropriate chapter relating to hospitals and medical facilities]*; a nursing home required to be licensed to serve adult pursuant to *[cite appropriate chapter relating to nursing homes]*; an agency, day care facility, or residential facility required to be licensed to serve adults pursuant to *[cite appropriate chapter]*; or a home health agency certified for participation in Titles XVIII or XIX of the Social Security Act, 42 USC 1395, *et seq.*

(E) "Licensing Agency" means:

(1) the *[designate appropriate commissioner of health]* for a facility required to be licensed or certified by the *[designate appropriate department of health]*;

(2) the *[designate appropriate commissioner of human services]* for a facility required to be licensed or certified;

(3) any licensing board which regulates persons pursuant to *[cite appropriate chapter relating to administrative procedure]*; and

(4) any agency responsible for credentialing human services occupations.

(F) "Life-resuscitating procedure" means any medical procedure or intervention that uses any means to restore a vital function of a person.

(G) "Life-sustaining procedure" means any medical procedure or intervention that uses mechanical or other artificial means to sustain, or supplant and vital function or a

personal terminally ill and serves only to artificially prolong the moment of death. “Life-sustaining procedure” does not include the usual care provided to patients, which would include routine care necessary to sustain patient comfort and the usual and typical provision of nutrition which in the medical judgment of the attending physician such person can tolerate, and subject to the provisions of Section 6 of this Act.

(H) “Local law enforcement officials” refers to the local law enforcement agents or other officials assigned to investigate a specific incidence of alleged abuse.

(I) “Necessary food and water” means nutrition and hydration, irrespective of the manner of provision or assistance, sufficient to maintain the patient at his highest possible level of health as determined by his attending physician in accordance with ordinary and accepted standards of medical care, but does not include nutrition and hydration, when, in the judgments of the patient’s attending physician and a second consulting physician:

- (1) the administration of nutrition or hydration will unavoidably and in itself cause severe, intractable or long-standing pain to the patient;
- (2) the administration of nutrition or hydration is not medically feasible, in that
  - (a) the patient is unable to ingest nutrients or incorporate fluids, or
  - (b) no technique or procedure is reasonably available to the attending physician for such administration; or
- (3) the death of the patient from a terminal illness imminent.

(J) “Neglect” means:

- (1) failure by a caretaker to supply the vulnerable adults with necessary food, water, clothing, shelter, health care, or supervision;
- (2) the absence or likelihood of absence of necessary food, water, clothing, shelter, health care, or supervision for a vulnerable adult; or
- (3) the absence or likelihood of absence of necessary financial management to protect adult against abuse. Nothing in the Section shall be construed to require a facility to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

(K) “Report” means any report received by local law enforcement officials, welfare agency, or licensing agency, pursuant to this Act.

(L) “Terminally ill” means the incurable condition of a person caused by injury, disease or illness, which regardless of the application of life-sustaining procedures will, within

reasonable medical judgment, produce death, and where the application of life-resuscitating procedures serve only to postpone the moment of death of the person.

(M) “Vulnerable adult” means any person 18 years of age or older:

- (1) who is a resident or inpatient of a facility;
- (2) who receives services from a facility, except a person receiving out-patient services for treatment of chemical dependency or mental illness;
- (3) who, regardless of residence or type of service received, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function or emotional status.

#### **Section 4. Persons mandated to report.**

(A) Those persons mandated to report and incident of alleged abuse will include persons who have knowledge of the abuse or neglect of a vulnerable adult, have reasonable cause to believe that a vulnerable adult is being or has been abused or neglected, or have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained by the history of injuries provided by the caretaker or caretakers of the vulnerable adult. Such persons shall immediately report the information to the local law enforcement officials. Upon receiving a report, the local law enforcement officials shall immediately notify the state Department of Justice and the appropriate licensing agency or agencies. The above specifically refers to:

- (1) a professional or his delegate engaged in the care of vulnerable adults, in education, in social services, law enforcement, or in any of the regulated occupations referenced in Sections 3(E)(3) and 3(E)(4);
- (2) and employee of a rehabilitation facility certified by the [designate appropriate commissioner of vocational rehabilitation]; or
- (3) an employee of or a person providing services in a facility;
- (4) medical examiners or coroners, in instances in which they believe that a vulnerable adult has died as a result of abuse or neglect.

(B) Nothing in this section shall be construed to require the reporting or transmittal of information regarding an incident of abuse or neglect or suspected abuse or neglect if the incident previously has been reported or transmitted to the appropriate person or entity.

Written reports received by local law enforcement officials shall be forwarded immediately to the local welfare agency. The local law enforcement official may keep copies of any reports received. Copies of written reports received by a local welfare agency shall be forwarded immediately to the local law enforcement officials and the appropriate licensing agency or agencies.

**Section 6. Report not required.**

(A) Where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected abuse or neglect under this Act, that person need not make a required report unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent of the disclosure of suspected abuse from each patient or resident, or his guardian, conservator, or legal representative, upon his admission to the facility. Persons are prohibited by federal law from reporting an incident of suspected abuse or neglect shall promptly seek consent to make a report.

(B) Except as provided in Section 3(A)(1), verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior of these persons does not constitute "abuse" for the purposes of Section 4 unless it causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior in a manner that facilitates periodic review by local law enforcement officials and licensing agencies.

(C) Nothing in this Section shall be construed to require a report of abuse, as defined in Section 3(A)(4), solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

**Section 7. Immunity from liability.**

(A) A person making a voluntary or mandated report under Section 4 or participating in an investigation under this Act is immune from any civil or criminal liability that otherwise might result from the person's actions, if the person is acting in good faith.

(B) A person employed by a local law enforcement authority or licensing agency who is conducting or supervising an investigation or enforcing the law in compliance with Section 12, 13, or 14 or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is acting in good faith and exercising due care.

**Section 8. Falsified reports.** A person who intentionally makes a false report under the provisions of this Act shall be liable in a civil suit for any actual damages suffered by the person or persons so reported.

**Section 9. Failure to report.**

(A) A person required by this Act to report, who intentionally fails to report, is guilty of a misdemeanor.

(B) A person required to report by this Act who negligently or intentionally fails to report is liable for damages caused by the failure.



**Section 10. Evidence not privileged.** No evidence regarding the abuse or neglect of the vulnerable adult shall be excluded in any proceeding arising out of the alleged abuse or neglect on the grounds of lack of competency under *[cite appropriate evidentiary code section.]*

**Section 11. Duties of local law enforcement officials upon receipt of a report.** In carrying out these duties, the local law enforcement official shall notify and seek the help of the local welfare agency.

(A) The local law enforcement officials shall immediately investigate and offer emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. Local law enforcement officials may enter facilities and inspect and copy records as part of investigations. In cases of suspected sexual abuse, the local law enforcement officials shall immediately arrange for and make available to the victim appropriate medical examination and treatment. The investigation shall not be limited to the written records of the facility, but shall include every other available source of information. When necessary in order to protect the vulnerable adult from further harm, the local law enforcement officials shall seek authority to remove the vulnerable adult from the situation in which the neglect or abuse occurred. The local law enforcement officials shall also investigate to determine whether the conditions which resulted in the reported abuse or neglect place other vulnerable adults in jeopardy of being abused or neglected and offer protective social services that are called for by its determination. In performing any of these duties, the local law enforcement officials shall maintain appropriate records.

(B) If the report indicates, or if the local law enforcement officials find, that the suspected abuse or neglect occurred at a facility, or while the vulnerable adult was or should have been under the care of or receiving services of a facility, or that the suspected abuse or neglect involved a person licensed by a licensing agency to provide care or services, the local welfare agency shall immediately notify each appropriate licensing agency, and provide each licensing agency with a copy of the report and its investigative findings.

(C) When necessary in order to protect a vulnerable adult from serious harm, the local law enforcement official shall immediately intervene on behalf of that adult to help the family, victim, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to *[cite appropriate rule of civil procedure]*;

(2) the appointment of a guardian or conservator, or guardianship or conservatorship pursuant to *[cite appropriate chapter relating to guardianship]*;

(3) replacement of an abusive or neglectful guardian or conservator and appointment of a suitable person as guardian or conservator, pursuant to *[cite appropriate chapter relating to guardianship]*; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under *[cite appropriate criminal procedure section]*.

(D) The expenses of legal intervention must be paid by the county in the case of indigent persons, under *[cite appropriate section relating to indigency]*.

(E) In guardianship and conservatorship proceedings, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county attorney shall contract with or arrange for a suitable person or non-profit organization to provide ongoing guardianship services. If the county presents evidence to the probate court that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ward or conservatee even if the action is adverse to the county's best interest. Any person retaliated against in violation of this Section shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

**Section 12. Notification of neglect or abuse in a facility.**

(A) When a report is received that alleges abuse or neglect of a vulnerable adult while in the care of a facility required to be licensed under *[cite appropriate chapter relating to day care or residential facilities]*, the local law enforcement officials investigating the report shall notify the guardian or conservator of a vulnerable adult under guardianship or conservatorship who is alleged to have been abused or neglected. The local law enforcement officials shall notify the person, if any, designated to be notified in case of an emergency regarding a vulnerable adult not under guardianship or conservatorship who is alleged to have been abused or neglected, unless consent is denied by the vulnerable adult. The notice shall contain the following information:

- (1) the name of the facility;
- (2) the fact that a report of alleged abuse or neglect of a vulnerable adult in the facility has been received;
- (3) the nature of the alleged abuse or neglect;
- (4) notice that the agency is conducting an investigation;
- (5) any protective or corrective measures being taken pending the outcome of the investigation; and

(6) notice that a written memorandum will be provided when the investigation is completed.

(B) In a case of alleged abuse or neglect of a vulnerable adult while in the care of a facility required to be licensed under *[cite appropriate section relating to day care or residential facilities]*, the local law enforcement officials may also provide the information is subsection (A) to the guardian or conservator of any vulnerable adult in the facility who is under guardianship or conservatorship, and to the person, if any, designated to be notified in case of an emergency regarding any other vulnerable adult in the facility who is not under guardianship or conservatorship, unless consent is denied by the vulnerable adult, if the investigative agency knows or has reason to believe that alleged neglect or abuse has occurred.

(C) When the investigation under section 12 is completed, the local welfare agency shall provide a written memorandum to every guardian or conservator or other person notified by the agency of the investigation under subsection (A) or (B). the memorandum shall protect the identity of the reporter and the alleged victim and shall not contain the name or, to the extent possible, reveal the identity of the alleged perpetrator or those interviewed during the investigation. The memorandum shall contain the following information:

- (1) the name of the facility investigated;
- (2) the nature of the alleged neglect or abuse;
- (3) the investigator's name;
- (4) a summary of the investigative findings;
- (5) a statement of whether the report was found to be sustained, inconclusive, or false; and
- (6) the protective or corrective measures that are being or will be taken.

(D) In case of neglect or abuse of a vulnerable adult while, in the care of a facility required to be licensed under *[cite appropriate sections relating to day care or residential facilities]*, the local law enforcement officials may also provide the written memorandum to the following individuals if the report is unsubstantiated or if the investigation is inconclusive and the report is a second or a subsequent report of neglect or abuse of a vulnerable adult while in the care of the facility:

- (1) the guardian or conservator of any other vulnerable adult in the facility who is under guardianship or conservatorship;
- (2) any other vulnerable adult in the facility who is not under guardianship or conservatorship; and

(3) the person, if any, designated to be notified in case of an emergency regarding and other vulnerable adult in the facility who is not under guardianship or conservatorship, unless consent is denied by the vulnerable adult.

(E) In determining whether to exercise the discretionary authority granted under subsections (B) and (D), the local law enforcement officials shall not provide any notice under subsection (A) or (B) or any memorandum under subsection (C) or (D) unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

**Section 13. Duties of licensing agencies upon receipt of report.** A licensing agency shall investigate immediately all reports or other information which indicates that a vulnerable adult may have been abused or neglected at a facility it has licensed, or that a person it has licensed or credentialed to provide health care or services may be involved in the abuse or neglect of a vulnerable adult, or that such a facility or person has failed to comply with the requirements of this Act. Subject to the [cite appropriate administrative procedure sections], the licensing agency shall have the right to enter facilities and inspect and copy records as part of its investigations. The investigation shall not be limited to the written records of the facility, but shall include every other available source of information. The licensing agency shall issue orders and take actions designed to prevent further abuse or neglect of vulnerable adults. Such actions may include the suspension or revocation of a person's license or the facility's license.

**Section 14. Records.**

(A) Each licensing agency shall maintain summary records of reports of alleged abuse or neglect and alleged violations of the requirements of this section with respect to facilities or persons licensed or credentialed by that agency. As part of these records, the agency shall prepare an investigation memorandum. The investigation memorandum shall be public record and a copy shall be provided to any public agency which referred the matter to the licensing agency for investigation. It shall contain a complete review of the agency's investigation, including, but not limited to:

- (1) the name of the facility investigated;
- (2) a statement of the nature of the alleged abuse or neglect or other violation of the requirements of this Section;
- (3) a statement of pertinent information obtained from medical or other records reviewed;
- (4) the investigator's name;
- (5) a summary of the investigation's findings;

(6) a statement of whether the report was found to be substantiated, inconclusive, or false; and

(7) a statement of any action taken by the agency.

The investigation memorandum shall protect the identity of the reporter and of the vulnerable adult and may not contain the name or, to the extent possible, the identity of the alleged perpetrator or those interviewed during the investigation. During the licensing agency's investigation, all data collected pursuant to this Act shall be classified as investigative data pursuant to [cite appropriate administrative code section]. After the licensing agency's investigation is complete, the data or individuals collected and maintained shall be private data on individuals. All data collected pursuant to this Section shall be made available to prosecuting authorities and law enforcement officials, local welfare agencies, and licensing agencies investigating the alleged abuse or neglect. Notwithstanding any law to the contrary, the name of the reporter shall be disclosed only upon a finding by the court that the report was false and made in bad faith.

(B) Notwithstanding any law to the contrary:

(1) all data maintained by licensing agencies, treatment facilities, or other public agencies which relates to reports which, upon investigation, are found to be false may be destroyed two years after the finding is made;

(2) all data maintained by licensing agencies, treatment facilities, or other public agencies which relates to reports which, upon investigation, are found to be inconclusive may be destroyed four years after the finding is made;

(3) all data maintained by licensing agencies, treatment facilities, or other public agencies which relates to reports which, upon investigation, are found to be substantiated may be destroyed seven years after the finding is made.

### **Section 15. Abuse prevention plans.**

(A) Each facility, except home health agencies, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(B) Each facility shall develop an individual abuse prevention plan for each vulnerable adult residing or receiving services there. The plan shall contain an individualized assessment of the person's susceptibility to abuse, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purpose of this clause, the term "abuse" includes self-abuse.



**Section 16. Internal reporting of abuse and neglect.** Each facility shall establish and enforce an ongoing written procedure in compliance with the licensing agencies' rules for insuring that all cases of suspected abuse or neglect are reported and investigated promptly.

**Section 17. Enforcement.**

(A) A facility which has not complied with this Section within 60 days of the effective date of passage of temporary rules is ineligible for renewal of its license. A person who is required by Section 4 to report and who is licensed or credentialed to practice an occupation by a licensing agency, who willfully fails to comply with this Act shall be disciplined after a hearing by the appropriate licensing agency.

(B) Licensing agencies shall as soon as possible promulgate rules necessary to implement the requirements of Sections 14,15,16,17,18, and 19 (A). Agencies may promulgate temporary rules pursuant to *[cite appropriate administrative procedure section]*.

(C) The *[cite appropriate commissioner of human services]* shall promulgate rules as necessary to implement the requirements of Section 12.

**Section 18. Retaliation prohibited.**

(A) A facility or person shall not retaliate against any person who reports in good faith suspected abuse or neglect pursuant to this Act, or against a vulnerable adult with respect to whom a report is made.

(B) Any facility or person which retaliates against any person who reports in good faith suspected abuse or neglect is liable to that person for actual damages and, in addition, a penalty of up to \$1,000.

(C) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this clause, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made and includes, but is not limited to:

- (1) discharge or transfer from the facility;
- (2) discharge or termination of employment;
- (3) demotion or reduction in remuneration for services;
- (4) restriction or prohibition of access to the facility or its residents; or
- (5) any restriction of rights set forth in *[cite appropriate section enumerating employee rights]*.



**Section 19. Outreach.** The *[designate appropriate commissioner of human services]* shall establish an aggressive program, using a variety of media, to educate those required to report, as well as the general public, about the requirements of this Act.

**Section 20. Penalty.** Any caretaker, operator, employee or volunteer worker thereof, who intentionally abuses or neglects a vulnerable adult, or being a caretaker, knowingly permits conditions to exist which result in the abuse or neglect of a vulnerable adult, is guilty of a *[specify misdemeanor]*.

**Section 21. {Severability Clause.}**

**Section 22. {Repealer Clause.}**

**Section 23. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1987.*

**Resolution On Disease Management of Chronic Obstructive Pulmonary Disease (COPD)**

**WHEREAS**, chronic obstructive pulmonary disease (COPD), also known as chronic bronchitis and emphysema, is the fourth-leading cause of death in the United States and is the only one of the top five causes whose prevalence and death rate are rising; and

**WHEREAS**, COPD is a chronic progressive disease which potentially impacts over 24 million Americans; and

**WHEREAS**, the annual cost to the nation for COPD in 2004 was estimated to be approximately \$37 billion dollars; and

**WHEREAS**, early diagnosis and management of COPD can effectively reduce the overall financial burden of the illness within public programs such as Medicaid; and

**WHEREAS**, proper management of COPD can lead to improved quality of life and self sufficiency on the part of patients cared for within public programs.

**NOW THEREFORE BE IT RESOLVED** that the general assembly of the state of {insert state} hereby encourages the {insert name of state health and human services department} to consider chronic disease management of COPD using available private sources of funding in an effort to reduce the financial and clinical burden of COPD illness upon the Medicaid program and the citizens of {insert state}.

*Approved by the Health and Human Services Task Force on July 20, 2006.*

**Resolution on Public Education of Respiratory Syncytial Virus (RSV)**

**WHEREAS**, in the United States, Respiratory Syncytial Virus (RSV) disease is the most frequent cause for hospitalizations of children under one year of age; and

**WHEREAS**, RSV is a highly-contagious disease which can be controlled with better education of parents, day-care workers, and health professionals; and

**WHEREAS**, while infection with this virus generally manifests itself in older children and adults as a mild upper respiratory tract infection, RSV can cause severe and even fatal disease in premature infants and those infants who have other compromising risk factors such as chronic lung disease or hemodynamically significant congenital heart disease; and

**WHEREAS**, this legislative body encourages active education efforts on the part of **{insert name of state public health department}** targeted to parents and providers in order to share current information on prevention and treatment of RSV, as well as methods of prophylaxis of RSV in high-risk individuals; and

**WHEREAS**, this legislative body encourages the importance of preventative activities for children at risk of contracting RSV and prophylaxis for children who are at high risk of complications from the disease;

**THEREFORE BE IT RESOLVED THAT** this legislative body encourages **{insert name of state public health department}** to provide information on immunizations to parents and providers, and also provide information on RSV, including the prevention of infection with this virus.

*Approved by the Health and Human Services Task Force on July 20, 2006.*

## **Resolution On The Use Of Chlorofluorocarbons (CFC'S) And Metered Dose Inhalers (MDI'S)**

**WHEREAS**, approximately thirty million (30, 000,000) Americans currently suffer from respiratory diseases including asthma, chronic obstructive pulmonary disease (COPD) and cystic fibrosis, requiring treatment with use of metered dose inhaler;

**WHEREAS**, nearly five million (5,000,000) of those are under the age of 18 who suffer from asthma and each year more than five thousand (5,000) Americans die from asthma alone;

**WHEREAS**, for many patients suffering from asthma, COPD, or cystic fibrosis, the primary and often sole treatment for their disease is through the use of a metered dose inhaler (MDI);

**WHEREAS**, while MDI's deliver medicines to open patient's breathing passages, chlorofluorocarbons (CFC's) are an essential part of the MDI delivery system and effectively carries medicines to the patient's lungs;

**WHEREAS**, as many patients and their physicians have discovered, even with the same medicine, one type of MDI may work better for them than another;

**WHEREAS**, while these devices have been helpful to patients and been proven for over forty (40) years, CFC's in large quantities are alleged by some to deplete the earth's stratospheric ozone layer and in 1987 an international treaty referred to as the Montreal Treaty was thereby adopted;

**WHEREAS**, this treaty calls for an end to the production of ozone helping chemicals including CFC's;

**WHEREAS**, the Environmental Protection Agency has the responsibility of implementing the protocol obligation in the United States except for exceptional cases in which a special permission – an Essential Use Exemption—is granted by the United States Food and Drug Administration;

**WHEREAS**, CFC used in metered dose inhalers is currently one exception. A principal reason for this is that pharmaceutical usage of CFC's for inhalation aerosol accounts for less than 1 percent of the cumulative worldwide consumption of CFC's. Potential benefits to the ozone layer from a premature product ban of CFC MDI's are negligible compared to the greater risk in patient health;

**WHEREAS**, the FDA, however, has recently issued an Advanced Notice of Proposed Rulemaking (ANPR) for the purpose of rethinking the essential use designation for MDI's;

**WHEREAS**, recognizing the medical necessity of some uses of CFC's, the treaty deemed those used in MDI's as an "essential use" and seeing a need to adopt a transition strategy to non-CFC MDI's by the year 2005, and to assist ongoing market forces in achieving a seamless transition for patients to non-CFC MDI's, the parties of the Montreal Protocol did adopt certain measures by which companies requesting CFC allowances must demonstrate their ongoing commitment. These measures are:

- Advancing research and development on non-CFC alternatives;
- Educating physicians and patients about transition;
- Conducting appropriate marketing of their CFC-free asthma treatments; and
- Minimizing CFC emissions during manufacture of MDI's and proper returned or defective CFC metered dose inhalers;

**WHEREAS**, pharmaceutical companies serving this patient population have invested significant resources in a research and development effort to offer patients suitable non-CFC alternatives to its current therapies well within the time frame established by the Montreal Protocol.

**THEREFORE**, be it resolved that until a broad range of satisfactory alternatives that meet governmental regulatory standards is developed for these pharmaceutical products, the American Legislative Exchange Council (ALEC) supports the continuation of the medical exception for CFC use.

*Approved by the Health and Human Services Task Force in 1997.*

**Resolution Calling For The Reform Of The Food And Drug Administration**

*Summary*

A Resolution urging Congress to reform the Food and Drug Administration (FDA) to ensure that health care products, therapies, and cures are brought to the American public as quickly as possible. It also suggests that the FDA should significantly cut back on its bureaucratic procedures and policies that tend to delay the time a drug or therapy hits the marketplace.

*Model Resolution*

**WHEREAS**, better health care for all Americans is a paramount national goal, and one component to improved health care is the development and approval of safe and effective new medical technology, and

**WHEREAS**, innovative private sector firms in the medical technology industry have research underway that is making significant advances in the practice of medicine, and

**WHEREAS**, new therapies derived from medical technology are improving the lives of millions of Americans, and with meaningful Food and Drug Administration (FDA) reform, could significantly reduce health care costs, and

**WHEREAS**, minimizing delays between the creation and eventual approval of a new product derived from the genius of medical technology is a vital public health goal, and

**WHEREAS**, the competitiveness of the United States biotechnology, medical devices and pharmaceutical industries is dependent on bringing products to the market quickly, and

**WHEREAS**, repeatedly the FDA has fallen short of its own guideline for clearing medical devices and new drug applications for sale on the market. This, despite a FDA staff increase of 449% since 1960 and an annual gross budget authority exceeding \$935 million, and

**WHEREAS**, regulatory delays are forcing companies to move their innovation overseas to countries that have regulatory systems consistent with the rapid pace of innovation.

**NOW THEREFORE BE IT RESOLVED**, that the American Legislative Exchange Council (ALEC) strongly urges Congress and the Administration to reform the governing



statutes and operation of the FDA this calendar year to ensure that health care products can be brought to the market as quickly as possible while preserving the safety of all Americans, and

**BE IT FURTHER RESOLVED**, that it is imperative that the federal government be responsive to the changing health care market and ensure that the excellence of medical innovation in the United States is maintained, and

**BE IT FURTHER RESOLVED**, that a reexamination of the policies and procedures of the FDA is necessary to facilitate better and more rapid access to new therapies and cures, and

**BE IT FURTHER RESOLVED**, that even with the acknowledged regulatory obstacles and bureaucratic foot-dragging by the FDA, its current attempt to enter the tobacco control arena, an area already regulated by 13 federal agencies, departments, commissions and agencies and 138 offices and programs within those federal agencies, would continue to erode vital resources intended for the job FDA was supposed to do, and

**BE IT FURTHER RESOLVED**, that the FDA should be denied power over any information-disseminating activities of a pharmaceutical manufacturer to the extent they concern cost-effectiveness comparisons between FDA-approved products.

*Approved by the Health and Human Services Task Force in 1996.*

## **Resolution on Preserving States' Rights to Regulate Health Insurance**

### *Summary*

The Resolution urges Congress not to institute federal review, oversight, or preemption of state health insurance laws. Congress is considering legislation that would impose restrictions on states ability to regulate health plans, including overriding already adopted state policies. The creation of a new federal system of regulation for health insurance would be inefficient, unnecessary, not cost-effective and further burden the health care delivery system. The states to continue to regulate all other plans within their borders and with their existing regulatory expertise without federal intervention.

### *Model Resolution*

**WHEREAS**, the states have been at the forefront of the health reform debate by aggressively leading the charge to ensure that their citizens are protected in health insurance transactions; and

**WHEREAS**, the state-based system of regulation of health insurance has served all interests well; and

**WHEREAS**, the U. S. Congress is considering legislation which would impose restrictions on the states ability to regulate health plans, including overriding already adopted state patient protections, and

**WHEREAS**, the federal government should regulate health plans only where they are given authority under the Employee Retirement Income Security Act (ERISA) and allow the states to continue to regulate all other plans within their borders and with their existing regulatory expertise without federal intervention; and

**WHEREAS**, the creation of a new federal system of regulation for health insurance would be inefficient, unnecessary, not cost-effective and further burden the health care delivery system;

**NOW THEREFORE BE IT RESOLVED**, that the legislature of the state of [State] urges Congress not to institute federal review, oversight, or preemption of state health insurance laws.

**BE IT FURTHER RESOLVED** that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S. House of Representatives.

*Adopted by Health and Human Services Task force at the States and Nation Policy Summit, December 1999. Approved by the ALEC Board of Directors January 2000.*

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## **Medical School Loan Repayment Act**

### ***Summary***

The purpose of this Act is to attract physicians to practice in rural areas. One of the major problems adversely effecting access to primary health care in rural communities is the lack of practicing physicians. Despite the growing number of physicians nationwide, the supply of doctors in rural communities has dropped dramatically. This occurrence can be attributed to the financial burden of repaying medical school with the lower incomes of rural physicians. This legislation creates an incentive to attract physicians to rural areas.

ALEC's bill would require the state to repay, on behalf of a physician, up to \$50,000 in educational loans obtained by the physicians from a public or private lending institution for education in an accredited school of medicine or for postgraduate medical training. In the contrast, a physician would agree to practice primary care exclusively in a rural, medical shortage area of the state.

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Medical School Loan Repayment Act**.

#### **Section 2. {Definitions.}**

(A) "Medical shortage area" means a county or service area in which the ratio of the population to the number of physicians who provide primary care is more than 2,500 to one (*or insert appropriate ratio*), or an area that is no less that 35 road miles or more away from the nearest medical doctor.

(B) "Primary care" means family medical practice, general internal medicine, and pediatrics.

#### **Section 3. {Eligibility.}**

The state may repay, on behalf of a physician, up to \$50,000 (*or insert appropriate amount*) in educational loans obtained by the physician from a public or private lending institution for education in an accredited school of medicine or for postgraduate medical training.

#### **Section 4. {Agreement.}**

(A) The state shall enter into a written agreement with the physician. In the agreement, the physician shall agree to practice primary care in this state exclusively in a medical shortage area.

(B) The agreement shall specify that the responsibility of the state to make payments under the agreement is subject to the availability of funds in the appropriations of the state budget.

**Section 5. {Loan Repayment.}**

Loans may be repaid by the state at the following rate:

(A) 10 percent of the principal of the loan or \$5,000, whichever is less, during the first year of practice in a medical shortage area;

(B) An additional 12.5 percent of the principal of the loan or \$6,250, whichever is less, during the second year of practice in a medical shortage area.

(C) An additional 15 percent of the principal of the loan or \$7,500, whichever is less, during the third year of practice in a medical shortage area.

(D) An additional 20 percent of the principal of the loan or \$10,000, whichever is less, during the fourth year of practice in a medical shortage area.

**Section 6. {Availability of Funds; No Right of Action Against State.}**

(A) The obligation of the state to make payments under an agreement entered into under Section (4)(A) is subject to the availability of funds in the appropriations.

(B) If the cost of repaying the loans of all eligible applicants when added to the cost of loan repayments scheduled under existing agreements, would exceed the total amount in the appropriations, the (*insert appropriate state department*) shall give priority in entering into new agreements to all of the following:

(1) physicians who resided in a medical shortage area prior to attending a college, university, or medical school;

(2) physicians who practice exclusively in cities, villages or towns in a medical shortage area with a per capita income of less than 75 percent of the statewide median per capita income;

(3) physicians practicing or who agree to practice in medical shortage areas with an extremely high need for medical care, as determined by the department.

(C) The (*insert appropriate state department*) may also enter into agreements with physicians who practice psychiatry, or obstetrics and gynecology, if the department determines that there is an unmet need for those services in a medical shortage area and the physician agrees to practice primarily in the medical shortage area.

(D) An agreement does not create a right of action against the state on the part of the physician or the lending institution for failure to make the payments specified in the agreement.

**Section 7. {Loan Participation.}**

The state shall encourage contributions to the program under this section by counties, cities, villages and towns. Revenues received under this Subsection shall be deposited in the fund.

**Section 8. {Administrative Contract.}**

From the appropriation, the (insert appropriate department) shall contract with the board of regents of the (insert state) university system for administration services from the office of rural health of the department of professional and community development (or insert appropriate department) or the (insert state) university hospital and clinic. Under the contract, the office of rural health shall:

(A) advise the department on the identification of communities with an extremely high need for medical care;

(B) advise the department of the identification of medical shortage areas, in which there is an unmet need for the services of physicians who practice psychiatry or obstetrics and gynecology;

(C) assist the department to publicize the program under this section to physicians and eligible communities;

(D) assist communities in obtaining physicians' services through the program under this Section; (5) assist the department with the general operation of the program under this section.

**Section 9. {Severity clause.}**

**Section 10. {Repealer clause.}**

**Section 11. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1992.*



## **Resolution on Anti-Trust Exemption for Physician Cartels**

### *Summary*

This Resolution urges states to reject legislation that would exempt independent, competing health care professionals from anti-trust laws and allow them to form cartels, and raises concern our Congress' misguided attempts to pass similar physician antitrust exemption legislation.

### *Model Resolution*

**WHEREAS**, competition benefits consumers because it results in more products and services at lower prices and of higher quality, and

**WHEREAS**, under current antitrust law, independent physicians are able to form legitimate joint ventures and multi-provider networks in order to collectively negotiate or actively compete with health plans, and

**WHEREAS**, exempting physicians from existing antitrust laws could result in such anti-competitive behavior by physicians as price-fixing, boycotts or other refusals to deal that are currently unlawful, and

**WHEREAS**, a physician antitrust exemption would authorize anti-competitive joint conduct by physicians that could seriously harm consumers and undermine efforts to promote high quality care and greater choice of products and services, and

**WHEREAS**, the US Department of Justice has found that "when health care professionals jointly negotiate with health insurers, without regard to antitrust laws, they typically seek to significantly increase their fees, sometimes by as much as 20-40%", and

**WHEREAS**, higher health care costs resulting from such an exemption will be shouldered by employers and consumers and will threaten to increase the number of uninsured and reduce access to care, and

**WHEREAS**, the Federal Trade Commission, the US Department of Justice and the Consumer Federation of America explicitly oppose a physician antitrust exemption for its potential harm to consumer welfare, and

**WHEREAS**, health plans already have a variety of mechanisms in place to allow a physician to discuss concerns about actions taken by the plan, and to contribute to efforts to improve efficiency and quality of care, and

**WHEREAS**, a physician antitrust exemption would give health care providers special treatment available to no other workers in the health care arena.

**NOW THEREFORE BE IT RESOLVED**, that the legislature of the state of [insert state] rejects any proposal to exempt independent health care professionals from antitrust laws that could permit them to collude, form cartels, price fix and engage in other collective activity that would otherwise be illegal, and also urges Congress not to enact legislation that provides for a similar physician antitrust exemption.

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S. House of Representatives.

*Approved by the Health and Human Services Task Force in January 2000.*

Obtained and released by:  
SUN Common Cause and  
The Center for Media and Democracy

**Resolution on Patient Access to Physical Therapists' Services Without Current Professional Practice Restrictions Regarding Referral**

**WHEREAS**, physical therapy is the care and services provided by or under the direction and supervision of a licensed physical therapist as authorized by state law. Physical therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, disorders or other causes. Physical therapy restores, maintains, and promotes optimal fitness, wellness, and quality of life as it relates to movement and health. Physical therapists' services include examination, evaluation, prognosis, and interventions, including consultation and education, regarding impairments, functional limitations, and disabilities. Physical therapy does not include medical diagnosis or the diagnosis of disease.

**WHEREAS**, several states still prohibit, within the professional practice act, an individual from obtaining physical therapists' services without a referral from another licensed health care provider.

**WHEREAS**, a majority of states and the United States uniformed services, the U.S. Army, the U.S. Navy, the U.S. Air Force, and the U.S. Public Health Service, have eliminated the professional practice restriction regarding referral.

**WHEREAS**, patient access to physical therapists' services is not a mandate for reimbursement or payment.

**WHEREAS**, patient access to physical therapists' services without current professional practice restrictions regarding referral promotes free-market health care and gives individuals the liberty to obtain treatment from a licensed physical therapist as the patient best sees fit.

**WHEREAS**, if the physical therapist's evaluation process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise, the physical therapist shall so inform the patient/client and refer to an appropriate practitioner.

**WHEREAS**, patients should have the ability to access physical therapists' services without current professional practice restrictions regarding referral.

**THEREFORE, BE IT RESOLVED**, that the American Legislative Exchange Council (ALEC) recognizes the benefits that access to physical therapists' services, without current professional practice restrictions regarding referral, provides to a free-market health care environment.

**BE IT FURTHER RESOLVED**, that [insert state] seek to enact legislation facilitating patient access to physical therapists' services by eliminating the professional practice restriction regarding referral.

*Adopted by the Health and Human Services Task Force on April 21, 2001, in Chicago, Illinois. Approved by American Legislative Exchange Council Board of Directors on May 30th, 2001. Approved by the Health and Human Services Task Force in Spring 2001.*

**Resolution on State Medical Board Sunshine and Patient Protection**

**WHEREAS**, State medical boards (“boards”) exist for the purpose of protecting patients by maintaining the high standards of excellence to which medical professionals in this country are held, and the public good is served by the boards’ oversight of these standards; and

**WHEREAS**, The practices of some boards (such as acceptance of anonymous complaints, the prohibition of notes and recordings in proceedings, the lack of due process and appeals, the prohibition of public monitoring of proceedings, failures to disclose conflicts-of-interest of board members, and staff- and board-appointed expert witnesses) have resulted in a lack of accountability of the boards and severely impair the ability of boards to serve the public.

**THEREFORE, BE IT RESOLVED THAT** The American Legislative Exchange Council advocates the elimination of the practices listed above that impair the ability of boards to serve the public, and advocates for their replacement with the following:

- 1) The increased transparency of charges and proceedings;
- 2) The increased accountability of the board members for their actions;
- 3) The increased integrity on behalf of board members in carrying out their responsibilities; and
- 4) The establishment of full due process in proceedings, including an appeal process.

*Passed by the Health and Human Services Task Force on December 8, 2007.*

**Resolution on State-Based Licensure and Regulation of Health Professionals in the Area of Telehealth**

**WHEREAS**, telehealth is a relatively recent innovation that utilizes telecommunications technology which transports patients or health professionals across great distances; and

**WHEREAS**, telehealth is an important state issue that offers enhanced quality, efficiency, and access to health care; and

**WHEREAS**, the state-based system of licensure and regulation of health professionals has served all interests well; and

**WHEREAS**, the transportation of patients or health professionals across state boundaries via telecommunications raises interstate commerce issues that the United States Constitution grants to Congress;

**WHEREAS**, the creation of duplicative federal system of regulation for health professionals would be inefficient, unnecessary, not cost effective and further burden the health care delivery system; and

**THEREFORE, BE IT RESOLVED**, that state {State} urges Congress to properly safeguard patient safety and ensure high professional standards in the area of telehealth while maintaining the traditional state regulation of health professionals.

**BE IT RESOLVED**, that {State} urges Congress to solely address the interstate commerce concerns of telehealth.

**BE IT RESOLVED**, that {State} urges Congress to ensure state autonomy and regulation of the health professionals.

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to the Governors.

*The Health and Human Services Task Force unanimously passed this Resolution as amended on May 22, 1999*



## Statement of Principles on Health IT

1. Health information technology (IT) is rapidly evolving and advancing toward its goal of improving quality of care, enhancing efficiency, and reducing costs.
2. To be effective, health IT systems must
  - a. be patient-centered and market driven;
  - b. be based on reasonable standards and sound policies developed with input from stakeholders including consumers, government, clinicians, hospitals, health plans, vendors, manufacturers, and others;
  - c. protect the privacy and security of all patient-identifiable health information;
  - d. promote interoperability; and
  - e. ensure the accuracy, completeness and uniformity of data.
3. Widespread adoption of health information technology—critical to its success—can best be achieved if:
  - a. the market provides users with a variety of products from which to choose those best suited to their needs, providing that those products are interoperable;
  - b. there are incentives for providers to adopt the use of health IT and rewards for providers who improve health care quality and efficiency through the use of health IT;
  - c. system managers implement protocols for addressing critical problems such as the unauthorized disclosure of protected patient-identifiable health information and inaccurate or incomplete data; and
  - d. the systems are financed by all who benefit from the increased quality, efficiency and savings that result from such technology—employers and other payers, state and federal governments, health plans, health care providers, and others.

*Approved by the Health and Human Services Task Force on July 27, 2007.*

## High-Risk Health Insurance Pool Model Act

### *Summary*

The purpose of this Act is to provide insurance for individuals with high-risk health conditions such as AIDS, diabetes, and cancer. Approximately 1 percent of the uninsured population is denied access to individual market health insurance because of pre-existing conditions. This bill establishes a state run high-risk pool and allows individuals who have been denied traditional insurance because of health problems to buy into the pool. This program is effective because it spreads the cost of coverage among all insurance carriers doing business in a state. Two critical goals that ALEC's high-risk pool accomplishes are guaranteed access to health care at reasonable rates to all of a state's uninsurable citizens, and that the costs of this guarantee are spread equitably among all of the state's citizens.

The pool is funded through the premiums charged to the individuals and through an assessment against insurers participating in the health insurance market. Any state resident would be eligible to participate in the pool, provided that certain conditions were met, and the pool would also serve as the state's guaranteed mechanism of providing group-to-individual health insurance portability, as required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The pool would operate under the supervision and approval of a Board of Directors appointed by the Commissioner of Insurance. (Drafting Note: or the appropriate regulator of insurance in your state.)

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the High-Risk Health Insurance Pool Act.

**Section 2.** For the purposes of this Act the following definitions apply:

(A) "Producer" means any person who is licensed to sell health insurance in this state.

(B) "Board" means the Board of Directors of the State Comprehensive Health Insurance Pool.

(C) "Health insurance" means any hospital or medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization, subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health

care services whether by insurance or otherwise, when sold to an individual or as a group policy. This term does not include short-term, accident, dental-only, fixed indemnity, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(D) "Insured" means a person who is a resident of this state and a citizen of the United States who is eligible to receive benefits from the pool. The term "insured" may include dependents and family members.

(E) "Insurer" means any entity that is authorized in this state to write health insurance or that provides health insurance in this state. For the purposes of this act, the insurer includes an insurance company, nonprofit health care services plan, fraternal benefits society, health maintenance organization, third party administrator, state or local governmental unit, to the extent permitted by federal law any self insured arrangement covered by Section 3, Employment Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), as amended, that provides health care benefits in this state, any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, and any reinsurer or stop-loss plan providing reinsurance or stop-loss coverage to a health insurer in this state.

(F) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 USC, Section 1395, et seq., as amended).

(G) "Pool" means the State High-Risk Health Insurance Pool.

(H) "Physician" means an individual licensed to practice medicine, as defined by this state.

(I) "Plan" means the Comprehensive Health Insurance Plan as adopted by the Board of Directors of the State Comprehensive Health Insurance Pool, or by rule.

(J) "Preexisting Condition" means a condition for which medical advice, care or treatment was recommended or received during the X months prior to effective date of coverage under the pool. Except as otherwise provided in this Act, preexisting conditions shall not be covered during the X months following the person's effective date of coverage under the plan.

(J) "Resident" means: (1) an individual who has been legally domiciled in (Insert State) for a minimum of 30 days for persons eligible for enrollment in the pool; or (2) an individual who is legally domiciled in (Insert State) and is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996; or (3) an individual who is legally domiciled in the pool and is eligible for enrollment as a result of the federal Trade Adjustment Assistance Act of 2002. (Drafting

note: The third criterion should only be used in states that wish to make their risk pools a purchasing option for individuals who are eligible for the health insurance tax credit established in the federal Trade Adjustment Assistance Act of 2002.)

### **Section 3.**

(A) There is hereby created a nonprofit legal entity to be known as the "(Insert State Name) High-Risk Health Insurance Pool." All insurers, as a condition of doing business in this state, shall be members of the pool.

(B) Health insurance policies available in accordance with this Act shall be available for sale within one year from the date of enactment of this Act.

### **Section 4.**

(A) Any individual person who is and continues to be a resident of (Insert State) and a citizen of the United States shall be eligible for coverage from the pool if evidence is provided of:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers, provided that at least two insurers offer individual health insurance coverage in the state. If only one insurer offers individual market health insurance coverage in the state, then one rejection shall be sufficient. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;

(2) a refusal by two insurers to issue insurance except at a rate exceeding the pool rate, provided that at least two insurers offer individual health insurance coverage in the state. If only one insurer offers individual market health insurance coverage in the state, then one quote that exceeds the pool rate shall be sufficient;

(3) a diagnosis of the individual with one of the medical or health conditions listed by the board in accordance with Section 6 (G) of this act. A person diagnosed with one or more of these conditions shall be eligible for a pool coverage without applying for health insurance coverage;

(4) for persons eligible due to eligibility under federal HIPAA law, the maintenance of health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days of which the most recent coverage was through an employer sponsored plan;  
or

(5) for persons eligible as a result of certification for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, coverage with no pre-existing conditions

limitation for individuals with three months of prior creditable coverage with a break in coverage of no more than 63 days. (Drafting Note: Optional section for states that wish to use their pool as a means of providing coverage to individuals eligible for the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002.)

(B) Each dependant of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool. In the instance of a child who is the primary insured, resident family members shall also be eligible for coverage.

(C) A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

(D) A person is not eligible for coverage from the pool if the person;

(1) has in effect on the date pool coverage takes effect health insurance coverage from an insurer or insurance arrangement;

(2) is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation except;

(a) coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person is satisfying any pre-existing condition waiting period under a pool policy; or

(b) employer group coverage conditioned by the limitations described by Subsections (A)(4) and (5) of this section; or

(c) individual coverage conditioned by the limitation described by Subsections (A)(1) –

(3) of this section;

(3) has terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

(4) is confined in a county jail or imprisoned in a state prison;

(5) has premiums that are paid for or reimbursed by any third party payer or under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider; or if the individual receives premium payment assistance through the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002. (Drafting Note: This section is optional and is for states that wish to use their pool as a means of providing coverage to



individuals eligible for the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002.)

(6) has not had prior coverage with the pool terminated for nonpayment of premiums or fraud.

(E) Pool preexisting condition requirements are waived for the following individuals:

(1) Individuals for whom, as of the date on which the individual seeks Plan coverage, the aggregate of the periods of creditable coverage is 18 or more months, and whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) Individuals who are eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, provided that as of the date on which the individual was certified as eligible for federal Trade Adjustment Assistance, the individual had at least three months of prior creditable coverage with no longer than a 63 day break in coverage as established by the federal Trade Adjustment Assistance Reform Act of 2002, as it may be amended, or the regulations under that Act. (Drafting Note: Optional section for states that wish to use their pool as a means of providing coverage to individuals eligible for the federal health insurance tax credit established by the federal Trade Adjustment Assistance Reform Act of 2002.)

(F) Pool coverage shall cease:

(1) on the date a person is no longer a resident of his state, except for a child who is a student under the age of 23 years and who is financially dependent upon the parent, a child for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent;

(2) on the date a person requests coverage to end;

(3) upon the death of the covered person;

(4) on the date state law requires cancellation of the policy;

(5) at the option of the pool, 30 days after the pool sends to the person any inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply.



(6) on the 31st day after the day on which a premium payment for pool coverage becomes due if the payment is not made before that date;

(7) a person has reached the maximum lifetime limit, as provided in Section 12 of this act; or

(8) at such time as the person ceases to meet the eligibility requirements of this section.

(G) A person who ceases to meet the eligibility requirements of this section may have his coverage terminated at the end of the policy period.

### **Section 5.**

(A) The pool shall operate under the supervision and approval of a seven member Board of Directors appointed by the Commissioner of Insurance, and shall consist of:

(1) two representatives of domestic insurance companies licensed to do business in this state;

(2) one representative of a nonprofit health care service plan;

(3) one representative of a health maintenance organization;

(4) one member representing the medical provider community, such as a physician licensed to practice medicine in this state or a hospital administrator;

(5) one member of the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to qualify for coverage in the pool. Representatives of the general public includes persons whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization are as an insured or person who has coverage through a plan provided by the corporation or organization.

(6) one member to represent resident licensed health insurance producers.

(C) In making appointments to the Board of Directors, the Commissioner shall strive to ensure that at least one person serving on the Board of Directors is at least 60 years of age.

(D) The original Board of Directors shall be appointed for the following terms:

(1) three members for a term of one year;

- (2) two members for a term of two years; and
- (3) two members for a term of three years.
- (4) All terms after the initial term shall be for three years.
- (E) The Board of Directors shall elect one of its members as Chairman.
- (F) Members of the Board of Directors may be reimbursed from monies of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board of Directors, but shall not otherwise be compensated for their services.
- (G) Members of the Board of Directors are not liable for an action or omission performed in good faith in the performance of powers and duties under this Act, and cause of action does not arise against a member for the action or omission.

The Board shall adopt a plan pursuant to this Act and submit its articles, bylaws, and operating rules to the State Commissioner of Insurance for approval. If the Board fails to adopt such a plan and suitable articles, bylaws, and operating rules within 180 days after the appointment of the Board, the State Commissioner of Insurance shall promulgate rules to effectuate the provisions of this Act, and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating procedures submitted by the Board and approved by the State Commissioner of Insurance.

**Section 6.** The Board shall:

- (A) establish administrative and accounting procedures for the operation of the pool;
- (B) establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the Board;
- (C) select an administering insurer in accordance with Section 8 of this Act;
- (D) collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made, in accordance with Section 9 of this act;
- (E) require that all policy forms issued by the Board conform to standard forms developed by the Board. The forms shall be approved by the State Commissioner of Insurance;
- (F) develop a program to publicize the existence of the plan, the eligibility requirements of the plan, and the procedures for enrollment in the plan, and to maintain public awareness of the plan;

(G) promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate; and

(H) no later than June 1 of each year, make an annual report to the governor, the state legislature, and the commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

### **Section 7.**

(A) The pool may exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the law of this state.

(B) As part of its authority, the pool may:

- (1) provide health benefits coverage to persons who are eligible for that coverage under this article;
- (2) enter into contracts that are necessary to carry out this article including, with the approval of the commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;
- (3) sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;
- (4) institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amount paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;
- (5) establish appropriate rates, rate schedules, rate adjustments, expense allowance, agents' referral fees, and claim reserve formulas and perform any actuarial function appropriate to the operation of the pool;
- (6) adopt policy forms, endorsements, and riders and applications for coverage;
- (7) issue insurance policies subject to this article and the plan of operation;
- (8) appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;

- (9) employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions.
- (10) contract for stop-loss insurance for risks incurred by the pool;
- (11) borrow money as necessary to implement the purposes of the pool;
- (12) issue additional types of health insurance policies to provide optional coverage which comply with applicable provisions of state and federal law, including Medicare supplemental health insurance;
- (13) provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization case management for the purpose of making the benefit plans more cost effective;
- (14) design, utilize, contract, or otherwise arrange for delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations; and
- (15) provide for reinsurance on either a facultative or treaty basis or both.

#### **Section 8.**

(A) The Board shall select an insurer, through a competitive bidding process, to administer the plan. The Board shall evaluate the bids submitted under this Subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

- (1) the insurer's proven ability to handle large group accident and health policies insurance;
- (2) the efficiency of the insurer's claims-paying procedures;
- (3) an estimate of total charges for administering the plan.

(B) The administering insurer shall serve for a period of three years. At least one year prior to the expiration of each three year period of service by an administering insurer, the Board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. The selection of the administering insurer for the succeeding three-year period shall be made at least six months prior to the end of the current three-year period.

(C) The administering insurer shall:

- (1) Perform all eligibility and administrative claims-payment functions relating to the plan;

(2) pay an agent's referral fee as established by the Board to each agent who refers an applicant to the plan, if the applicant is accepted. The selling or marketing of plans shall not be limited to the administrating insurer or its agents. The referral fees shall be paid by the administrating insurer from moneys received as premiums for the plan;

(3) establish a premium billing procedure for collection of premiums from persons insured under the plan; and

(4) perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:

(a) making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made;

(b) evaluating the eligibility of each claim for payment under the plan;

(c) notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised.

(5) submit regular reports to the Board regarding the operation of the plan. The frequency, content, and form of the reports shall be determined by the Board.

(6) following the close of each calendar year, determine net premiums, re-insurance premiums less administrative expenses allowance, the expense of administration pertaining to the re-insurance operations of the pool, and the incurred losses for the year, and report this information to the Board and to the Commissioner of Insurance; and

(7) pay claims expenses from the premium payments received from, or on behalf of, covered persons under the plan. If the payments by the administrating insurer for claims expenses exceeds the portion of premiums allocated by the Board for the payment of claims expenses, the Board shall assess the additional funds necessary for payment of claims expenses.

## **Section 9.**

### *OPTION ONE*

(A) For the purposes of providing the funds necessary to carry out the powers and duties of the pool, the board of directors shall assess member insurers at such time and for such amounts as the board finds necessary. Assessments shall be due in not less than 30 days after prior written notice to the member insurers and shall accrue interest at twelve percent per annum on and after the due date.

(B) Each insurer shall be assessed in an amount not to exceed Two Dollars (\$2.00) per covered person insured or reinsured by each insurer per month.

(C) The board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stoploss insurance to include in its count of covered persons all individuals whose coverage is insured (including by way of excess or stoploss coverage) in whole or in part. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stoploss insurer for the purposes of determining its assessment under this section.

(D) The board, based on annual statements and other reports deemed to be necessary by the board, may verify each insurer's assessment. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

(E) If assessments and other receipts by the pool, board or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

(F) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. Such forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars (\$100.00) per month.

#### *OPTION TWO*

(A) Each insurer shall be assessed by the Board a portion of the operating losses of the plan; such portion being determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's premium and subscriber contract charges pertaining to the direct writing of health insurance written in this state during the preceding calendar year and the denominator of which equal's the total of all such premiums and subscriber contract charges written by participating insurers in this state during the previous calendar year. The computation of assessments shall be made with a reasonable degree of accuracy, with the recognition that exact determinations may not always be possible.

(B)(1) If assessments and other receipts by the pool exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce premiums.

(2) As used in this Subsection, the term "future losses" includes reserves for claims incurred but not reported.



(C)(1) Each insurer's proportion of participation in the plan shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

(2) Any deficit incurred under the plan shall be recouped by assessment apportioned among participating insurers by the Board in the manner set forth in Subsection (A) of this Section; and the insurers may recover the net loss, if any, after the tax offset provided in Section 10 of this Act in the normal course of their respective businesses without time limitation.

**Section 10.** The coverage provided by the plan shall be directly insured by the pool, and the policies administered through the administering insurer.

**Section 11.**

(A) The plan shall offer in an annually renewable policy the coverage specified in this Section for each eligible person. In approving any of the benefit plans to be offered by the Plan, the Board shall establish such benefit levels, deductibles, coinsurance factors, exclusions, and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with individual market health insurance that is provided in the individual health insurance market in the state.

(B)(1) The plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under Subsection (E) of this Section up to a lifetime limit of \$1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarially equivalent benefit may be substituted by the Board.

(2) The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experiences reasonably expected to occur as a result of Medicare payments.

(C)(1) The usual customary charges or negotiable reimbursement for the following services and articles, when prescribed by a physician and medically necessary, shall be covered expenses:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at his direction;

(c) drugs requiring a physician's prescription;

- (d) services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred (100) calendar days during a policy year, if the services and reimbursements are the type which would qualify as reimbursable services under Medicare;
- (e) services of a home health agency, of which the services are of a type which would qualify reimbursable services under Medicare;
- (f) use of radium or other radioactive materials;
- (g) oxygen;
- (h) anesthetics;
- (i) prosthesis, other than dental prosthesis;
- (j) rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
- (k) diagnostic x-rays and laboratory tests;
- (l) oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;
- (m) services of a physical therapist;
- (n) transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
- (o) processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and
- (p) services for the treatment of alcohol and drug abuse, but the insured shall be required to make a 50 percent co-payment and the payment of the plan shall not exceed \$4,000.
- (2) as an option, the plan shall make available, at an additional premium, coverage for services provided by a duly licensed chiropractor.
- (D) Covered expenses shall not include the following:
- (1) any charge for treatment for cosmetic purposes, other than for repair or treatment of any injury or congenital bodily defect to restore normal bodily functions;
- (2) any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid;

- (3) any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;
- (4) that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary;
- (5) any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the services or articles;
- (6) any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred;
- (7) any charge for routine physical examinations;
- (8) any charge for the services of blood donors and any fee for the failure to replace the first three pints of blood provided to an eligible person annually; or
- (9) any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

(E)(1) The board shall provide for at least two choices of annual deductibles for major medical expenses, plus the benefits payable under any other type of insurance coverage or workers' compensation, provided that if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

(F) (1) The board shall annually determine the schedule of premium rates for each benefit plan option offered by the pool.

(2) Rates and rate schedules may be adjusted for appropriate risk factors including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(3) The board shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial pool rate may not be less than 135 percent and may not exceed 150 percent of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed 150 percent of rates applicable to individual standard risks.

(4) All rates and rate schedules shall be submitted to the state commissioner of insurance for approval, and the commissioner must approve the rates and rate schedules of the pool before the pool uses them. The commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided by this section.

(G) The Board shall provide that the pool shall be the last payer of benefits whenever any other benefit or source of third party payment is available.

**Section 12. {Severability clause.}**

**Section 13. {Repealer clause.}**

**Section 14. {Effective date.}**

*As amended by the HHS Task Force at the States and Nation Policy Summit in December 2002. Approved by the ALEC Board of Directors January, 2003.*

## **Insurance Pool Act**

### ***Summary***

The purpose of this Act is to provide insurance for individuals with high-risk health conditions such as AIDS, diabetes, and cancer. Approximately 1 percent of the uninsured population are denied access to insurance because of pre-existing conditions. This bill establishes a state run high-risk pool and allows individuals who have been denied traditional insurance because of health problems to buy into the pool. This program is effective because it spreads the cost of coverage among all insurance carriers doing business in a state. Two critical goals that ALEC's high-risk pool accomplishes are guaranteed access to health care at reasonable rates to all of a state's uninsurable citizens, and that the costs of this guarantee is spread equitably among all of the state's citizens.

The pool is funded through the premiums charged to the individuals and through an assessment against insurers participating in the health insurance market. Any resident of the state would be eligible, including the insured's spouse and dependents, if they are not currently receiving health benefits under any federal or state program and if such person has been rejected by at least two insurers for coverage substantially similar to the pool's plan. The pool operates under the supervision and approval of a Board of Directors appointed by the Commissioner of Insurance.

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the Comprehensive Health Insurance Pool Act.

**Section 2.** For the purposes of this Act the following definitions apply:

(A) "Agent" means any person who is licensed to sell health insurance in this state.

(B) "Board" means the Board of Directors of the State Comprehensive Health Insurance Pool.

(C) "Health insurance" means any hospital or medical expense incurred policy or nonprofit health care services plan contract, whether sold as an individual or group policy. The term does not include any policy covering short-term accident only, a fixed-indemnity policy, a limited benefit policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation.

(D) "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include medical services plans, hospital plans health maintenance organizations and self-insurance arrangements, which shall be designated as engaged in the business or insurance for the purposes of this Act.

(E) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 USC, Section 1395, et seq., as amended).

(F) "Pool" means the State Comprehensive Health Insurance Pool.

(G) "Physician" means a physician, osteopath, podiatrist, or, for purposes of oral surgery only, a dental surgeon, each duly licensed by this state.

(H) "Plan" means the Comprehensive Health Insurance Plan as adopted by the Board of Directors of the State Comprehensive Health Insurance Pool, or by rule.

### **Section 3.**

(A) Every insurer shall participate in the pool.

(B) Health insurance policies available in accordance with this Act shall be available for sale one year from the date of enactment of this Act.

### **Section 4.**

(A) Except as provided in Subsection (B) of this Section, any resident of this state shall be eligible for coverage under the plan, including:

(1) the insured's spouse;

(2) any dependent unmarried child of the insured, from the moment of birth. Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of 19, whichever occurs first. However, if the dependent is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of 23.

(B)

(1) No person who is currently receiving health care benefits under any federal or state program providing financial assistance and/or preventive and rehabilitative social services is eligible under the plan.



(2) No person who is covered under the plan and who terminates coverage is again eligible for coverage unless 12 months has elapsed since the coverage was terminated.

(3) No person on whose behalf the plan has paid out \$500,000 or more in covered benefits is eligible for coverage under the plan.

(4) The coverage of any person who ceases to meet the eligibility requirements of this Section may be terminated at the end of the policy period.

(5) No person is eligible for coverage under the plan unless such person has been rejected by at least two insurers for coverage substantially similar to the plan coverage without material underwriting restriction at a rate equal to or less than the pool plan rate, and no person is eligible for coverage who has on the date of issue of coverage under the plan, equivalent coverage under another contract or policy.

(6) No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment, and rehabilitation facility shall be eligible for coverage under the plan.

#### **Section 5.**

(A) There is hereby created a nonprofit legal entity to be known as the "State Comprehensive Health Insurance Pool." All insurers, as a condition of doing business in this state, shall be members of the pool.

(B)

(1) The pool shall operate under the supervision and approval of a seven member Board of Directors appointed by the Commissioner of Insurance, and shall consist of:

(a) two representatives of domestic insurance companies licensed to do business in this state;

(b) one representative of a nonprofit health care service plan;

(c) one representative of a health maintenance organization;

(d) one member from a health-related profession;

(e) one member from the general public, who is not associated with the medical profession, a hospital, or an insurer, and

(f) one member to represent a group considered to be "uninsurable."

(2) In making appointments to the Board of Directors, the Commissioner shall strive to ensure that at least one person serving on the Board of Directors is at least 60 years of age.

- (3) The original Board of Directors shall be appointed for the following terms:
- (a) three members for a term of one year;
  - (b) two members for a term of two years; and
  - (c) two members for a term of three years.
- (4) All terms after the initial term shall be for three years.
- (5) The Board of Directors shall elect one of its members as Chairman.
- (6) Members of the Board of Directors may be reimbursed from monies of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board of Directors, but shall not otherwise be compensated for their services.
- (7) The Board shall adopt a plan pursuant to this Act and submit its articles, bylaws, and operating rules to the State Commissioner of Insurance for approval. If the Board fails to adopt such a plan and suitable articles, bylaws, and operating rules within 180 days after the appointment of the Board, the State Commissioner of Insurance shall promulgate rules to effectuate the provisions of this Act and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating procedures submitted by the Board and approved by the State Commissioner of Insurance.

**Section 6.** The Board shall:

- (A) establish administrative and accounting procedures for the operation of the pool;
- (B) establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the Board;
- (C) select an administering insurer in accordance with Section 8 of this Act;
- (D)
  - (1) collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made.
  - (2) the level of assessments.
  - (3) the insurer at the end of each calendar year. However, in addition to such assessments, the Board shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred prior to the receipt of the first calendar year assessments. Organizational assessments shall be equal for all insurers, but shall not exceed \$100 per insurer for all such

assessments. Assessments shall be due and payable within 30 days of receipt of the assessment notice by the insurer.

(E) require that all policy forms issued by the Board conform to standard forms developed by the Board. The forms shall be approved by the State Commissioner of Insurance.

(F) develop a program to publicize the existence of the plan, the eligibility requirements of the plan, and the procedures for enrollment in the plan, and to maintain public awareness of the plan.

**Section 7.** The Board shall:

(A) exercise powers granted to insurers under the laws of this state;

(B) sue or be sued;

(C) in addition to imposing assessments under Section 6 of this Act, levy interim assessments against insurers to insure the financial ability of the plan to cover claims expenses and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of the calendar year. Any interim assessment shall be due and payable within 30 days of the receipt of the assessment notice by the insurer. Interim assessments shall be credited against the insurer's annual assessment.

**Section 8.**

(A) The Board shall select an insurer, through a competitive bidding process, to administer the plan. The Board shall evaluate the bids submitted under this Subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

(1) the insurer's proven ability to handle large group accident and health policies insurance;

(2) the efficiency of the insurers claims-paying procedures;

(3) an estimate of total charges for administering the plan.

(B) The administering insurer shall serve for a period of three years. At least one year prior to the expiration of each three year period of service by an administering insurer, the Board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. The selection of the administering insurer for the succeeding three-year period shall be made at least six months prior to the end of the current three-year period.

(C) The administering insurer shall:

- (1) perform all eligibility and administrative claims-payment functions relating to the plan;
- (2) pay an agent's referral fee as established by the Board to each agent who refers an applicant to the plan, if the applicant is accepted. The selling or marketing of plans shall not be limited to the administrating insurer or its agents. The referral fees shall be paid by the administrating insurer from moneys received as premiums for the plan;
- (3) establish a premium billing procedure for collection of premiums from persons insured under the plan;
- (4) perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:
  - (a) making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made;
  - (b) evaluating the eligibility of each claim for payment under the plan;
  - (c) notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised.
- (5) submit regular reports to the Board regarding the operation of the plan. The frequency, content, and form of the reports shall be determined by the Board.
- (6) following the close of each calendar year, determine net premiums, re-insurance premiums less administrative expenses allowance, the expense of administration pertaining to the re-insurance operations of the pool, and the incurred losses for the year, and report this information to the Board and to the Commissioner of Insurance.
- (7)
  - (a) Pay claims expenses from the premium payments received from, or on behalf of, covered persons under the plan.
  - (b) If the payments by the administrating insurer for claims expenses exceeds the portion of premiums allocated by the Board for the payment of claims expenses, the Board shall assess the additional funds necessary for payment of claims expenses;

#### **Section 9.**

(A) Each insurer shall be assessed by the Board a portion of the operating losses of the plan; such portion being determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's premium and subscriber contract charges pertaining to the direct writing of health insurance written in this state during the preceding calendar year and the denominator of which equal's the total of all such premiums and subscriber contract charges written by participating insurers in this state

during the previous calendar year. The computation of assessments shall be made with a reasonable degree of accuracy, with the recognition that exact determinations may not always be possible.

(B)

(1) If assessments and other receipts by the pool exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce premiums.

(2) As used in this Subsection, the term "future losses" includes reserves for claims incurred but not reported.

(C)

(1) Each insurer's proportion of participation in the plan shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

(2) Any deficit incurred under the plan shall be recouped by assessment apportioned among participating insurers by the Board in the manner set forth in Subsection (A) of this Section; and the insurers may recover the net loss, if any, after the tax offset provided in Section 10 of this Act in the normal course of their respective businesses without time limitation.

#### **Section 10.**

(A) Any assessment may be offset, in an amount equal to the amount of the assessment paid to the pool, against the state corporate income tax or the premium tax payable by that participating insurer for the year in which the assessment is levied or the four years subsequent to that year.

(B)

(1) The Board may abate or defer, in whole or in part, the assessment of a participating insurer if, in the opinion of the Board, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.

(2) In the event that an assessment against a participating insurer is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other participating insurers in a manner consistent with the basis for assessments set forth in Subsection (A) of Section 9 of this Act, and the insurer receiving the abatement or deferment shall remain liable to the pool for the deficiency for four years.

(C) Notwithstanding any provisions of this Act to the contrary, no participating insurer may be assessed in any one calendar year an amount greater than the amount which that insurer paid to the state in the previous year as premium tax and corporate income tax on the business to which this tax applies, or one-hundredth of one percent (0.001 percent) of the total written premiums on such business in this state, whichever is greater.

**Section 11.** The coverage provided by the plan shall be directly insured by the pool, and the policies administered through the administering insurer.

**Section 12.**

(A)

(1) The plan shall offer in an annually renewable policy the coverage specified in this Section for each eligible person, except that if an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

(2) Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of the termination of the previous coverage.

(3) The plan shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within 60 days to continue under the same or different contract.

(4) No coverage provided to a person who is eligible for Medicaid benefits shall be issued as a Medicaid supplement policy.

(B)

(1) The plan shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under Subsection (E) of this Section up to a lifetime limit of \$500,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarially equivalent benefit may be substituted by the Board.

(2) The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experiences reasonably expected to occur as a result of Medicare payments.

(C)



(1) The usual customary charges for the following services and articles, when prescribed by a physician, shall be covered expenses:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at his direction;

(c) drugs requiring a physician's prescription;

(d) services of a licensed skilled nursing facility for eligible individuals, ineligible for medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;

(e) services of a home health agency, of which the services are of a type which would qualify reimbursable services under Medicare;

(f) use of radium or other radioactive materials;

(g) oxygen;

(h) anesthetics;

(i) prosthesis, other than dental prosthesis;

(j) rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

(k) diagnostic x-rays and laboratory tests;

(l) oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(m) services of a physical therapist;

(n) transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(o) processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and

(p) services for the treatment of alcohol and drug abuse, but the insured shall be required to make a 50 percent co-payment and the payment of the plan shall not exceed \$4,000.

(2) as an option, the plan shall make available, at an additional premium, coverage for services provided by a duly licensed chiropractor.

(D) Covered expenses shall not include the following:

- (1) any charge for treatment for cosmetic purposes, other than for repair or treatment of any injury or congenital bodily defect to restore normal bodily functions;
- (2) any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid;
- (3) any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;
- (4) that part of any charge for services or articles rendered or provided by a physical or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary;
- (5) any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the services or articles;
- (6) any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred;
- (7) any charge for routine physical examinations;
- (8) any charge for the services of blood donors and any fee for the failure to replace the first three pints of blood provided to an eligible person annually; or
- (9) any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

(E)

- (1) The plan shall provide for a choice of annual deductibles for major medical expenses in the amount of \$1,000, \$1,500, \$2,000, \$5,000, and \$7,500, plus the benefits payable under any other type of insurance coverage or workers' compensation, provided that if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.
- (2) the schedule of premiums and deductibles shall be established by the Board.
- (3) rates for coverage issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing coverage.
- (4) Separate schedules of premium rates based on age may apply for individual risks.

(5) Rates are subject to approval by the Commissioner of Insurance.

**Section 13. {Severability clause.}**

**Section 14. {Repealer clause.}**

**Section 15. {Effective date.}**

*Originally adopted and approved in 1990. Amended by the HHS Task Force in 2002.*

## Rural Hospital Deregulation Act

### *Summary*

The purpose of this Act is to review and waive state regulations and restricted reimbursement policies that pertain to rural hospitals. Burdensome restrictions and staffing requirements are major factors contributing to the closure of rural hospitals. Rural hospitals simply cannot comply with state regulations that are designed for large urban hospitals.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Rural Hospital Deregulation Act**.

**Section 2.** The legislature finds that excessive regulation has had an adverse impact on the stability of rural hospitals. It is therefore the intent of the legislature to improve the stability of rural hospitals by exempting them from unnecessary procedural, licensure, and bureaucratic restrictions.

### **Section 3. {Definitions.}**

(A) “Department” means the *(insert appropriate state department health agency)*.

(B) “Director” means the Director of *(insert appropriate state department health)*.

(C) “Rural hospital” means an acute care hospital that is no less than 35 road miles from the nearest existing acute care hospital.

(D) “Medical shortage area” means a county or service area in which the nearest acute care hospital is no less 35 road miles from the nearest existing acute care hospital.

### **Section 4. {Intent.}**

The legislature recognizes the need to strengthen and, in some cases, salvage rural hospitals to ensure the adequate access to services is provided to residents of rural areas as well as tourist and travelers. Further, the legislature recognizes that this will require a comprehensive approach.

### **Section 5. The State Department of Health Services shall:**

(A) Provide regulatory relief to rural hospitals when appropriate through program flexibility for such items as staffing, space, and physical plant requirements;

- (B) Modify inpatient limitations for Medicaid so as not to single out rural hospitals for application;
- (C) Set reimbursement rates for outpatient services at a level that provides incentives for rural hospitals to focus on the provision of outpatient services and that reduces the financial losses incurred by rural hospitals in providing those services;
- (D) Seek any necessary waivers from the federal Health Care Financing Administration;
- (E) Implement regulatory changes to reduce the requirements for the licensing and rural hospitals.

**Section 6. {Increase Mid-Level Providers.}**

- (A) A licensing board shall not prohibit registered nurses from performing services as physician substitutes in a medical shortage area.
- (B) Certified nurses or certified midwives shall be permitted to deliver babies in a medical shortage area. A rural hospital without a physician performing obstetrics shall not restrict a certified nurse midwife from admitting patients. Home delivers shall not be restricted in a medical shortage area.
- (C) Graduate medical students and residents may, on weekends and at other times, be used as health care providers. Such service could be fully counted as certification in their residency programs.

**Section 7. {Limit Barriers.}**

- (A) A “certificate of need” shall not be required for any rural hospital in a medical shortage area.
- (B) Any state owned building not on the tax rolls and not occupied for three or more months may be leased at fair market value to any health care provider.

**Section 8. {Severability clause.}**

**Section 9. {Repealer clause.}**

**Section 10. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1993.*

## **An Act to be Amended to ALEC's Medical Savings Account Bill**

### ***Summary***

This act would allow individuals to contribute tax-exempt dollars into a medical savings account. The act can be enacted as stand alone legislation to provide medical savings accounts to individuals or as amendment to ALEC's model Medical Savings Account Bill. This act will require a fiscal impact statement.

### ***Model Legislation***

#### **Section 1.**

(A) For the 1994 tax year and each tax year after 1994, a taxpayer other than a resident, estate or trust, may credit against the tax imposed by this act an amount equal to 3.3% of the amount contributed in the tax year by the taxpayer or on behalf of the taxpayer to a medical care savings account to the extent that the contribution is accepted by an account administrator pursuant to the medical care savings account act.

(B) The credit under this section shall not be taken unless the taxpayer who establishes a medical care savings account or on whose behalf a medical care savings account is established is not covered by any health coverage policy, certificate, or contract or self-funded plan other than a qualified higher deductible health plan purchased pursuant to the medical care savings account act.

(C) If the taxpayer files a tax return, each joint filer may take the credit under this section if he or she meets the restriction under subsection (B). If the taxpayer is married and files a single return or is not married, the taxpayer may take the credit under this section if he or she meets the restriction under subsection (B).

(D) A taxpayer shall deduct from the amount of a contribution used to calculate the credit under this section the following amounts:

(1) Any amount that the taxpayer withdraws in the tax year for the purpose other than 1 of the following:

(a) A purpose for which those funds may be utilized as described in section (3) of the medical care savings account act.

(b) A distribution or transfer pursuant to section (8) or (5) of the medical care savings act.



(2) Any amount that the taxpayer withdraws in the tax year, other than an amount pursuant to subdivision 1(a) or (b), at any time other than the last business day of the account administrator's business year.

(E) If the amount of the credit exceeds the tax liability of the taxpayer for the tax year, that portion of the credit that exceeds the tax liability shall not be refunded.

(F) The credit under this section shall not be taken by a taxpayer in the tax year in which a federal income tax deduction or credit becomes available for contributions to a medical care savings account or any similar federal program or in any subsequent year.

(G) As used in this section, "account administrator" and "medical care savings account" mean those terms in the medical care savings account act.

**Section 2.** This amendment act shall not take effect unless the medical savings account bill is enacted into law.

**Section 3. {Severability Clause.}**

**Section 4. {Repealer Clause.}**

**Section 5. {Effective Date.}**

*Approved by the Health and Human Services Task Force.*

## Health Savings Account Act

### *Summary*

A bill to permit the establishment and maintenance of health savings accounts; to provide penalties and remedies; to exempt contributions from taxation; and to prescribe the requirements of and restrictions on health savings accounts.

### *Model Legislation*

**Section 1. Title.** This Act shall be known and may be cited as the “Health Savings Account Act.”

**Section 2. Definitions.** As used in this Act:

(A) “Eligible individual” means the individual taxpayer, including employees of an employer who contributes to health savings accounts on the employees’ behalf, whom:

(1) Must be covered by a “High Deductible Health Plan” individually or with his or her dependent as defined in this act;

*[Note: HSA eligible individuals must be covered by a qualified high deductible health plan. See: IRC Sec. 223 (c) (1) (A).]*

(2) May not be covered under any health plan that is not a high deductible health plan, except for:

(i) coverage for accidents, disability, dental care, vision care, long term care,

(ii) workers compensation insurance,

(iii) insurance for a specified disease or illness,

(iv) insurance paying a fixed amount per day per hospitalization, and

(v) coverage for tort liabilities or liabilities relating to ownership or use of property; and

*[Note: HSA eligible individuals may be covered by certain other types of insurance coverage. See: IRC Sec. 223 (c)(1)(B) and (c)(3).]*

(3) Who establishes or on whose behalf the health savings account is established.

(B) “Deductible” means the total deductible for an eligible individual and all the dependents of that eligible individual for a calendar year.

(C) “Dependent” means the spouse or child of the eligible individual as defined in Section 152 of the Internal Revenue Code subject to any additional modifications imposed by Section 223(d)(2) of the Internal Revenue Code.

*[Note: The Working Families Tax Relief Act of 2004 amended the definition of “dependent” in IRC Sec. 152 and unintentionally placed limits on who could be considered a dependent for purposes of an HSA. Congress intends to correct this problem later this year by amending the HSA law in IRC Sec. 223. See: Tax Technical Corrections Act of 2004 (S. 3019).]*

(D) “Qualified medical expense” means an expense paid by the taxpayer for medical care described in Section 213(d) for the Internal Revenue Code.

(E) “High deductible health plan” means a health plan with:

(1) In the case of self-only coverage, an annual deductible which is not less than \$1000 and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed \$5,000, or such other amounts for an annual deductible and out-of-pocket expenses established in accordance with Section 6.

*[Note: The stated dollar amounts are those permitted for HSAs for tax year 2005. (Treasury Department Revenue Ruling 2004-71) and Section 6 allows for automatic increases for cost-of-living adjustments.]*

(2) In the case of family coverage, an annual deductible of not less than \$2000 and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed \$10,200, or such other amounts for an annual deductible or out-of-pocket expenses established in accordance with Section 6.

*[Note: The stated dollar amounts are those permitted for HSAs for tax year 2005. (Treasury Department Revenue Ruling 2004-71) and Section 6 allows for automatic increases for cost-of-living adjustments.]*

(3) A plan shall not fail to be treated as a high deductible plan by reason of failing to have a deductible for preventive care or, in the case of network plans, for having out-of-pocket expenses or annual deductibles for services provided outside the network that exceed the limitations in this section.

*[Note: This clarifies the exemption from the applicability of the limitations to out-of-network services under IRC Sec. 223(c)(2)(D).]*

(F) “Health savings account” or “account” means a trust or custodian established pursuant to a health savings account program exclusively to pay the qualified medical expenses of an eligible individual or his or her dependents, but only if the written governing instrument creating the account meets the following requirements:

*[Note: There is no limitation on where HSA accounts can be established so long as the trustee or custodian meets the qualifications in the Internal Revenue Code. See: IRC Sec. 223 (d)(1)(B).]*

(1) Except in the case of a rollover contribution, no contribution will be accepted:

(a) unless it is in cash, or

(b) to the extent such contribution, when added to the previous contributions to the account for the calendar year, exceeds 100 percent of the eligible individual’s deductible or \$2600 for an individual or \$5150 per family (or such dollar amounts as established in accordance with Section 6.), whichever is lower;

*[Note: Dollar amounts are those permitted for HSAs for tax year 2005 (Treasury Department Revenue Ruling 2004-71) and Section 6 allows for automatic increases for cost-of-living adjustments.]*

(2) The trustee or custodian is a bank, an insurance company, or another person approved by the U.S. Department of Treasury;

*[Note: The HHS Secretary does not approve trustees or custodians.]*

(3) No part of the trust assets will be invested in life insurance contracts;

(4) The assets of the account will not be commingled with other property except as allowed for under Individual Retirement Accounts;

(5) Eligible individual’s interest in the account is nonforfeitable; and

(6) Eligible individuals who have attained age 55 before the end of the year may make additional catch-up contributions into the account in the amount determined in accordance with the following table:

2005	\$600
2006	\$700
2007	\$800
2008	\$900
2009 and thereafter	\$1,000.

*[Note: Individuals age 55 and older are permitted to make additional catch-up contributions into an HSA. See: IRC Sec. 223 (b)(3).]*

(G) “Health Savings Account program” or “program” means a program that includes all of the following:

- (1) The purchase by an eligible individual or by an employer of a high deductible health plan; and
- (2) The contribution into a health savings account by or on behalf of an eligible individual or on behalf of an employee by his or her employer. The total annual contribution may not exceed the amount of the plan’s higher deductible or the amounts listed in Section F (1)(b).

*[Note: Family members and others may contribute to an HSA of an eligible individual. See: IRC Sec. 223 (a).]*

*[Note: High deductible health plan is defined in subsection 2.E.]*

### **Section 3. Applicability and Scope.**

*[Note: This section is stricken to avoid confusion since the rest of the model follows federal law for purposes of defining an HSA.]*

(A) For taxable years beginning after {insert year}, contributions may be made into a health savings account by or on behalf of a resident of {insert state}, pursuant to subsection 2.F.

*[Note: This clarifies that others may contribute to an individual’s account and that the definition of health savings account sets forth the requirements for contributions.]*

(B) Except as provided in Section 5, principal contributed to and interest earned on a health savings account and money reimbursed to an eligible individual or an employee for qualified medical expenses are exempt from taxation under (the Income Tax Act).

### **Section 4. Distribution of HSA Funds.**

(A) The trustee or custodian shall utilize the funds held in a health savings account solely for the purpose of paying the qualified medical expenses of the eligible individual or his or her dependents, or to purchase a health coverage policy certificate, or contract, if the eligible individual is receiving unemployment compensation, is exercising continuation privileges under federal law, is purchasing a long term care insurance contract, or to pay for health insurance other than a Medicare supplemental policy for those who are Medicare eligible. Funds held in a health savings account shall not be used to cover expenses of the eligible individual or his or her dependents that are otherwise covered, including but not limited to, medical expense covered pursuant to an automobile insurance policy, worker’s compensation insurance policy or self-insured plan, or another employer-funded health coverage policy, certificate, or contract.

## **Section 5. HSA Withdrawals.**

(A) Notwithstanding Section (C), (D), (E), or (F) an eligible individual may withdraw money from his or her health savings account for any purpose other than a purpose described in Section 4 (A).

(B) Subject to subsection (C), if the eligible individual withdraws money for any purpose other than a purpose described in section 4 (A) at any other time, all of the following apply:

- (1) The amount of the withdrawal is income for the purposes in the (Income Tax Act) in the tax year of the withdrawal; and
- (2) Interest earned on the account during the tax year in which a withdrawal under this subsection is made is income for the purposes of the (Income Tax Act).

(C) The amount of disbursement of any assets of a health savings account pursuant to a filing for protection under Title 11 of the United States Code, 11 U.S.C. 101, et seq. by an eligible individual or person for whose benefit the account was established is not considered a withdrawal for purposes of this section. The amount of a disbursement is not subject to taxation under (the Income Tax Act) and subsection (B) does not apply.

(D) The transfer of an eligible individual's interest in a health savings account to an eligible individual's spouse or former spouse under a divorce or separation instrument shall not be considered a taxable transfer made by such eligible individual, notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the eligible individual.

(E) Upon the death of the eligible individual, the trustee or custodian shall distribute the principle and accumulated interest of the health savings account to the estate of the deceased.

(F) If an employee becomes employed with a different employer that participates in a health savings account program, the employee may transfer his or her health savings account to that new employer's trustee or custodian, or to an individually purchased account program.

## **Section 6. Dollar Amounts.**

The U.S. Department of Treasury may make cost-of-living adjustments to dollar amounts for requirements for deductibles and out-of-pocket expenses in accordance with Internal Revenue Code Section 223. If such adjustments are made, then the corresponding amounts in subsections 2.(E) and 2.(F) will be considered to be increased to reflect such adjustments.



*[Note: This is intended to avoid the need to amend the Act to reflect Treasury cost-of-living adjustments.]*

**Section 7. {Severability clause}**

**Section 8. {Repealer clause}**

**Section 9. {Effective date}**

*Approved by the Health and Human Services Task Force on May 1, 2005.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

SUNSHINE

## Individual Medical Accounts Act

### *Model Legislation*

(Title, enacting clause, etc.)

**Section 1.** This Act may be cited as the **Individual Medical Account Act**.

**Section 2.** For the purpose of this Act the following definitions apply:

(A) "Account holder" means the individual on whose behalf the individual medical account is established.

(B) "Dependent child" means any person under the age of 21 years or any person who is legally entitled or subject to a court order for the provision of proper and necessary subsistence, education, medical care, or any other care necessary for his health, guidance, or well-being, and who is not otherwise emancipated, married or a member of the armed forces of the United States, or who is so mentally or physically incapacitated that he cannot provide for himself.

(C) "Individual medical account" means a trust created or organized to pay the eligible medical, dental, and long-term care expenses of the account holder.

(D) "Trustee" means a chartered state bank, savings and loan association or trust company authorized to act as a fiduciary; a national banking association or savings and loan association authorized to act as a fiduciary; or an insurance company.

### **Section 3.**

(A) For taxable years beginning on or after 1991, a resident individual shall be allowed to deposit contributions to his or her individual medical account. The amount of deposit for the first taxable year subsequent to the effective date of this Act shall not exceed:

(1) \$2,000 for the account holder; or

(2) \$2,000 for the account holder and \$1,000 for each dependent child of the account holder.

(B) The maximum allowable amount of deposit for subsequent years shall be increased annually by a percentage equal to the previous year's increase in the national Consumer Price Index (CPI).

(C) Interest earned on an individual medical account shall be exempt from taxation as adjusted gross income in this State.

(D) Upon agreement between an employer and employee, an employee may either have his employer contribute to the employee's individual medical account or continue to make contributions under the employee's existing health insurance policy or program, subject, however, to the restrictions in Subsection (F)(1) of this Section.

(E) The individual medical account shall be established as a trust under the laws of this State and placed with a trustee. The trustee shall:

- (1) purchase long term care coverage for each account holder to cover all medical, dental, and long-term care expenses in excess of \$10,000; and
- (2) utilize the trust assets solely for the purpose of paying the medical, dental, and long-term expenses of the account holder.

(F) Individual medical account funds may be withdrawn by the account holder at any time for any purpose, subject to the following restrictions and penalties:

- (1) There shall be a distribution penalty for early withdrawal of individual medical account funds by the account holder. Such penalty shall be 10% of the amount of interest earned as of the date of withdrawal on the account, and, upon such withdrawal, the interest earned during the tax year in which withdrawal occurs shall be subject to taxation as adjusted gross income in this Section.
- (2) After an account holder reaches 60 years of age, withdrawals shall be permitted for medical, dental or long-term care expenses only, and may be withdrawn without penalty.

(G) Upon the death of the account holder, the account principle, as well as any interest accumulated thereon, shall be distributed to the decedent's estate as part of the estate.

**Section 4.** {Severability Clause.}

**Section 5.** {Repealer Clause.}

**Section 6.** {Effective Date.}

*Approved by the Health and Human Services Task Force in March 2002.*

**Resolution Urging Congress to Create Private Individual Medical Accounts**

***Summary***

The Resolution urges Congress to enact legislation that would amend the Medicare program so as to authorize the use of Private Individual Medical Accounts to assist individuals in saving the resources necessary to pay for their health care needs in retirement.

***Model Resolution***

**WHEREAS**, it is widely agreed that the Medicare program is in need of major structural changes if it is to remain a viable alternative for the health care needs of future generations; and

**WHEREAS**, in 1996 Medicare expenditures made up twelve percent (12%) of the federal budget, more than double the level in 1975; and

**WHEREAS**, the Congressional Budget Office estimates that at the current rate, by 2006 Medicare will consume eighteen percent (18%) of the federal budget -- more than the United States' education, crime, and defense budgets combined; and

**WHEREAS**, during the lifetime of the next generation, Medicare's income will only cover sixty percent (60%) of its expenditures; and

**WHEREAS**, the existing method of funding Medicare by taking an ever increasing payroll tax out of the paychecks of working Americans to pay for the medical benefits of retired Americans, is a pyramid scheme which cannot be maintained in future years; and

**WHEREAS**, in 1998 there are four workers to pay taxes to support each Medicare beneficiary, by the year 2030 there will only be two workers for each beneficiary; and

**WHEREAS**, in the 1996 *Annual Report of Trustees of the Federal Hospital Insurance Trust Fund*, the Medicare Trustees predicted that the Medicare program would be depleted by the year 2001.

**NOW THEREFORE BE IT RESOLVED**, that the State/Commonwealth of {*Insert State/Commonwealth Name*} urges the U.S. Congress to enact legislation amending the Medicare program to allow for the creation of a system of Individual Medical Accounts wherein individuals will build a fund over their working careers that will provide the

resources to pay for their health care needs in retirement.

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S House of Representatives.

*Approved by the Health and Human Services Task Force.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

**SENATE**

**VIEW**

## **Blood Safety Act**

### ***Summary***

This bill ensures that all donated blood, semen, tissue, or organ shall be tested for evidence of viral infections known to be blood-borne, including, but not limited to HIV and HCV. All the public and private facilities or organizations that accept directly from the donor any blood, semen, tissue, or organ donation must test for blood-borne viral infections. This bill allows for any individual to make a designated donation, which means the exclusive use of the donor's own blood, or blood, semen, tissue, or organ as donated for a specific individual or use, or for storage to be held for a later specified use. Except in cases of bonafide medical emergency, blood, semen, tissue or organ may not be used in any case until it is confirmed that the specimen to be used does not evidence any viral infection known to be blood-borne, including, but not limited to, HIV and HCV.

### ***Model Legislation***

#### **Section I: Title**

This Act may be cited as the "Blood Safety Act."

#### **Section II: Definitions**

For the purposes of this Act the following definitions apply:

(A.) "HIV" means the human immunodeficiency virus identified or any other identified causative agents of acquired immunodeficiency syndrome (AIDS).

(B.) "HCV" means the Hepatitis C virus.

(C.) "Donor" means the individual who voluntarily gives blood, semen, tissue or organs for his or her future use or for a recipient in need of blood, semen, tissue or organs.

(D.) "Medically Appropriate Purpose" means use of donated blood, semen, tissue or organs to be determined by certified medical care individuals.

#### **Section III: Testing of Donations**

All the public and private facilities or organizations that accept directly from the donor any blood, semen, tissue, or organ donation, with or without recompense to the donor and for any purpose, shall test or have tested the blood, semen, or organ for evidence of viral infections known to be blood-borne, including, but not limited to HIV and HCV.



#### **Section IV: Designated Donation**

(A.) Any individual desiring a designated donation, which means the exclusive use of the donor's own blood, or blood, semen, tissue, or organ as donated for a specific individual or use, or for storage to be held for a later specified use, shall inform the facility of the donor's intent to make a designated donation. The individual in charge of the facility shall accept a designated donation and ensure that the donor's blood, semen, tissue or organ will be held and used exclusively for the use specified by the donor. The facility may charge reasonable fees to cover the administrative and storage costs for such directed donations.

(B.) Any blood, semen, tissue, or organ donated for designated use under Subsection (A) of this Section shall be reserved for use by the designated recipient. Any individual desiring a designated donation, must be notified and provide consent upon donation that thirty (30) days prior to the expiration date of the donation, but not less than thirty days from the date of the donation, if it has not been used, it may be used for any other medically appropriate purpose. The individual donor must be notified {insert amount} days ahead of the other medically appropriate purpose

#### **Section V:**

Except in cases of bonafide medical emergency, blood, semen, tissue or organ may not be used in any case until it is confirmed that the specimen to be used does not evidence any viral infection known to be blood-borne, including, but not limited to, HIV and HCV, unless the recipient, or his or her legal representative, signs a waiver providing that the recipient assumes all liability for becoming infected with AIDS, the AIDS antibodies, HIV or HCV virus if infection occurs as a result of such use by the recipient and that the recipient releases the facility or organization providing the blood, semen, or organ from all liability for such infection.

#### **Section VI: Facility Registration**

The state Department of Health shall establish a registry of all blood, tissue, organ, or sperm banks operating in this state. All blood tissue, organ or sperm banks operating in this state shall register with the Department of Health prior to the opening of a facility and annually by May 1 of each year. Any person, hospital, clinic, corporation, partnership, or other legal entity, which operates a blood tissue, organ or sperm bank in this state and fails to register with the Department pursuant to this Section, shall be subject to a fine of \$10,000 per occurrence.

#### **Section VII: Disclosures for Elective Surgery**

(A.) Physicians and surgeons shall explain to each elective surgery patient the probability of a blood transfusion during the patient's surgery and the positive and negative aspects of autologous blood options, including intraoperative autologous transfusions, blood from

relatives and friends, and blood products from blood banks.

(B.) Prior to the scheduled date of surgery the physician or surgeon shall obtain a consent form signed by the patient stating the explanation required pursuant to Subsection (A) has been made, and that the patient consents to any needed blood transfusion.

(C.) The failure of a physician and surgeon to comply with the provisions of this Act shall constitute unprofessional conduct.

**Section VIII: Severability Clause**

**Section IX: Repealer Clause**

**Section X: Effective Date**

*Approved by the Health and Human Services Task Force in 1990.*

## **Emergency Public Safety Measure Act**

### ***Summary***

This bill authorizes the State Department of Health, by clear and convincing evidence, to seek a court order requiring an individual to undergo blood tests for evidence of the HIV virus without a prior consent form from the individual. The court shall grant such order whenever there is probable cause to believe that an individual has HIV infection and there is clear and convincing evidence of a serious and present health threat posed to others by the infectious individual. Treatment, such as counseling, hospitalization, and education, would be provided to the infected individual.

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** This act may be cited as the **Emergency Public Safety Measure Act**.

**Section 2.** (A) The State Department of Health may seek in its own name in a court of competent jurisdiction a court order directing an individual to undergo testing for evidence of infection with the human immunodeficiency virus (HIV) without the right of refusal after reasonable efforts have been made to obtain written, informed consent to HIV testing. The court shall grant such order whenever there is probable course to believe that an individual has the HIV infection and there is clear and convincing evidence of a serious and present health threat posed to others by the individual infected.

(B) The record of any action brought under Subsection (A) of this Section shall be closed to the public and, at the request of the individual, any hearing shall be held in camera.

**Section 3.** The State Department of Health may petition a court of competent jurisdiction to order an individual to be hospitalized, placed in another health care or residential facility, or isolated from the general public in his own or another's residence, or a place to be quarantined and made off-limits to the public as the result of the probable spread of a sexually transmitted disease, including, but not limited to, the human immunodeficiency virus (HIV), until such time as the condition can be corrected or the threat to the public's health eliminated or reduced in such a manner that a substantial threat to the public's health no longer exists.

**Section 4.** No individual may be ordered to be hospitalized, placed in another health care or residential facility, or isolated from the general public in his own or another's residence, or a place to be quarantined and made off-limits to the public, except upon the order of a court of competent jurisdiction and upon proof:

(A) By clear and convincing evidence that the public's health and welfare are significantly endangered by an individual with a sexually transmitted disease; and

(B) That the individual with the sexually transmitted disease has been counseled about the disease, about the significant threat the disease poses to other members of the public, and about methods to minimize the risk to the public, and that, despite such counseling, the individual with the sexually transmitted disease evidences a disregard for the health of the public and refuses to conduct himself in such a manner as not to place others at risk; and

(C) That all other reasonable means of correcting the problem have been exhausted and so no less restrictive alternatives exists.

**Section 5.** (A) No individual may be ordered to be hospitalized, placed in another health care or residential facility, or isolated from the general public in his own or another's residence, or a place to be quarantined and made off-limits to the public, unless a hearing has been held of which the individual has received at least 72 hours prior written notification, and unless that person has relieved a list of the proposed actions to be taken and the reasons for each action.

(B) The individual has the right to attend the hearing, to cross-examine witnesses, and to present evidence.

(C) The individual has the right to an attorney to represent him, and to have an attorney appointed on his behalf if he cannot afford one.

**Section 6.** An order for hospitalization, placement in another health care or residential facility, or isolation from the general public in his own or another's residence, if issued, will be valid for no more than 120 days, or for a shorter period of time if the State Department of Health, or the court upon petition, determines that the individual no longer poses a threat to the community. Orders for hospitalization, placement in another health care or residential facility, or isolation from the general public in his own or another's residence may contain additional requirements for adherence to a treatment plan or participation in counseling or education programs as appropriate. Such orders may not be renewed without affording the individual all rights conferred in Section 3 and 4.

**Section 7.** No order for hospitalization or placement in another health care or residential facility may require the placement of an individual under the age of 18 years in a unit of a facility where adults reside, are hospitalized, or have been placed.

**Section 8. {Severity clause.}**

**Section 9. {Repealer clause.}**

**Section 10. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1990.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

**SUNSHINE VIEW**

## **Emergency Services Personnel Protection Act**

### ***Summary***

This bill ensures the safety of emergency personnel, who have been exposed to the blood or other bodily fluids of a patient, through the post-exposure notification protocol. Every facility that receives a patient shall adopt a post-exposure notification protocol for emergency services personnel. The protocol must include: a method for emergency services personnel to notify the facility that they were exposed to the blood or other bodily fluids of a patient transported to the facility; a process to investigate whether an exposure has occurred of a nature which could transmit HIV, Hepatitis B, or HCV, if present; a process to determine whether the patient is infected with HIV, Hepatitis B, or HCV; and a process for notifying the exposed emergency medical services personnel and for making recommendations for appropriate testing and counseling.

### ***Model Legislation***

#### **Section I: Title**

This Act may be cited as the “Emergency Services Personnel Protection Act.”

#### **Section II: Definitions**

For the purposes of this Act the following definitions apply:

(A.) “HIV” means the human immunodeficiency virus identified or any other identified causative agent of acquired immunodeficiency syndrome (AIDS).

(B.) “Hepatitis B” means the Hepatitis B virus.

(C.) “HCV” means the Hepatitis C virus.

(D.) “Emergency Services Agency” means an agency, entity, or organization that employs or uses emergency services personnel as employees or volunteers.

(E.) “Emergency Services Personnel” means:

(1.) individuals employed to provide pre-hospital emergency medical services;

(2.) persons employed as police officers and corrections officials;

(3.) firefighters, paramedics, emergency medical technicians, licensed nurses, reserved



squad personnel, or other individuals who serve as employees or volunteers of an ambulance service and/or provide prehospital emergency medical services; and

(4.) crime lab personnel.

(F.) "Patient" means any individual who is received by a health care facility and who has contact with emergency personnel in the official performance of their duties. Patient includes but is not limited to a victim of accident or injury or deceased person.

(G.) "Facility" means a licensed hospital or freestanding medical care facility that receives patients cared for by emergency services personnel.

### **Section III. Post-Exposure Notification Procedures**

(A.) Every facility that receives a patient shall adopt a post-exposure notification protocol for emergency services personnel who have been exposed to a patient's bodily fluids.

(B.) The post-exposure notification protocol must include the following:

(1.) a method for emergency services personnel to notify the facility that they were exposed to the blood or other bodily fluids of a patient transported to the facility. The facility shall provide to the emergency medical services personnel an exposure report form to be completed by the emergency medical services personnel in a timely fashion;

(2.) a process to investigate whether an exposure has occurred of a nature which could transmit HIV, Hepatitis B, or HCV, if present. This process is to be completed within 72 hours of the exposure report;

(3.) if the exposure has been of such a nature, a process to determine whether the patient is infected with HIV, Hepatitis B, or HCV;

(4.) if the patient is infected with HIV, Hepatitis B, or HCV, or if disease diagnosis is not determinable, a process for notifying the exposed emergency medical services personnel and for making recommendations for appropriate testing and counseling for the emergency medical services personnel;

(5.) procedures to prevent the unauthorized disclosure of the patient's HIV, Hepatitis B, or HCV infection; and

(6.) a process for providing counseling for the emergency services personnel filing the exposure report.

### **Section IV: Emergency Services Personnel Request for Testing**

If the exposure of emergency services personnel to a patient's bodily fluids is of a nature which could transmit HIV, Hepatitis B, or HCV if present, it shall not be necessary to

obtain the patient's consent to test him or her for HIV, Hepatitis B, or HCV at the request of the exposed personnel.

**Section V: Facility Immunity**

The facility which discloses information in accordance with the provisions of this Act shall be presumed, in the absence of evidence to the contrary, to be acting in good faith and shall be immune from any liability, civil or criminal, which might otherwise be incurred or imposed in an action resulting from such disclosure.

**Section VI: Severability Clause**

**Section VII: Effective Date**

*Approved by the Health and Human Services Task Force in 1990.*

## The HIV Assault Act

### *Summary*

This bill would allow for civil charges against an individual who commits an HIV assault. The accused would be held civilly liable to the victim should the individual become infected with the HIV virus.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This act may be cited as the **HIV Assault Act**.

**Section 2.** (A) A male or female commits the crime of HIV Assault if, knowing that he or she is infected with the Human Immunodeficiency Virus (HIV), he or she:

- (1) engages in intimate contact with another;
- (2) transfers, donates, or provides his or her blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, insemination, or other administration to another; or
- (3) dispenses, delivers, exchanges, sells, or in any other way transfers to another any nonsterile intravenous or intramuscular drug paraphernalia used by said person.

(B) HIV assault is a felony and shall be punished by a fine of not more than \$20,000, or imprisonment in a state correctional institution for not less than one year or more than several years, or both.

(C) Nothing in this section shall be construed to require that an infection with HIV has occurred in order for a person to have committed HIV assault.

**Section 3.** Any individual who commits the crime of HIV assault under Section 2 of this Act shall be civilly liable for damages if another individual becomes infected with the human immunodeficiency virus as a result of such violation.

**Section 4.** It shall be an affirmative defense that the person exposed knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and consented to the action with that knowledge.

**Section 5.** For purposes of the Act:

(A) “HIV” means any human immunodeficiency virus (HIV) or any other identified causative agent of acquired immune deficiency syndrome (AIDS).

(B) “Intimate contact” means the exposure of the body of one person to the bodily fluid of another person in a manner that can transmit the HIV virus.

(C) “Intravenous or intramuscular drug paraphernalia” means any equipment, products, or material of any kind that is peculiar to and used for injecting a controlled substance into the human body.

**Section 6. {Severability Clause.}**

**Section 7. {Repealer Clause.}**

**Section 8. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1990.*

## **The HIV Partner Notification Act**

### *Summary*

The purpose of this bill is to authorize the Department of Public Health to confidentially notify partners of infected individuals of the possibility of being exposed to the HIV virus. Specifically, whenever the Department of Public Health receives a report that an individual is infected with HIV, an employee of the Department of Public and confidentially interview the individual to seek the names and whereabouts of the sexual partners and/or needle-sharing partners of the infected individual.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This act may be cited as the **HIV Partner Notification Act**.

**Section 2.** (A) The state Department of Public Health shall establish a program for partner notification and referral services for persons with Human Immunodeficiency Virus (HIV) infection.

(B) As of the effective date of this Act, every physician or health care provider receiving a confirmed positive HIV test result shall confidentially report to the Department of Public Health the name, address and any other information the Department may require by rule, of any person found to be infected with HIV. In addition, every person performing HIV testing by court order or as manipulated by law receives notification of a confirmed positive HIV test result shall similarly report to the Department of Public Health.

(C) Whenever the Department of Public Health receives a report than an individual is infected with HIV, an employee of the Department shall personally and confidentially interview the individual who is the subject of the report and shall seek to obtain the names and whereabouts of the sexual partners and/or needle-sharing partners of the infected individual. Such an infected individual may not be penalized for refusing or failing to volunteer the identity of his sexual and/or needle-sharing partners.

(D) The Department shall attempt to notify each individual named as a partner under Subsection (C) of this Section and shall inform that individual of:

- (1) the possibility that the individual has been exposed;
- (2) the methods of transmission and methods of prevention of HIV infection;

- (3) the availability of diagnostic testing;
- (4) the reliability of testing procedures;
- (5) the availability of medical treatment for the infection and its resultant secondary infections if diagnosed;
- (6) the presumption that a person who is infected with HIV is infected for life; and
- (7) the responsibility of an infected person not to knowingly infect others;

(E) The Department may not disclose to the partner the name or other identifying information concerning the identity of the individual supplying the partner's name.

(F) The information given under this Section concerning a partner of an individual who has AIDS or HIV infection is confidential and may be used only for the purpose of notifying the partner and providing information to the partner.

**Section 3.** The Department of Public Health shall request monthly HIV infection reports on this state's residents and intended residents tested by federal agencies, including, but not limited to the Job Corps, Peace Corps, Foreign Service, State Department, Department of Defense (including applicants, active duty personnel, and reserves), National Guard, and the Immigration and Naturalization Service. The reports requested by the Department shall include, whenever possible, the name, address, and telephone number of persons testing positive for HIV infection, for purpose of partner identification and notification under this Act. The Department shall publish a monthly statistical compilation report of reports received under this Section.

**Section 4.** The Department of Public Health shall annually report to the legislature an evaluation of its partner notification program, including:

- (A) The number of individuals reported to the Department of to the designated local health authorities as being infected with HIV;
- (B) The number of infected individuals interviewed for purposes of seeking the names of their sexual and/or needle-sharing partners;
- (C) The number of notified sexual and/or needle-sharing partners notified who subsequently were reported as infected; and
- (D) The number of notified sexual and/or needle-sharing partners notified who subsequently were reported as infected; and
- (E) Any other elements of a program evaluation which the Department or the State Auditor deems reasonable.



**Section 5.** For purposes of the Act:

(A) “HIV” means the human immunodeficiency virus (HIV) or any other identified causative agent of acquired immune deficiency syndrome (AIDS).

(B) “HIV test” means an enzyme-linked immunosorbent assay (ELISA) to determine the presence of antibodies to the human immunodeficiency virus (HIV), or such other test as may be approved by the Department of Public Health; in the event of a positive result, the Western Blot Assay, or a more reliable confirmatory test, shall also be administered prior to notification of the test result.

(C) “Sexual partner” means a person with whom the HIV-infected individual has had intimate sexual relations during the period in which the Department employee believes the individual may have been infected;

(D) “Needle-sharing partner” means any person with whom the HI-infected person has shared equipment, products, or materials of any kind which are used to inject a substance into the human body.

**Section 6. {Severability Clause.}**

**Section 7. {Repealer Clause.}**

**Section 8. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1990.*

## **HIV Prison Testing Act**

### ***Summary***

This bill authorizes the Department of Corrections to individuals test committed persons for infection of the human immunodeficiency virus. All testing will occur upon taking custody of a committed person. Individuals incarcerated prior to the enactment of this Act will be tested at their next medical visit.

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** This act may be cited as the **HIV Prison Testing Act**.

**Section 2.** (A) Upon taking custody of a committed person (including each adult male, adult female, and juvenile) the Department of Corrections shall provide for the testing of such committed persons for infection with human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome (AIDS). Such testing shall also be provided for committed persons incarcerated before the effective date of this Act at their next regular medical examination provided by the Department.

(B) Any person committed to any institution or facility of the Department of Corrections (including institutions for each adult male, adult female, and juvenile) shall, not more than 30 nor fewer than 15 days prior to release, discharge, or non-emergency furlough from the institution or facility, be given an HIV test by the Department. The Department shall notify the person's spouse, if any, if such test indicates the presence of HIV infection, and shall counsel the HIV-infected prior to his release. This Subsection does not apply if the individual is being transferred between facilities.

(C) Within five days of receiving notification of a diagnosis of HIV infection in a committed person, the warden of the institution or facility where that person is committed shall report to the Department of Public Health the name and whereabouts of the infected person and shall cooperate with the Department of Public Health in making with the provisions of the HIV Partner Notification Act.

(D) Each month, the Department of Corrections shall report such statistical information on the testing program as the Department of Public Health shall require. That information shall include, at a minimum, the age, gender, race, and county of residence of each committed person found to be HIV – infected, whether the person has a history of intravenous drug use, and the crime or crimes for which the person is incarcerated. This

information shall be incorporated into the Department of Public Health's regular reports on HIV infection.

(E) The Department shall not house a committed person who is HIV – infected in a cell with a person who is not so infected or whose infection status is undetermined, and the Department shall, to the extent possible, separate all committed persons who are HIV – infected from all other committed persons.

(F) For the purpose of this Act the following definitions apply:

(1) “HIV” means the human immunodeficiency virus or any other identified causative agents of acquired immunodeficiency syndrome (AIDS).

(2) “HIV test” means as enzyme-linked immunosorbent assay (ELISA) to determine the presence of antibodies to the human immunodeficiency virus (HIV), or such other test as may be approved by the Department of Public Health; in the event of a positive result, the Western Blot Assay, or a more reliable confirmatory test, shall also be administered prior to notification of the test result.

**Section 3.** Notwithstanding any other Act of regulation, the result of the blood test to detect evidence of infection by the HIV shall be disclosed to the warden of the institution or facility where the individual is committed and may be disclosed by the warden to such other employees of the Department of Corrections as have a need to know in order to perform their necessary duties in the assignment of committed persons within institutions or facilities.

**Section 4. {Severability Clause.}**

**Section 5. {Repealer Clause.}**

**Section 6. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1990.*

## The HIV Testing For Insurance Act

### *Summary*

This bill ensures that insurance companies obtain the applicant's written informed consent prior to requiring HIV testing. The insurer is responsible for informing the applicant of the results of the HIV tests as well as educating the applicant on the HIV virus.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **HIV Testing for Insurance Act**.

**Section 2.** For the purpose of this Act the following definitions apply:

(A) "HIV" means the human immunodeficiency virus or any other identified causative agent of acquired immune deficiency syndrome (AIDS).

(B) "Applicant" means the individuals proposed for insurance coverage.

(C) "HIV test" means an enzyme-linked immunosorbent assay (ELISA) to determine the presence of antibodies to the human immunodeficiency virus (HIV) or such other test as may be approved by the State Health Department; in the event of a positive or indeterminate result, the Western Blot Assay or an equivalent or more reliable confirmatory test shall also be administered prior to notification of the test result.

(D) "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the insurance underwriting business, except insurance agents and brokers. This term shall also include medical service plans and hospital plans and health maintenance organizations, which shall be designed as engaged in the business of insurance for the purpose of this Act.

**Section 3.** No insurer shall request or require that an applicant submit to an HIV test unless the insurer first:

(A) Obtain the applicant's prior written informed consent;

(B) Reveals to the applicant the use to which the HIV test result may be put and entities to whom test results may be disclosed pursuant to Subsections (A) and (B) of Section 4 of this Act;

(C) Provides the applicant with printed material prior to testing which contains factual information describing HIV, its causes and symptoms, the tests used to detect HIV infection, and what the applicant should do if the test result is positive. Such information shall include:

- (1) the methods of transmission and methods of prevention of HIV infection;
- (2) the medically accepted degree of reliability of the testing procedures;
- (3) the opportunity of medical treatment for HIV infection and any related infections if diagnosed;
- (4) the presumption that a person who is infected with HIV is infectious for life; and
- (5) the responsibility of an infected person not to knowingly infect others.

(D) No positive ELISA test result may be used for any purpose unless it has been confirmed by a Western Blot Assay or an equivalent or more accurate confirmatory test.

**Section 4.** (A) Except as provided in Section 5 of this Act, on the basis of the applicant's written informed consent as specified in Section 3 of this Act, an insurer may disclose an applicant's HIV test result to its reinsurer or to those contractually retained medical personnel and insurance affiliates, excluding agents and brokers, who are involved in underwriting or claims decisions regarding the individual's application, provided disclosure is necessary to make underwriting or claims decisions regarding such an application.

(B) An insurer may report positive or indeterminate HIV results to a medical information exchange agency, such as the Medical Information Bureau, provided that:

- (1) the informed consent form clearly explains that such disclosure may be made; and
- (2) the results are reported in a manner that only identifies that the applicant has had an abnormal blood test result.

**Section 5.** An insurer shall notify the applicant in writing of an adverse underwriting decision based upon the results of such applicant's blood test but shall not disclose the specific results of such blood test to the applicant. The insurer shall also inform the applicant that the result of the blood test will be sent to the physician designated by the applicant at the time of application and that such physician should be contacted for information regarding the applicant's blood test. If a physician was not designated at the time of application, the insurer shall request that the applicant name a physician to whom a copy of the blood test may be sent.

**Section 6. {Severability clause.}**

**Section 7. {Repealer clause.}**

**Section 8. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1990.*

Obtained and released by:  
Common Cause and  
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**SUNSHINE VIEW**



## **Infectious Disease Prison Testing Act**

### ***Summary***

This Act allows the Department of Corrections, upon taking custody, to provide for the testing of persons committed (including each adult male, adult female and juvenile) for infection with human immunodeficiency virus (HIV) and any other identified causative agent of acquired immunodeficiency syndrome (AIDS), and Hepatitis C virus (HCV). Also, such testing shall also be provided for committed persons incarcerated at their next regular medical examination provided by the Department. The Department shall notify the person's spouse, if any, if such test indicates the presence of HIV or HCV infection, and shall counsel the infected individual prior to his or her release. This Act does not allow the housing a committed person, who is HIV or HCV infected, in a cell with a person, who is not so infected or whose infection status is undetermined.

### ***Model Legislation***

#### **Section 1. Title**

This Act may be cited as the "Infectious Disease Prison Testing Act."

#### **Section 2. Definitions**

For the purposes of this Act the following definitions apply:

(A.) "HIV" means the human immunodeficiency virus identified or any other identified causative agents of acquired immunodeficiency syndrome (AIDS).

(B.) "HCV" means the Hepatitis C virus.

(C.) "HIV and HCV Test" means an enzyme-linked immunosorbent assay (ELISA) to determine the presence of antibodies to the human immunodeficiency virus or Hepatitis C virus, or such other tests as may be approved by the Department of Public Health; in the event of a positive result, a more reliable confirmatory test, shall also be administered prior to notification of the test result.

#### **Section III: Testing Requirements**

(A.1.) Upon taking custody of a committed person (including each adult male, adult female and juvenile) the Department of Corrections shall provide for the testing of such committed persons for infection with human immunodeficiency virus (HIV) and any other identified causative agent of acquired immunodeficiency syndrome (AIDS), and

Hepatitis C virus (HCV). Such testing shall also be provided for committed persons incarcerated before the effective date of this Act at their next regular medical examination provided by the Department. {Drafting note: this section could either include HCV testing upon entry or HCV testing whenever a standard blood test reveals and elevated ALT (liver enzyme test). Most prisons do standard blood screens as part of the entry work-up for a new prisoner. If elevated ALT then, complete a HCV blood test.}

(B.1.) Any person committed to any institution or facility of the Department of Corrections (including institutions for each adult male, adult female, and juvenile) shall, not more than thirty (30) nor fewer than fifteen (15) days prior to his/her release, discharge, or non-emergency furlough from the institution or facility, be given HIV and HCV tests by the Department. The Department shall notify the person's spouse, if any, if such test indicates the presence of HIV or HCV infection, and shall counsel the infected individual prior to his or her release.

(2.) This Subsection does not apply if the individual is being transferred to facilities.

(C.) Within five (5) days of receiving notification of a diagnosis of HIV or HCV infection in a committed person, the warden of the institution or facility where that person is committed shall report to the Department of Public Health the name and whereabouts of the infected person and shall cooperate with the Department of Public Health the name and whereabouts of the infected person and shall cooperate with the Department of Public Health in making the person available for a confidential interview by an employee of the Department of Public Health in accordance with the provisions of ALEC's HIV Partner Notification Act.

(D.) Each month, the Department of Corrections shall report such statistical information on the testing program as the Department of Public Health shall require. That information shall include, at a minimum, the age, gender, race, and county of residence of each committed person found to be HIV and HCV infected, whether the person has a history of intravenous drug use, and the crime or crimes for which the person is incarcerated. This information shall be incorporated into the Department of Public Health's regular reports on HIV and HCV infection.

(E.) The Department shall not house a committed person who is HIV or HCV infected in a cell with a person who is not so infected or whose infection status is undetermined, and the Department shall, to extent possible, separate all committed persons who are HIV or HCV infected from all other committed persons.

#### Section IV: Disclosure

Notwithstanding any other Act or regulation on, the results of the blood test to detect evidence of infection by HIV or HCV shall be disclosed to the warden of the institution or facility where the individual is committed and may be disclosed by the warden to such other employees of the Department of Corrections as have a need to know in order to perform their necessary duties in the assignment of committed persons within institutions

or facilities.

**Section 5: {Severability Clause}**

**Section 6: {Repealer Clause}**

**Section 7: {Effective}**

*Approved by the Health and Human Services Task Force.*

Obtained and released by:  
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## Resolution on Pandemic Flu Preparedness

**WHEREAS**, Influenza pandemics occurred three times in the previous century, and history and science suggest that the United States and the world will face at least one pandemic in this century; and

**WHEREAS**, A pandemic can cause severe illness, death, and disruption throughout the country and the world, and outbreaks can occur in many different locations all at the same time; and

**WHEREAS**, An informed and prepared public is essential to minimizing the health effects of a pandemic and the resulting consequences to society, and this is achieved through learning important health and safety information concerning pandemic influenza with material targeted for groups such as families, travelers, workers, communities, and health professionals; and

**WHEREAS**, A worldwide influenza pandemic could have a major effect on the global economy which directly impacts the economy of the United States as well as state and local governments including travel, trade, tourism, food, consumption, and eventually investment and financial markets; and

**WHEREAS**, Preparing for an influenza pandemic requires coordinated action at all levels of government—federal, state, and local—and all sectors of society, including businesses, schools, faith-based and community organizations, families, and individuals; and

**WHEREAS**, The federal government has committed to taking a leadership role in creating a prepared nation by monitoring international and domestic outbreaks, providing funding and technical assistance to foster state and local preparedness, stockpiling and distributing countermeasures, developing new treatments, and coordinating the national response; and

**WHEREAS**, The secretary of the United States Department of Health and Human Services (HHS) has committed to holding pandemic planning summits in all 50 states, assisting states to improve their level of preparedness; and

**WHEREAS**, The President of the United States has asked the United States Congress for emergency spending authority to prepare the United States against the possibility of a pandemic, and Congress has provided over \$3 billion for that purpose in the federal “Defense Appropriations Act” for 2006, including funding for state and local planning purposes; and

**WHEREAS**, States and local communities are responsible under their own authorities for responding to an outbreak within their jurisdictions and having comprehensive pandemic preparedness plans and measures in place to protect their citizens; and

**WHEREAS**, Consistent with its authorities and availability of funding, HHS may provide additional resources for state and local influenza planning and preparedness activities, and may require the identification and achievement of specific preparedness goals by states and local governments as a condition of financial assistance; and

**WHEREAS**, Preparedness plans must be continuously exercised and updated to make certain that they work and to achieve a stronger level of preparedness; and

**WHEREAS**, Pandemic preparedness will help communities deal with any type of medical emergency and will have lasting benefits for the health of our nation and economic security.

**THEREFORE BE IT RESOLVED THAT** The {insert state legislative body here} encourages {insert state department of health or appropriate state agency here} to adopt additional policies to better prepare {insert state} for a pandemic outbreak to protect the health of our citizens, to protect our economies as a result of a pandemic, and to remain vigilant in guarding against a pandemic; and to

- A) Augment state and local planning with state and local pandemic preparedness summits;
- B) Update {insert state}'s state pandemic programs based on guidance provided by HHS, the *National Strategy for Pandemic Influenza*, and any other guidance concerning the use of countermeasures necessary to address a pandemic;
- C) Assure that {insert state}'s operational plans for pandemic influenza are an integral element of the overall state and local emergency response plan that will coordinate effectively with emergency support, health and medical services, and the national incident management system;
- D) Ensure that {insert state} establishes a pandemic preparedness coordinating committee which represents governmental, public health, health care, emergency response, agriculture, education, business, communications, and community-based and faith-based sectors, as well as private citizens, and this committee will assist {insert state} in articulating strategic priorities and overseeing the development and execution of {insert state}'s operational plan;
- E) Provide the U.S. Centers for Disease Control and Prevention (CDC) with a self-assessment of {insert state}'s readiness to receive a portion of available federal funds from the federal "Defense Appropriations Act" immediately; and

F) Achieve specific preparedness goals, targets, and timelines as agreed to by HHS and CDC in order to receive additional federal funds.

*Approved by the Health and Human Services Task Force on December 9, 2006.*

Obtained and released by:  
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## **Victims of Sexual Offenses Protection Act**

### ***Summary***

This bill authorizes the prosecuting party to request a blood sample from the person charged with a sexual offense to determine whether or not the individual has the HIV virus. The department of Health will confidentially disclose the information to the victim of the sexual offense.

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Victims of Sexual Offenses Protection Act**.

**Section 2.** For the purpose of this Act the following definitions apply:

(A) “HIV” means the human immunodeficiency virus identified as the causative agent of acquired immune deficiency syndrome (AIDS) and includes all HIV-related viruses that damage the cellular branch of the human immune or neurological system and leave the infected person immunodeficient or neurologically impaired.

(B) “HIV test” means performing a medically recognized test or tests for the primary or ancillary purpose of determining the presence of HIV or its antibodies.

(C) “Victim” means a victim of an alleged assault or other criminal act in which it appears from the facts of the case involved that there may have been the transmission of bodily fluids from one person to another. The term “victim” shall include the parental or legal guardian of a minor who is the victim of an alleged sexual offense in which it appears from the facts of the case involved that there have been the transmission of bodily fluids from one person to another.

### **Section 3.**

(A) Upon the written request of a victim of a sexual offense to the State’s Attorney, the person charged by indictment with committing that sexual offense shall furnish a blood sample to determine if the person charged has the human immunodeficiency virus (HIV).

(B) Promptly after receiving the request of the victim, the State’s Attorney shall inform the state Department of Health of the request.

(C) The state Department of Health shall have all blood samples obtained under Subsection (A) of this Section tested for the presence of HIV antibodies. Such testing will take place under a protocol of two ELISA tests and a confirmatory Western Blot test

or an equally reliable screening or confirmatory test protocol as determined by the State Department of Health.

(D) The State Department of Health shall notify the victim of the results of the test performed under Subsection (A) of this Section. Such notification shall:

- (1) be made within 48 hours of confirmation of the defendant's test results;
- (2) include subsequent written confirmation of possible exposure to HIV;
- (3) be conducted in a manner that will protect the confidentiality of the victim; and
- (4) to the extent possible, be conducted in a manner that will protect the confidentiality of the defendant.

**Section 4. {Severability Clause.}**

**Section 5. {Repealer Clause.}**

**Section 6. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1990.*

## **Consumer Awareness Act of Future Premium Rates**

### *Summary*

This bill is to be introduced in conjunction with the Long-Term Care Insurance Act. Its purpose is to protect the consumer from unknowing increases in future premium rates when purchasing long-term care insurance policies.

ALEC's bill stipulates that all long-term care insurance policies must state that the policy premium rates may rise based on claims incurred by all policyholders. Any representation that the policyholder's rates will not rise is unauthorized and should not be relied upon.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as **The Consumer Awareness Act of Future Premium Rates For Long-Term Care Insurance.**

**Section 2.** For any Long Term Care insurance policy or certificate issued or delivered in this state that does not guarantee to a policyholder that the original premium rate will not increase over time, the following language or substantially similar language must be disclosed in bold ten-point type on the cover page of the policy or certificate:

"This policy has premium rates that may rise from time to time for all policyholders based on the claims incurred by all policyholders. Any representation that your rates will not rise is unauthorized and should not be relied upon. Limitations on future rate increases, if there are any, should be stated immediately below this disclosure."

**Section 3.** {Severability Clause}

**Section 4.** {Repealer Clause}

**Section 5.** {Effective Date}

*Approved by the Health and Human Services Task Force in March 2002.*

## **The Consumer Awareness Act of Long-Term Care Inflation Protection**

### *Summary*

This Act is intended to be introduced in conjunction with the Long-Term Care Insurance Act. The purpose of this bill is to protect the purchaser of long-term care insurance from a reduction in benefits due to inflation.

ALEC's bill requires that no insurer may offer a long-term care insurance policy unless the insurer also offers the insured the option to purchase a policy that increases benefit levels over time to account for inflationary growth. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

- A policy that increases benefit levels annually, in a manner so that the increases are compounded annually at a rate not less than five percent;
- A policy that guarantees the insured the right to periodically increase benefit levels; or
- Or a policy that covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

Inflation protection benefit increases under a policy would continue without regard to an insured's age and without regard to whether an insured has or has not had a claim. Inflation protection shall be included in all long-term care insurance policies unless an insurer obtains a rejection of inflation protection signed by the insured.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Consumer Awareness Act on Long-Term Care Inflation Protection**.

**Section 2.** No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for inflation protection that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(A) Increase benefit levels annually, in a manner so that benefits increase at a rate not less than five percent of the base benefit; or

(B) Are compounded annually at a rate not less than five percent; or

(C) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(D) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

**Section 3.** Where a policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in Section 4 of the Long-Term Care Insurance Act other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

**Section 4.** The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

**Section 5.** Insurers shall include the following information in or with the outline of coverage:

(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(B) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

**Section 6.** An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure required under

**Section 7.** Inflation protection benefit increases shall continue without regard to an insured's age and without regard to whether an insured has or has had a claim.

**Section 8.** An offer of inflation protection which provides for automatic benefit increases shall also include an offer of a premium for such benefits. Such offer shall disclose in a conspicuous manner that the premium is not guaranteed to remain constant unless such a

guarantee is made by the insurer.

**Section 9.** Inflation protection, as provided in Section 1A, paragraph (1) of this Act, shall be included in a long-term care insurance policy unless an insurer obtains a written rejection of inflation protection signed by the insured.

**Section 10.** {Severability clause.}

**Section 11.** {Repealer clause.}

**Section 12.** {Effective date.}

*Approved by the Health and Human Services Task Force in March 1992.*

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## **Long-Term Care Equity Protection Act**

### ***Summary***

This Act is intended to be introduced in conjunction with the Long-Term Care Insurance Act. Its purpose is to require insurers offering long-term care policies to offer a nonforfeiture provision within the policy. A nonforfeiture provision offers to the consumer a specified value if the long-term care plan should lapse.

ALEC's bill stipulates that each insurer offering a long-term care insurance policy shall offer a nonforfeiture provision. The provision shall be appropriately captioned and shall provide that in the event of default in any premium payment, after premiums have been paid for at least two full years, the insurer shall grant upon proper request a reduced paid-up nonforfeiture benefit on a plan stipulated in the policy. Nonforfeiture values suggested in the model act include one or more of the following:

- A reduced paid up plan;
- An extended term;
- A return of premium; and
- Cash value.

Applicants who decline to have a nonforfeiture provision included in the policy shall sign a separate form indicating their decision to decline the nonforfeiture provision.

### ***Model Legislation***

#### **Section 1. Title.**

This Act may be cited as the Long-Term Care Equity Protection Act.

Each insurer offering a long term care insurance policy shall offer a nonforfeiture provision. The nonforfeiture provision shall be appropriately captioned and shall provide that in the event of default in any premium payment after premiums have been paid for a number of years stipulated in the policy the insurer shall grant upon proper request a nonforfeiture benefit including without limitation one or more of the following:

- (1) Reduced paid-up;
- (2) Extended term;

(3) Return of premium; and

(4) Cash value.

All non-forfeiture benefits shall be determined on the basis of assumptions consistent with those contained in the premium rates charged to the policyholder immediately prior to the date of default and all such benefits shall be of equal value.

Applicants who decline to have a nonforfeiture provision included in the policy that is applied for shall sign a separate form indicating their decision to decline the non-forfeiture provision.

**Section 2. Severability Clause.**

**Section 3. Repealer Clause.**

**Section 4. Effective Date.**

*Approved by the Health and Human Services Task Force in March 1992.*

## Long-Term Care Insurance Act

### *Summary*

The purpose of this Act is to create a viable market for long-term care insurance. By enacting carefully constructed consumer protection legislation, the long-term care insurance market will grow into an area of interest to both consumers and insurance underwriters. Private long-term care insurance offers both the consumer and the nation the most cost-effective method of providing long-term care services to the nation's rapidly growing elderly population. In fact, the American Health Care Association calculates that, if the majority of persons over the age of 55 were covered with private long-term care insurance, the percentage of persons paid for nationally by Medicaid in nursing homes would fall from the current 67 percent to 25 percent within 25 years.

The Long-Term Care Insurance Act defines long-term care insurance as providing coverage for not less than 12 months for a variety of health, therapeutic, and personal services other than in an acute care unit of a hospital. The bill stipulates that no long-term care insurance policy may be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder. The Act defines the authorities of the Commissioner of Insurance to adopt regulations regarding the content and disclosures of long-term care policies. Insurance policies would be required to include a less restrictive definition for pre-existing conditions, and, a right to return policy after 30 days. All policies would need to contain a description of principle benefits and a statement of the principal exclusions.

### *Model Legislation*

#### **Section 1. Title.**

This Act may be cited as the Long-Term Care Insurance Act.

#### **Section 2. Purpose.**

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

#### **Section 3. Scope.**

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the

obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulation designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

#### **Section 4. Definitions.**

(A) “Long-term care insurance” means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. “Long-term care insurance” includes group and individual annuities and life insurance policies or riders that provide directly or that supplement long-term care insurance. “Long-term care insurance” also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, or limited benefit health coverage. Long-term care insurance does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this Act.

(B) “Applicant” means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

(C) “Certificate” means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(D) “Commissioner” means the Insurance Commissioner of this state.

(E) “Group long-term care insurance” means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustee(s) of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 members and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that:

(a) The association or associations hold regular meetings not less than annually to further purposes of the members;

(b) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(c) The members have voting privileges and representation on the governing board and committees.

(d) Thirty days after such filing, the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(F) “Policy” means, for the purposes of this Act, any policy, contract, subscriber agreement, rider, or endorsement, delivered or issued for delivery in this state by an insurer, fraternal benefit society, prepaid health plan, health maintenance organization, or

any similar organization.

**Section 5. Extraterritorial Jurisdiction; Group Long-Term Care Insurance.**

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in Section 4, unless the other state has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state.

**Section 6. Disclosure and Performance Standards for Long-Term Care Insurance.**

(A) The Commissioner may adopt regulations that include standards for full and fair disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, non-duplications of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

(B) No long-term care insurance policy may:

- (1) Be cancelled, not renewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or
- (2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
- (3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(C) {Pre-existing condition}:

- (1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4(E)(1) shall use a definition of “pre-existing condition” that is more restrictive than the following: Pre-existing condition means a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.
- (2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4(E)(1) may exclude coverage for a loss or confinement that is the result of a pre-existing condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.
- (3) The Commissioner may extend the limitation periods set forth in Sections



6(C)(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of “pre-existing condition” does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a pre-existing condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6(C)(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in Section 6(C)(2).

(D) {Prior hospitalization or institutionalization}:

(1) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

- (a) Conditions eligibility for any benefits on a prior hospitalization requirement;
- (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
- (c) Conditions eligibility for any benefits other than waiver or premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(2)

- (a) A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly describe in a separate paragraph of the policy or certificate entitled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.
- (b) A long-term care insurance policy or rider that conditions eligibility for non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

(3) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(E) The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(F) {Right to return; free look.} Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in Section 4(E)(1) of this Act, the applicant is not satisfied for any reason.

(G)

(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The Commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(b) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(f) A brief description of the relationship of cost to care and benefits.

(H) A certificate issued pursuant to a group long-term care insurance policy which policy, is delivered or issued for delivery in this state, shall include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and
- (3) A statement that the group master policy determines governing contractual provisions.

(I) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

- (1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
- (2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;
- (3) Any exclusions, reductions, and limitations on benefits of long-term care; and
- (4) If applicable to the policy type, the summary shall also include:
  - (a) A disclosure of the effects of exercising other rights under the policy;
  - (b) A disclosure of guarantees related to long-term care costs of insurance charges; and
  - (c) Current and projected maximum lifetime benefits.

(J) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

- (1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, such as death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

(K) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this Act.

**Section 7. Authority to Promulgate Regulations.**

The Commissioner shall issue reasonable regulations to establish minimum standards for marketing practices, agent testing, penalties, and reporting practices for long-term care insurance.

**Section 8. Administrative Procedures.**

Regulations adopted pursuant to this Act shall be in accordance with the provisions of *(insert appropriate state legislation)*.

**Section 9. Penalties.**

In addition to any other penalties by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

**Section 10. Severability Clause.**

**Section 11. Repealer Clause.**

**Section 12. Effective Date.**

*Approved by the Health and Human Services Task Force in March 2000.*

## Long-Term Care Partnership Program Resolution

A Resolution urging the Congress of the United States to amend section 1917(b)(1)(C) of the Social Security Act by deleting May 14, 1993 as the deadline for approval by states of long-term care partnership plans.

**WHEREAS**, Current Federal and state medical assistance expenditures for long-term care services in {insert state} exceed {insert dollar amount} annually, with the state's annual share at approximately {insert dollar amount}; and

**WHEREAS**, Skyrocketing costs of providing care to persons who need assistance to meet daily needs have hit the middle class particularly hard; and

**WHEREAS**, The national average cost for nursing home care is approximately \$50,000 per year; and

**WHEREAS**, Costs to the {insert state} will rise on account of increasing demands for services as our population ages; and

**WHEREAS**, The purpose of the long-term care partnership program is to provide incentives to individuals to purchase long-term care insurance, and consequently to relieve the financial burdens on the states when they assume payment for the long-term care needs of their citizens under the Medicaid program by allowing individuals who exhaust qualified private long-term care policy benefits to protect an equivalent value of assets and still satisfy Medicaid's financial eligibility requirements; and

**WHEREAS**, The concept of long-term care partnerships results in private insurance paying first and government paying last; and

**WHEREAS**, The four states that have had partnership plans for almost a decade, specifically California, Connecticut, Indiana and New York, have experienced significant savings to taxpayers, and have seen less than 100 total partnership purchasers qualify for Medicaid; and

**WHEREAS**, American citizens in 46 states, the District of Columbia and territories of the United States are being discriminated against by not being able to enjoy the benefits provided by long-term care partnership plans due to a restriction present in section 1917(b)(1)(C) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396p(b)(1)(C)) which has discouraged additional states from enacting long-term care partnership programs by effectively removing the major incentive for individuals to participate; therefore be it

**RESOLVED**, That the {insert legislative body} memorialize the United States Congress

to amend section 1917(b)(1)(C)) of the Social Security Act (49 Stat. 620, 28 42 U.S.C. § 1396p(b)(1)(C)) by deleting May 14, 1993, as the deadline for approval by states of long-term care partnership plans, thus affording states throughout the nation the ability to give their citizens the same rights to participate in those types of plans; and be it further

**RESOLVED**, That copies of this resolution be transmitted to the presiding officers of each house of the United States Congress and to each member of the {insert state} Congressional delegation.

*Approved by the Health and Human Services Task Force in Winter 2003.*

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SUNSHINE



## **Long-Term Care Tax Credit Act**

### *Model Legislation*

#### **Section 1. Title.**

This Act may be cited as **the Long-Term Care Tax Credit Act**.

#### **Section 2. Main Provisions.**

A. A taxpayer shall be allowed a credit against the state income tax in an amount equal to 10 percent to 20 percent of the premium cost paid during the taxable year for a long-term care insurance policy that offers coverage to either the individual, the individual's spouse, or a dependent for whom the individual was allowed to deduct a personal exemption for the taxable year.

B. No taxpayer shall be entitled to such credit with respect to the same expended amount for long-term care insurance which are claimed by another taxpayer.

#### **Section 3.**

A. The credit allowed by this Act may not exceed five hundred dollars (\$500) or the taxpayers income tax liability, whichever is less, for each long-term care insurance policy.

B. Any unused tax credit shall not be allowed to be carried forward to apply to the taxpayer's succeeding years' tax liability.

C. No credit shall be allowed under this Act with respect to any premium for long-term care insurance either deducted or subtracted by the taxpayer in arriving at [the state's] net taxable income or with respect to any premiums for long-term care insurance for which amounts were excluded from [the state's] net taxable income.

#### **Section 4. Severability Clause.**

#### **Section 5. Repealer Clause.**

#### **Section 6. Effective Date.**

*Approved by the Health and Human Services Task Force in April 1997.*

## The Reverse Mortgage Enabling Act

### *Summary*

This Act would allow persons to meet their financial needs by accessing the equity in their home through a reverse mortgage. Monies secured by this means would allow elderly homeowners to maintain ownership of their homes while being able to pay for long-term care, whether at home or in an institution. These resources could also be used to pay for the premiums for long-term care, if needed. Home equity of the elderly is estimated to be over \$800 billion, which is a vast resource of financing long-term care. In fact, 75 percent of the population over the age of 65 own their own homes.

### *Model Legislation*

#### **Section 1. Title.**

This Act may be cited as the Reverse Mortgage Enabling Act.

#### **Section 2. Purpose.**

It is the intent of this legislation that elderly homeowners be permitted to meet their financial needs by accessing the equity in their homes through a reverse mortgage.

The legislature recognizes that many restrictions and requirements that exist to govern traditional mortgage transactions are inapplicable in the context of reverse mortgages.

In order to foster reverse mortgage transactions and better serve the elderly citizens of this state, this legislature authorizes the making of reverse mortgages, and expressly relieves reverse mortgage lenders and borrowers from compliance with inappropriate requirements.

#### **Section 3. Definitions.**

(A) "Reverse mortgage" means a non-recourse loan secured by real property which:

- (1) Provides cash advances to a borrower based on the equity in a borrower's owner-occupied principal residence;
- (2) Requires no payment of principal or interest until the entire loan becomes due and payable; and
- (3) Is made by any lender authorized to engage in business as a bank, savings institution, or credit union under the laws of **{insert state}** of the United States, or any other lender authorized to make reverse mortgage loans by the **{insert**

**name of state agency}.**

**Section 4. General Rules for Reverse Mortgages.**

Reverse mortgage loans shall be governed by the following rules, without regard to the requirements set out elsewhere for other types of mortgage transactions:

(A) {Prepayment} Payment, in whole or in part, shall be permitted without penalty at any time during the period of the loan.

(B) {Intervening Liens} All advances made under a reverse mortgage and all interest on such advances shall have priority over any lien filed after the closing of a reverse mortgage.

(C) {Interest} A reverse mortgage may provide for an interest rate which is fixed or adjustable, and may also provide for interest that is contingent on appreciation in the value of the property.

(D) {Periodic Advances} If a reverse mortgage provides for periodic advances to a borrower, such advances shall not be reduced in amount or number based on any adjustment in the interest rate.

(E) {Lender Default} Lenders failing to make loan advances as required in the loan documents, and failing to cure such default as required in the loan documents, shall forfeit any right to collect interest. Lenders may also be subject to administrative penalty as determined by the department.

(F) {Mortgage Recordation Tax} The recordation tax on reverse mortgages shall not exceed the actual cost of recording the mortgage.

(G) {Repayment}:

(1) The mortgage shall become due and payable upon the occurrence of any one of the following events:

(a) The home securing the loan is sold,

(b) All borrowers cease occupying the home as a principal residence, subject to the additional conditions set forth in Section 7, Subsections 2(a) and 2(b);

(c) Any fixed maturity date agreed to by the lender and the borrower is reached; or

(d) An event occurs that is specified in the loan documents and that jeopardizes the lender's security.

(2) The repayment requirement is also expressly subject to the following additional conditions:

- (a) Temporary absences from the home not exceeding 60 consecutive days shall not cause the mortgage to become due and payable;
- (b) Temporary absences from the home exceeding 60 consecutive days but less than one year shall not cause the mortgage to become due and payable so long as the borrower has taken prior action that secures the home in a manner satisfactory to the lender;
- (c) The lender's right to collect reverse mortgage proceeds shall be subject to the applicable statute of limitations for loan contracts in **{insert title}**, **{insert Section}**. Notwithstanding **{insert Section}**, the statute of limitations shall commence on the date that the mortgage becomes due and payable;
- (d) The lender must prominently disclose any interest or other fees to be charged during the period that commences on the date that the mortgage becomes due and payable, and ends when repayment in full is made.

**Section 5. Inapplicability of Related Statutes.**

Reverse mortgage loans may be made or acquired without regard to the following provisions for other types of mortgage transactions set out in the statutes specified below:

- (A) Limitations on the purpose and use of future advances or any other mortgage proceeds;
- (B) Limitations on future advances to a term of years, or limitations on the term of credit line advances;
- (C) Limitations on the term during which future advances take priority over intervening advances;
- (D) Requirements that a maximum mortgage amount be stated in the mortgage;
- (E) Limitations on loan-to-value ratios;
- (F) Prohibitions on balloon payments;
- (G) Prohibitions on compounded interest and interest on interest;
- (H) Interest rate limits under the usury statutes; and
- (I) Requirements that a percentage of the loan proceeds must be advanced prior to loan assignment.

**Section 6. Treatment of Reverse Mortgage Loan Proceeds by Public Benefit Programs.**

(A) Reverse mortgage loan payments made to a borrower shall be treated as proceeds from a loan and not as income for the purpose of determining eligibility and benefits under means-tested programs of aid to individuals.

(B) Undisbursed funds shall be treated as equity in a borrower's home and not as proceeds from a loan for the purpose of determining eligibility and benefits under means-tested programs of aid to individuals.

(C) This Act applies to any law relating to payments, allowances, benefits, or services provided on a means-tested basis by this state, including but not limited to supplemental security income, low-income energy assistance, property tax relief, medical assistance, and general assistance.

**Section 7. Consumer Information and Counseling.**

(A) No reverse mortgage commitment shall be made by a lender unless the loan applicant attests, in writing, that the applicant received from the lender at time of initial inquiry a statement prepared by {insert state agency} regarding the advisability and availability of independent information and counseling services on reverse mortgages.

(B) The {insert state agency} shall be responsible for:

- (1) Providing independent consumer information on reverse mortgages and alternatives; and
- (2) Referring consumers to independent counseling services with expertise in reverse mortgages.

**Section 8. Severability Clause.**

**Section 9. Repealer Clause.**

**Section 10. Effective Date.**

*Approved by the Health and Human Services Task Force in March 2002.*

## **Senior Financial Security Program Act**

### ***Summary***

This Act creates a state program to loan money for nursing home care costs to those aged 65 and over who cannot otherwise afford it, but do possess assets that can be used as security for the loan. A lien is placed on the participant's assets and the state eventually collects the value of the loan when the assets are sold or upon the death of the participant of his/her last surviving dependant. If the value of the loan exceeds the value of the participant's assets, the participant is placed in Medicaid or other public assistance program.

### ***Model Legislation***

#### **Section 1. Title.**

This Act may be cited as the Senior Financial Security Program Act.

#### **Section 2. Definitions.**

As used in this Act:

- (A) "Senior" means a person age 65 and over.
- (B) "Participant" means an eligible person in the Senior Financial Security Program as described under Section 4 of this Act.
- (C) "Transfer of assets" means any divestiture of purchasing power including but not limited to gifts, purchase of exempt assets, divorce, purchase of unsalable or undivideable property, divestment into trusts, or converting assets into joint tenancy.
- (D) "Lien" means an encumbrance placed on real or personal property for the satisfaction of a debt.

#### **Section 3. Purpose.**

The purpose of the Senior Financial Security Program (SFSP) is to protect seniors who are unable to take care of themselves. The program does not replace any individual's responsibility to provide for their own long-term care. Program requirements that prohibit divestiture of assets, require security for benefits paid, and mandate recovery from estates are expressly intended to encourage all citizens to plan ahead, purchase quality long-term care insurance, pay privately for appropriate, cost-effective levels of care, and rely on the SFSP only as a last resort.



#### **Section 4. Eligibility Requirements.**

(A) Seniors who need nursing home care may qualify for the SFSP for the following reasons:

- (1) A person's income could not adequately pay for nursing home care; or
- (2) A person's non-exempt assets do not exceed \$2,000.

(B) To qualify for assistance under the SFSP, a person must provide a net worth statement confirmed by a certified public accountant. This net worth statement constitutes security offered by program participants to assure repayment of benefits received. As the participant receives benefits, the cost to the SFSP will be deducted from the participant's net worth ledger. As long as the ledger has a positive balance, the program participant is in receipt of a government-sponsored loan. When the ledger's balance turns negative, the participant converts to Medicaid, or to a comparable public assistance program.

(C) Exempt assets that SFSP participants may retain are the following:

- (1) One single-family residence qualifies as an exempt asset. Homes purchased within eight years of applying for benefits will be treated as a transfer of assets in order to qualify in so far as the homes exceed the median home value in the state.
- (2) One automobile of any value qualifies as an exempt asset, provided it is used for the benefit of the program participant. Transfer of an automobile will be deemed a transfer of assets subject to penalty. Program participants may not give away exempt assets and replace them with new exempt assets as a means to qualify for assistance or avoid estate recovery.
- (3) One prepaid funeral plan qualifies as an exempt asset, not to exceed the average cost in {insert state} of a simple funeral service and disposal of remains.

#### **Section 5. Divestiture Policy.**

(A) Any assets transferred for less than fair market value within eight years of applying for assistance constitute a debt owed to {insert state} up to the total public benefits paid. Any such debt is payable by the transferees who received the assets and/or by the estate of the program participant or by such persons who may have received the assets by means other than a formal probated estate. Any asset transferred in contemplation of qualifying for the SFSP or of avoiding estate recovery shall be considered a fraudulent conveyance.

(B) No purchasing power possessed within eight years of application by anyone who later depends on the SFSP shall be used for any other purpose than the care and maintenance of the owner or reimbursement to the SFSP for providing such care and maintenance.

(C) If any purchasing power shall have been taken from an SFSP participant improperly

or illegally, the program shall petition the appropriate court to appoint a private attorney as the participant's conservator (reimbursed on contingency) to recoup the misappropriated assets on behalf of the participant and the program. Such recoupment may include relitigating abusive divorce decrees, reversing improper asset transfers, invading inappropriate trusts, and partitioning undivided property.

#### **Section 6. Lien Security.**

(A) As a condition of eligibility for the SFSP, all participants must allow the state to place a lien on their property in order to assure that the SFSP can recover benefits paid as appropriate, and can terminate eligibility if appropriate. The lien shall apply to all real and personal property retained by the participant with the exception of the \$2,000 liquid asset exclusion and certain highly private personal property (to be defined).

(B) Such liens shall be officially recorded in the appropriate legal manner and shall be enforceable upon sale of the asset or upon the death of a program participant, or if the participant is survived by a legitimate dependent, upon the death of the last surviving exempt dependent relative (to be defined by the state).

#### **Section 7. Estate Recovery.**

(A) Each participant in the SFSP must agree in writing to pay back the entire cost of care from his or her estate, or from the proceeds of sale of real or personal property during program eligibility up to the total value of the estate or sale. If the program participant should predecease a spouse or other legitimate dependent heir or joint tenant, the participant's share of any jointly owned property or purchasing power shall be recovered from such third party as soon as it is no longer needed for the maintenance of the dependent, and in any case, no later than upon the death of the dependent third party.

(B) The intent of this rule is to assure that people pay for their own long-term care, either directly by retaining providers in the private marketplace or indirectly by reimbursing the SFSP. The financial viability of the SFSP and its ability to provide care to less fortunate participants depends on strong estate recovery enforcement.

#### **Section 8. Public Education.**

(A) Ten percent (or such proportion as shall be necessary to achieve the objective) of the revenue generated by SFSP's lien and estate recovery efforts shall be used exclusively to support a public education initiative on long-term care. The purpose of this initiative is to educate the public, the medical profession, the bar, the judiciary, financial advisors, and all other individuals in the community who influence the lives of older people, concerning the importance of long-term care planning.

(B) Such education and training will include but not be limited to:

- (1) The probability of requiring long-term care;
- (2) The average incidence, duration and cost of nursing home care;

(3) The principles of how to identify and select a reliable long-term care insurance policy;

(4) The kinds of free and fee-for-service assistance available to postpone institutionalization (e.g., meals on wheels, chore services, adult day care, congregate care, assisted living, etc.); and

(5) The eligibility, lien and estate recovery requirements associated with dependency on the SFSP.

**Section 9. Severability Clause.**

**Section 10. Repealer Clause.**

**Section 11. Effective Date.**

*Approved by the Health and Human Services Task Force in 1993.*

## **Elimination of Non-Federally Mandated Benefits**

### *Summary*

This legislation eliminates all Medical Assistance benefits not mandated by the federal government. The chronically needy General Assistance recipient would continue to receive federally man-dated Medical Assistance coverage. All optional services would no longer be made available.

**Section 1. {Title.}**

**Section 2. {Definitions.}**

**Section 3. {Restrictions on Medical Assistance Services.}** Notwithstanding any provision of this act to the contrary, on and after {insert date}, Medical Assistance services for eligible recipients, including chronically needy General Assistance recipients, shall be limited solely to those Medical Assistance services required to be provided by federal law or regulation.

**Section 4. {Severability clause.}**

**Section 5. {Repealer clause.}**

**Section 6. {Effective date.}**

*Approved by the Health and Human Services Task Force.*

## **Mandated Benefits Review Act**

### *Model Legislation*

#### **Section 1. Title.**

This Act may be cited as the Mandated Benefits Review Act.

#### **Section 2. Statement of Purpose.**

The purpose of this Act is to provide for a review of mandated benefits. This Act requires that a proposed mandated benefit or an amendment to an existing law or an amendment to a proposal for mandated health benefits, mandated health insurance coverage, or mandated offerings of health benefits, be reviewed by the Department of Insurance. The Department of Insurance shall provide to the legislature an actuarially-based review with regard to the proposal's medical efficacy and financial impact. **{Insert percentage}** of existing mandated benefits shall be reviewed annually through the process outlined in this Act.

#### **Section 3. Definitions.**

A. "Mandated benefits" shall include:

1. Any mandated coverage for specific medical or health-related services, treatments, medications or practices;
2. Any mandated coverage of the services specific to health care practitioners;
3. Any mandate requiring an offering of specific services, treatments, practices; or an expansion of an existing coverage, and
4. Any mandated reimbursement amount to specific health care practitioners.

B. "Offering" means that every carrier or health plan must offer the mandated benefit to prospective customers.

C. "Report" means an independent, actuarially-based review.

#### **Section 4. Mandated Health Benefits Review.**

A. **{Report.}** A proposal or an amendment to an existing law or an amendment to a proposal for a new mandated health benefit shall be evaluated as to the proposal's medical efficacy and financial impact. The legislative committee having jurisdiction shall refer the proposal or any amendment to an existing law or any new amendment to a proposal to the **{insert the appropriate state insurance department}** for review.

B. **{Department of Insurance Review.}** The Department of Insurance shall retain an

independent actuary to review the proposal or amendment within **{insert time frame}** after the documentation is submitted and assure that appropriate assumptions are used to accurately demonstrate the financial impact of the proposed mandate or amendment to a proposed mandate or an amendment to an existing law. The Department of Insurance shall include the results of this review in the report required by Paragraph C of this Section.

**C. {Department of Insurance Report.}** The Department of Insurance shall review the documentation submitted with the proposed legislation and shall issue a report within **{insert time frame}** as to whether:

1. The information is complete;
2. The research cited meets professional standards;
3. All relevant research has been brought to light; and
4. The conclusions and interpretations drawn from the evidence are consistent with the data presented. The Department of Insurance will provide the report to the appropriate legislative committee and to the leadership of the originating legislative body **{i.e. House or Assembly, or Senate}**.

**D. {Guidelines.}** In preparing the report required in Paragraph C, the Department of Insurance shall apply the following guidelines in determining the adequacy of the information presented:

1. If the insurance coverage is not generally in place, to what extent the lack of coverage of the proposed benefit results in financial hardship.
2. What is the demand for the proposed health care coverage from the public at large and in collective bargaining negotiations, and to what extent voluntary coverage of the proposed benefit is available.
3. The Department of Insurance, in consultation with relevant medical experts, shall consider evidence of medical efficacy:

(a) If the legislation seeks to mandate coverage of a particular therapy:

(i) the results of at least one clinical trial demonstrating the medical consequences of that therapy compared to no therapy and to alternative therapies; and

(ii) the results of any other relevant clinical research.

(b) If the legislation seeks to mandate coverage of a specific class of practitioners or medical specialty:



(i) the results of at least one professionally-acceptable, controlled trial demonstrating the medical results achieved by the specific class of practitioners or medical specialty relative to those already covered; and

(ii) the results of any relevant research.

4. The Department of Insurance shall review evidence of financial impact, including but not limited to:

(a) the extent to which coverage will increase or decrease the cost of treatment or service;

(b) the extent to which the same or similar mandates have affected charges, costs, utilization and payments in other states;

(c) the extent to which the coverage will increase the appropriate use of the treatment or service;

(d) the extent to which the mandated treatment or service will be a substitute for more expensive or less expensive treatments or services;

(e) the extent to which the coverage will increase or decrease the administrative expenses of third party payers and the premium and administrative expenses of policyholders;

(f) the financial impact of the mandated benefit on small employers, medium-sized employers, large employers and the state employees health benefit plan; and

(g) the financial impact of the mandated benefit purchasers of individual coverage, state high-risk pools and the state retirement program.

*(Drafting Note: Some states must refer the report to the health department rather than the state insurance department for review.)*

#### **Section 5. Review of Existing Mandated Benefits.**

*(Drafting note: This section is optional.)*

A. In addition to the duties prescribed in this Act, the Department of Insurance shall annually review **{insert percentage}** of existing state mandated benefits, mandated health insurance coverage, and mandated offerings of health benefits in the same manner as prescribed in Sections 2 and 3 of this Act. The Department of Insurance shall report the findings of such review to the chair(s) of the legislative committee(s), the legislative committee(s) having jurisdiction, the Speaker of the House and President of the Senate, and the state budget department, no later than **{insert date}**.

B. **{Insert percentage}** of existing mandated benefits shall expire on July 1 of every year after the effective date of this Act unless specifically reauthorized by the legislature. Consideration of reauthorization shall be based upon the review process required under Paragraph C of Section 4.

**Section 6. {Severability clause.}**

**Section 7. {Repealer clause.}**

**Section 8. {Effective date.}**

*Approved by the Health and Human Services task Force in August 1999. Amended by the Health and Human Services Task Force in March 2002.*

## Consumer Compensation Fund Act

### *Summary*

The civil justice section of *The 1987-88 Source Book* addresses the acute shortage of adequate liability insurance and the powerful need for state tort reform. The proposals set forth in the civil justice section confirm that the basic tenets of the judicial system should be fair compensation of victims, deterrence of wrongdoing and targeting of liability to responsible parties. Absent reform, today's civil justice system is crippled by frivolous lawsuits, long delays, exorbitant awards and unpredictable outcomes. In our litigious society, professionals must be ever-mindful of the threat of malpractice actions against them.

The **Consumer Compensation Fund Act** creates an alternative system whereby injured customers receive fair compensation and professionals receive protection from unpredictable, often excessive noneconomic damage awards. The Act includes the following elements:

- (1) the establishment of a Consumer Compensation Fund, made up of contributions from professionals practicing in the state, which is used to fund malpractice awards in excess of a professional's personal liability per incident, as established in the Act;
- (2) full recovery of actual economic damages and a cap of \$250,000 for noneconomic damages;
- (3) an *ad damnum* clause provision which prohibits a plaintiff from using a specific dollar amount in his prayer for damages;
- (4) A statute of limitation which requires claims to be brought within two years from the date of the alleged act;
- (5) protection for an individual professional from personal liability for noneconomic damages in excess of \$100,000;
- (6) a provision which limits attorney's fees to 15% of the recovery from the Consumer Compensation Fund;
- (7) A Professional Review Panel whose consideration of an alleged malpractice act is a prerequisite to bringing suit against professionals covered under the Act.

This Act is modeled after Indiana's Medical Malpractice Act, P.L. 146 (1975).

## ***Model Legislation***

(Title, enacting clause, etc.)

**Section 1.** *[Short title.]* This Act may be cited as the **Consumer Compensation Fund Act**.

**Section 2.** *[Definitions.]* The following words, as used in this Act, shall have the meaning set forth below, unless the context clearly requires otherwise:

(A) “Actual economic damages” means objectively verifiable pecuniary damages arising from medical expenses and medical care, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income, burial costs, loss of use property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and other objectively verifiable monetary losses.

(B) “Authority” means the Residual Malpractice Insurance Authority established under *[appropriate residual malpractice insurance authority]*.

(C) “Commissioner” means the Commissioner of Insurance in this state.

(D) “Consumers” refers to individuals who use, maintain, and dispose of services rendered.

(E) “Injury” refers to pain and suffering, bodily injury, and mental diseases.

(F) “Insurer” means the authority or an insurance company engaged in making this state malpractice liability insurance pursuant to *[cite applicable state insurance regulation]*.

(G) “Malpractice” means any tort or breach of contract based on professional services rendered, or which should have been rendered, by a professional, to or for a consumer.

(H) “Noneconomic damages” means subjective, nonpecuniary damages arising from pain, suffering, inconvenience, physical impairment, disfigurement, mental anguish, emotional distress, loss of society and companionship, loss of consortium, injury to reputation, humiliation, other nonpecuniary damages, and any other theory such as fear of loss, illness, or injury:

(I) “Nonprofit” refers to an organization which meets the following qualifications:

- (1) a group organized for purposes other than generating profit, such as a charitable, scientific, or literary organization;

(2) an organization which, for purposes of federal income taxation, may be an exempt organization if it is organized and operated exclusively for one of more of the following purposes:

- (a) religious,
- (b) charitable,
- (c) scientific,
- (d) testing for public safety,
- (e) literary,
- (f) educational,
- (g) prevention of cruelty to children or animals, or
- (h) to foster national or international sports; and

(3) an organization that meets any other qualifications necessary to file for a tax exemption under Section 501 (C)(3) of the Internal Revenue Code.

(J) “Profession” refers to a vocation or an occupation, whether nonprofit or for profit, which requires special, usually advanced, education and skill.

(K) “Professional” means a person licensed by this state to provide services respective to his or her professions.

(L) “Representative” means the spouse, parent, guardian, trustee, attorney, or other legal agent of the consumer.

(M) “Risk” means any professional which shall apply for malpractice liability insurance coverage under *[cite applicable state provisions]*.

(N) “Risk Manager” means an insurance company admitted to make malpractice liability insurance and actively engaging in making malpractice liability insurance, which company is appointed by the Commissioner to manage the Authority.

(O) “Tort” means any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

**Section 3.** *[Qualifications required for professional.]* A professional who fails to qualify under this statute is not covered by its provisions and is subject to liability under the law without regard to the provisions of this Act. If a professional does not so qualify, the consumer’s remedy will not be affected the terms and provisions of this Act.

**Section 4.** *[Claims – Filing complaint.]* A consumer or his representative having a claim under this Act for injury on account of malpractice may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury. No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises.

**Section 5.** *[Limitation of recovery – Exemptions.]*

(A) A claim based on an occurrence of malpractice against a governmental entity or an employee of a governmental agency, shall be governed exclusively by the provisions of this Act if the governmental entity or employee is qualified under the provisions of this Act.

(B) The following are exempt from the provisions of this Act:

(1) technical contractual personnel and services retained by the Commissioner for protecting and administering the Consumer Compensation Fund (established in Section 12 of this Act); and

(2) purchasing of annuities for structuring settlements from the Fund or in combination with the fund and the professional's insurer.

**Section 6.** *[Limitation of recovery – Qualifications.]*

(A) To be qualified under the provisions of this Act, a professional or the professional's insurance carrier shall:

(1) file with the Commissioner proof of financial responsibility as provided by this Act in the amount of \$100,000 or more; and

(2) pay the surcharge assessed by this Act on all professions according to Section 12 of this Act.

(B) The officers, agents or employees of a professional, while acting in the course and scope of his employment may be qualified under the provisions of this Act if he is individually named, or is a member of a named class, in the proof of financial responsibility filed by the professional under Section 9 and if the surcharge assessed under Section 12 of this Act is paid.

**Section 7.** *[Recovery of damages.]*

(A) In any malpractice action, the prevailing plaintiff may be awarded:

(1) compensation for actual economic damages suffered by the injured plaintiff; and

(2) compensation for the noneconomic damages suffered by the injured plaintiff not to exceed \$250,000.



(B) A professional qualified under this Act is not liable for noneconomic damages in excess of \$100,000 for a claim of malpractice. Any award for noneconomic damages which is in excess of the combined liability per incident of all liable professionals, shall be paid from the Consumer Compensation Fund pursuant to Section 12.

(C) In the event of a professional qualified under this Act admits liability or is adjudicated liable solely by reason of the conduct of another professional who is an officer, agent, or employee of the professional acting in the course and scope of his employment and qualified under this section, the total amount which shall be paid to the claimant on behalf of the officer, agent or employee and the professional, by such professional or its insurer, shall be all actual economic damages and the first \$100,000 of any noneconomic damages awarded. The balance of any adjudicated sum to which the claimant is entitled, if any, shall be paid by other liable professionals and/or the Consumer Compensation Fund.

**Section 8.** *[Admission of liability and advance payments.]*

(A) Any advance payment made by a professional or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for malpractice.

(B) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the plaintiff's judgment to the extent of the advance payment. The advance payment shall ensure the exclusive benefit of the defendant or his insurer who is making the payment.

(C) A consumer's claim for compensation under this Act is not assignable.

**Section 9.** *[Proof of responsibility.]* Financial responsibility of a professional and its officers, agents, and employees while acting in the course and scope of his employment with such professionals may be established.

**Section 10.** *[Statute of limitations – Time for filing a claim.]*

(A) No claim, whether in contract or tort, may be brought against a professional based upon professional services that have been rendered or that should have been rendered unless filed within two years of the time that the injury, disease, disability, or death is or, in the exercise of reasonable diligence, should have been discovered by the plaintiff. This section applies to all persons regardless of minority or other legal disability, except as provided in subsection (B).

(B) In the case of a consumer who meets the criteria stated in the Section 25(B)(2)(c) the applicable limitations period is equal to the period that would otherwise apply to the consumer under subsection (A) plus 180 days.

**Section 11.** *[Statute of limitations – Prior action.]* A claim made by a minor or other person under legal disability against a professional stemming from professional services rendered, whether in contract or tort, based on alleged injury, disease, disability, or death,

which occurred prior to *[effective date of this Act]*, shall be brought only within the longer of:

(A) two years of the effective date of this Act; or

(B) the period described in Section 10 of this Act.

**Section 12.** *[Establishment of a Consumer Compensation Fund.]* This Section will address the creation, levy of annual surcharge and disposition of funds in establishing a Consumer compensation Fund.

(A) There is created a Consumer Compensation Fund to be collected and received by the Commissioner for exclusive use for the purposes stated in this Act. The Fund and any income from it shall be held in a trust, deposited in a segregated account, invested, and reinvented by the Commissioner and shall not become a part of the general fund of the state.

(B) To create the Fund, an annual surcharge shall be levied on all professionals in *[state]*. The surcharge shall be determined by the Commissioner based on actuarial principles and shall not exceed ten percent of the cost to each professional for maintenance of fiscal responsibility. The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager and surplus lines agents.

(C) Such surcharge shall be due and payable within 30 days after the premiums for professional liability insurance have been received by the insurer, risk manager and surplus lines agents from the professionals in this state. Before the date of enactment, the Commissioner shall send to each insurer, the risk manager and lines agents a statement explaining the provisions of this Section together with any other information necessary for their compliance with this Section.

(D) If the annual premium surcharge is not paid within the time limited above, the certificate of authority of the insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

(E) All expenses of collecting, protecting and administering the Fund shall be paid from the Fund.

(F) If the Fund exceeds the sum of \$15,000,000 at the end of any calendar year after the payment of all claims and expenses, the Commissioner shall reduce the surcharge provided in this Section in order to maintain the Fund at an approximate level of \$15,000,000.

(G) All claims from the Consumer Compensation Fund shall be computer on December 31 in the year of which the claim becomes final. All claims shall be pain on or before January 15 of the following year. If the Fund would be exhausted by payment in full of all claims allowed in a calendar year, then the amount paid to each claimant shall be prorated. Any amounts due and unpaid shall be paid in the following calendar year.

**Section 13.** *[Payment from Consumer Compensation Fund after exhaustion of insurance coverage.]* In the event of an annual aggregate for a professional qualified under this Act has been paid by or on behalf of any such professional, noneconomic damages which may thereafter become due and payable to a claimant arising out of an act of malpractice of such professional occurring during the year in which the annual aggregate was exhausted shall be paid from the Consumer Compensation Fund under the following terms and conditions:

(A) The professional whose annual aggregate has been exhausted shall have no right to object or refuse permission to settle any such claim.

(B) If the professional or the Insurance Commissioner and claimant agree on a settlement the following procedure must be followed.

(1) A petition shall be filed by the claimant with the court in which the action is pending against the professional or, if none is pending, in the circuit or superior court of *[name of appropriate county]* seeking approval of the agreed settlement.

(2) A copy of the petition shall be served on the Commissioner and the professional at least ten days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the amount of the proposed settlement.

(3) The Commissioner may agree to the settlement or may file written objections thereto. The agreement or objections shall be filed within 20 days after the petition is filed.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the professional and the Commissioner.

(5) At the hearing, the Commissioner, the claimant and the professional may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner and the claimant cannot agree on the amount, if any, to be paid out of the Consumer Compensation Fund, then the court shall determine the amount for which the Fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid to the Consumer Compensation Fund, the court shall consider the liability of the professional as admitted and established.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court. The Commissioner may promulgate rules and regulations implementing the provisions of this Section.

**Section 14.** *[Claims process for Consumer Compensation Fund.]* The auditor of this state shall issue a warrant in the amount of each claim submitted to him against the Fund on June 30 and December 31 of each year. The only claim against the Fund shall be a voucher or other appropriate request by the Commissioner after he receives:

- (A) a certified copy of a final judgment against a professional; or
- (B) a certified copy of a court-approved settlement against a professional.

**Section 15.** *[Procedure upon failure of professional to pay agreed settlement.]* If the professional, his surety or liability insurance carrier fails to pay any agreed settlement or final judgment within 90 days, the same shall be paid from the Consumer Compensation Fund. The Fund shall be subrogated to any and all of claimant's rights against said professional, his surety and/or liability insurance carrier with interest, reasonable costs and attorney's fees.

**Section 16.** *[Consumer Compensation Fund – Procedure for excessive claims.]* If a professional or its insurer has agreed to settle its liability on a claim for noneconomic damages by payment of its policy limits of \$100,000, and the claimant is demanding as amount in excess thereof, then the following procedure must be followed:

(A) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the Circuit or Superior Court of *[name of appropriate county]* at the claimant's election, seeking:

- (1) approval of an agreed settlement, if any, or
- (2) demanding payment of noneconomic damages from the Consumer Compensation Fund.

(B) A copy of the petition with summons shall be served on the Commissioner, the professional and his insurer, at least ten days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(C) The Commissioner and either the professional or the insurer of the professional may agree to a settlement with the claimant from the Consumer Compensation Fund, or the Commissioner, the professional or the insurer of the professional may file written objections to the payment of the amount demanded. The agreement or objection to the payment demand shall be filed within 20 days after service of summons with a copy of the petition attached thereto.

(D) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the professional, the insurer of the professional, and the Commissioner.

(E) At the hearing, the Commissioner, the claimant and the insurer of the professional may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. Of the Commissioner, the professional, the insurer of the professional and the claimant cannot agree on the amount, if any, to be paid out of the Consumer Compensation Fund, then the court, after hearing any relevant evidence on the issue of claimants damages, submitted by any of the parties described in this Section, shall determine the amount of claimant's noneconomic damages, if any, in excess of \$100,000 already paid by the insurer of the professional. The court shall determine the amount for which the Fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the Consumer Compensation Fund, the court shall consider the liability of the professional as admitted and established.

(F) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contest proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(G) A release executed between the parties shall not bar access to the Consumer Compensation Fund unless the release specifically provides otherwise.

**Section 17.** *[Discharge of obligation to pay amount from Fund.]* The obligation to pay an amount from the Consumer Compensation Fund may be discharged through:

- (A) payment in one lump sum;
- (B) an agreement requiring periodic payments from the Fund over a period of years;
- (C) the purchase of an annuity payable to the consumer; or
- (D) any combination of subdivisions (A), (B), and (C).

The Commissioner may contract with approved insurers to ensure the ability of the Fund to make these periodic payments under subsection (B).

**Section 18.** *[Attorney's fees.]*

(A) When a plaintiff is represented by an attorney in the prosecution of his claim, the plaintiff's attorney fees from any award made from the Consumer's Compensation Fund may not exceed 15% of any recovery from the Fund.

(B) A consumer has the right to elect to pay for the attorney's services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment.

**Section 19.** *[Reporting of claims.]* All malpractice claims settled or adjudicated to final judgment against a professional shall be reported to the Commissioner by the plaintiff's



attorney and by the professional or his insurer or risk manager within 60 days following final disposition of the claim. The report to the Commissioner shall state the following:

- (A) nature of the claim;
- (B) damages asserted and alleged injury;
- (C) suspension of the professional's license for a determinate period; or
- (D) revocation of the license.

**Section 20.** *[Review of claims.]* The Commissioner shall forward the name of every professional against whom a settlement is made or judgment is rendered under this Act to the [appropriate boards of professional registration and examination] for review of the fitness of the professional to practice his profession. In each case involving review of a professional's fitness to practice under this Act, the board shall have the power, in appropriate cases, to take the following disciplinary action:

- (A) censure;
- (B) imposition of probation for a determinate period;
- (C) suspension of the professional's license for a determinate period; or
- (D) revocation of the license.

**Section 21.** *[Malpractice coverage.]*

- (A) Only while malpractice liability insurance remains in force are the professional and his insurer liable to a consumer, or his representative, for malpractice to the extent and in the manner specified in this Act.
- (B) The filing of proof of financial responsibility with the Commissioner shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this Act.
- (C) Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this Act is void.
- (D) Every policy issued under this Act is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the general assembly of this state as fully as if it were written therein:
  - (1) the insurer assumes all obligations to pay an award imposed against its insured under the provisions of this Act; and



(2) any termination of this policy by cancellation is not effective as to consumers claiming against the insurer covered hereby, unless at least 30 days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the Commissioner at their offices.

(E) If an insurer fails or refuses to pay a final judgment, except during the pending of an appeal, or fails, or refuses to comply with any provision of this Act, in addition to any other legal remedy, the Commissioner may also revoke approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this Act and resubmitted its policy form and received approval of the Commissioner.

**Section 22.** *[Risk manager – Authority.]* The purpose of this Act is to make malpractice liability insurance available to risks as defined in this Act.

(A) There is created the Residual Malpractice Insurance Authority. The state Department of Insurance is designated as the authority for the purpose of this Act.

(B) The Commissioner shall appoint a risk manager for the authority. The separate, personal or independent assets of the risk manager shall not be liable for or subject to use or expenditure for the purpose of providing insurance by the authority.

(C) In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

- (1) be subject to all laws and regulations of the state which apply to malpractice liability insurance;
- (2) prepare and file appropriate forms with the state Department of Insurance;
- (3) prepare and file premium rates with the state Department of Insurance,
- (4) perform the underwriting function;
- (5) dispose of all claims and litigations arising out of insurance policies;
- (6) maintain adequate books and records;
- (7) obtain private reinsurance for the authority, if necessary;
- (8) prepare and file for approval of the Commissioner a schedule of agent's compensation; and
- (9) prepare and file a plan of operations with the Commissioner for approval.

(D) The risk manager shall receive as compensation for its services, a percentage of all premiums received by it under the terms of this Section, as determined by the Commissioner. The compensation by be adjusted by the Commissioner.

(E) If a risk, after diligent effort has been declined by at least two insurers, the risk may, together with evidence of the two declinations, forward his application to the risk manager.

(F) If the risk manager declines to accept the risk, notice of declination, together with the reasons, shall be sent to the applicant and the Commissioner. The applicant shall have ten days from the date of notice to file an appeal for review by the Commissioner. On appeal, the Commissioner shall review the decision of the risk manager and enter an appropriate order.

(G) All sums appropriated by this state, and any surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the Commissioner, and investment income generated shall remain in the Fund.

**Section 23.** *[Professional Review Panel – Filing of proposed complaints, tolling statute of limitations, and requests for formation of Panel.]*

(A) Provision is made for the establishment of a Professional Review Panel to review all proposed malpractice complaints against professionals covered by this Act.

(B) The filing of a proposed complaint tolls the applicable statute of limitations to and including a period of 90 days following the receipt of the opinion of the Professional Review Panel by the complainant. A proposed complaint under this Section shall be deemed filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail a copy to each professional named as a defendant as his last and usual place of residence or his office.

(C) Not earlier than 20 days after the filing of a proposed complaint, either party may request the formation of a Professional review Panel by serving a request by registered or certified mail upon all parties and the Commissioner.

**Section 24.** *[Professional Review Panel – Prerequisite to suit.]*

(A) Except as provided in subsection (B), no action against a professional may be commenced in any court of this state before the claimant's proposed complaint has been presented to a Professional Review Panel established pursuant to this Section and an opinion is rendered by the Panel.

(B) A claimant may commence an action in court for malpractice without the presentation of the claim to a Professional Review Panel if the claimant and all parties named as defendants in the action agree that the claim is not to be presented to a Professional Review Panel. The agreement must be in writing and must be signed by each party or an authorized agent of the party. The claimant must attach a copy of the

agreement to the complaint filed with the court in which the action is commenced.

**Section 25.** *[Professional Review Panel – Commencement of the action without submission of complaint to Panel.]*

(A) Notwithstanding Section 24, a consumer may commence an action against a professional for malpractice without submitting a proposed complaint to the Professional Review Board if the consumer's pleadings include a declaration that the consumer seeks damages from the professional in an amount no greater than \$15,000.

(B) In an action commenced under this Section, the consumer is barred from recovering any amount greater than \$15,000, except:

(1) a consumer who commences an action with the reasonable belief that damages equal to or less than \$15,000 are adequate compensation for the injury, may move that the action be dismissed without prejudice and,

(a) upon dismissal of the action, the consumer may file a proposed complaint under Section 23 based upon the same allegations of malpractice as were asserted in the action dismissed under this Section; then

(b) in the second action commenced in court following the Professional Review Panel's proceeding on the proposed complaint, the consumer may recover an amount greater than \$15,000, so long as the consumer's motion for dismissal is filed within two years after the commencement of the original action; or

(2) in the case of the consumer who:

(a) commences an action under subsection (A);

(b) moves for dismissal of the action in accordance with subsection (B)(1);

(c) files a proposed complaint under Section 23 based upon the same allegations of malpractice as were asserted in the action dismissed under subsection (1); and

(d) commences a second action in court following the Professional Review Panel proceeding on the proposed complaint.

**Section 26.** *[Professional Review Panel – Composition, selection and challenge.]* The Professional Review Panel shall consist of one retired judge or magistrate and three professionals. The three professionals shall be licensed to practice in the state in the same discipline as the person or persons alleged to have been professionally negligent. The retired judge or magistrate shall act as chairman of the Panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the Panel, and to expedite the Panel's review of the proposed complaint. The chairman may establish a reasonable schedule for submission

of evidence to the Professional Review Panel but must allow sufficient time for the parties to make full and adequate presentation or related facts and authorities. The Professional Review Panel shall be selected in the following manner:

(A) Within 15 days after filing the request for formation of a Professional Review Panel under Section 23, the party shall:

(1) select a Panel chairman by agreement, or

(2) if no agreement can be reached, either party may request the clerk of the Supreme Court to draw at random a list of five names of retired judges or magistrates who have adjudicated in the county of venue designated in the proposed complaint or in contiguous county. Prior to selecting the random list, the clerk shall collect a \$25 Professional Review Panel selection fee from the party making the request for the formation of the random list. The clerk shall notify the parties and the parties shall then strike names alternately with the plaintiff striking the first until one name remains, and that remaining judge or magistrate shall be the chairman of the Panel. After the striking, the plaintiff shall notify the chairman of his selection and inform all other parties of the name of the chairman. If a party does not strike a name within five days after receiving notice from the clerk:

(a) the opposing party shall, in writing, request the clerk to strike one for the party; and

(b) the clerk shall strike for that party. When one name remains, the clerk shall within five days notify the chairman of his selection and inform all other parties of the name of the chairman; the chairman shall, within 15 days after being notified by the clerk of his selection, send a written acknowledgment of his appointment to the clerk or shall show good cause for relief from serving as provided in subsection (D).

(B) All professionals in this state who hold a license to practice their profession in this state shall be available for selection as members of the Professional Review Panel. Each party to the action shall have the right to select one professional. The two professionals thus selected shall select the third panelist. When there are multiple plaintiffs or defendants, there shall only be one professional selected by the prosecution and one professional selected by the defense. If an individual defendant is a professional who specializes in a limited area, two of the panelists selected must be professionals who specialize in the same area as the defendant.

(1) Within 15 days after the chairman is selected, both parties shall select a professional and they shall notify the other party and the chairman of the selection. If a party fails to make a selection within the time provided, the chairman shall make the selection and notify both parties.

(2) Within ten days after any selection, written challenge without cause may be made to the Panel member. Upon challenge or excuse, the party whose appointee was

challenged or dismissed shall select another panelist. If the challenged or dismissed Panel member was selected by the other two panel members, they shall make another selection.

(C) When the Professional Review Panel is formed, the chairman shall within five days notify the Commissioner and the parties by registered or certified mail of the names and addresses of the Panel members and the date on which the last member was selected.

(D) A panelist selected as provided in subsections (A) or (B) shall serve unless the parties by agreement excuse him, or, for good cause shown, he may be excused as provided in this Section. To show good cause for relief from serving, the retired judge or magistrate selected as chairman must serve an affidavit upon the clerk of the Supreme Court. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The clerk may excuse the retired judge or magistrate from serving and the retired judge or magistrate shall notify all parties who shall then select a new chairman as provided in subsection (A). To show good cause for relief from serving, a professional Panel member must serve an affidavit upon the Panel chairman. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The chairman may excuse the member from serving and notifying all parties.

**Section 27.** *[Professional Review Panel – Time limit for Panel to render opinion.]*

(A) The Panel shall render its expert opinion within 180 days after of the selection of the last member.

(B) A party, attorney or panelist who fails, without good cause shown, to act as required by this Section is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint.

**Section 28.** *[Professional Review Panel – Form of evidence, oath of Panel members and duties of chairman.]*

(A) The evidence in written form to be considered by the Professional Review Panel shall promptly by the respective parties. The evidence may be consist of medical charts, x-rays, lab tests, excerpts of treatises, dispositions of witnesses including parties, and any other form of evidence allowable by the Professional Review Panel. The chairman shall ensure that before the Panel renders its expert opinion under Section 31 of this Act, each Panel member has the opportunity to review every item of evidence submitted by the parties.

(B) Before considering any evidence or deliberating with any other Panel members, each member of the Professional Review Panel shall take an oath in writing on a form provided by the Panel chairman, which must be read as follows:

“I (swear) (affirm) under penalties of perjury that I will well and truly consider the evidence submitted by the parties and that I will render my opinion without bias



thereon; that I have not and will not communicate with any party or representative of a party before rendering my opinion, except as authorized law.”

Neither a party or a parties agent, a party’s attorney, nor a party’s insurance carrier may communicate with any member of the Panel, except as authorized by law, before the rendering of the Panel’s expert opinion under Section 31 of this Act.

**Section 29.** *[Professional Review Panel – Questioning Panel’s decision.]* Either party, after submission of all evidence and upon ten days notice to the other side, shall have the right to convene the Panel at any time and place agreeable to the members of the Panel. Either Party may question the Panel concerning any matters relevant to issues to be decided by the Panel before the issuance of their report. The chairman of the Panel shall preside at all meetings. Meetings shall be informal.

**Section 30.** *[Professional Review Panel – Examination of reports.]* The Panel shall have the right and duty to request all necessary information. The Panel may consult with any experts or authorities of the profession in question. The Panel may examine reports of such other professionals as are necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the Panel.

**Section 31.** *[Professional Review Board – Written opinion by Panel.]* The Panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion the defendant or defendants acted or failed to act within the appropriate standards or care as charged in the complaint. After reviewing all evidence and after any examination of the Panel by counsel representing either party, the Panel shall, within 30 days, render one more of the following expert opinions which shall be in writing and signed by the panelists:

(A) the evidence supports the conclusion that defendant or defendants failed to meet the applicable standard of care as charged in the complaint;

(B) the evidence does not support the conclusion that defendant or defendants failed to meet the applicable standard of care as charged in the complaint;

(C) there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury; and

(D) the conduct complained was or was not a factor of the resultant damages. If so, whether the plaintiff suffered:

(1) any disability and the extend and duration of the disability,

(2) any permanent impairment and the percentage of the impairment,

(3) any injuries identified in Section 2 of this Act.



**Section 32.** *[Professional Review Panel – Admissibility of evidence.]* Any report of the expert opinion reached by the Professional Review Panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the Professional Review Panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this Act.

**Section 33.** *[Professional Review Panel – Compensation and fees.]*

(A) Each professional member of the Professional Review Panel shall be paid up to \$150 per diem plus all reasonable travel expenses for work performed as a member of the Panel exclusive of time involved if called as a witness to testify in court.

(B) The chairman of the Panel shall be paid at the rate of \$200 per diem plus reasonable travel expenses. The record of expenses shall be submitted to the party or parties for payment with the Panel's support.

(C) Fees of the Panel including travel expenses and other expenses of the review shall be paid by the side against whom the majority opinion is written. If there is no majority opinion, then each side shall pay one-half the cost.

(D) The chairman shall submit a copy of the Panel's report to the Commissioner and all parties and attorneys by registered or certified mail within five days after the Panel renders its opinion.

**Section 34.** *[Preliminary determination and discovery authorized.]* A court having jurisdiction over the subject matter and the parties proposed complaint filed with the Commissioner under this Act may, upon the filing of the copy of the proposed complaint and a written motion under this Section:

(A) preliminarily determine any affirmative defense or issue of law or fact that may be preliminarily determined under the rules of civil procedure; or

(B) compel discovery in accordance with the rules of civil procedure; or

(C) both.

The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written opinion by the Professional Review Panel under Section 31 of this Act. The court has jurisdiction to entertain any motion filed under this Section only during that period of time after a proposed complaint is filed with the Commissioner under this Act but before the Professional Review Panel renders its written opinion under Section 31 of this Act. The failure of any party to move for a preliminary determination or to compel discovery under this Act before the Professional Review

Panel renders its written opinion under Section 31 of this Act shall not constitute the waiver of any affirmative defense or issue of law or fact.

Under this Act, the Commissioner or the chairman of any Professional Review Panel, if any, may invoke the jurisdiction of the court by paying the statutory filing fee to the clerk and filing a copy of the proposed complaint and motion with the clerk. The filing of a copy of the proposed complaint and motion with the clerk shall confer jurisdiction upon the court over the subject matter and the parties to the proceeding for the limited purposes stated in this Section, including the taxation and assessment of costs or the allowance of expenses, including reasonable attorney's fees, or both. The moving party or his attorney shall cause as many summonses as are necessary to be issued by the clerk and served on the Commissioner, each nonmoving party to the proceedings and the chairman of the Professional Review Panel, if any, unless the Commissioner or the chairman is the moving party, together with a copy of the proposed complaint and a copy of the motion pursuant to rules of this state which pertain to this matter.

**Section 36.** *[Response, hearing, and ruling.]* Each nonmoving party to the proceeding, including the Commissioner and the chairman of the Professional Review Panel, if any, shall have a period of 20 days after service, or a period of 23 days after service if the service is by mail, to appear and file and serve his written response to the motion, unless the court, for cause shown, orders the period enlarged. The court shall enter its ruling on the motion within 30 days after it is heard, or if no hearing is requested, granted or ordered, within 30 days after the date on which the last written response to the motion is filed, and shall order the clerk to serve a copy of its ruling on the motion by ordinary mail on the Commissioner, each party to the proceeding and the chairman of the Professional Review Panel, if any.

**Section 37.** *[Stay pending ruling.]* Upon the filing of a copy of the proposed complaint and motion with the clerk of the court, all further proceedings before the Professional Review Panel shall be stayed automatically until the court has entered its ruling on the motion.

**Section 38.** *[Enforcement.]* The court may enforce its ruling on any motion filed under this Act in accordance with this state's rules of procedure, subject to the right of appeal.

**Section 39.** {Severability clause.}

**Section 40.** {Repealer clause.}

**Section 41.** {Effective date.}

*Approved by the Health and Human Services Task Force in 1987.*

## **Emergency Care Immunity Act**

### ***Summary***

The purpose of this Act is to provide immunity from liability for physicians, health care providers and private citizens who in good faith provide emergency care. ALEC's bill provides that any physician who assists in emergency care without any direct compensation would be exempt from liability. This is true in all cases except those involving gross negligence.

### ***Model Legislation***

**{Title, enacting clause, etc.}**

**Section 1.** This Act may be cited as the **Emergency Care Immunity Act**.

#### **Section 2.**

(A) Any person who, in good faith, renders emergency care or assistance, without compensation, to any injured person at the scene of an accident, fire, or any life-threatening emergency, or enroute therefrom to any hospital, medical clinic, or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance.

(B) Any person or health care provider who, in the absence of gross negligence, renders emergency obstetrical care or assistance to a female in active labor who has not previously been cared for in connection with the pregnancy by such person or by another professionally associated with such person and whose medical records are not reasonably available to such person shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care or assistance. The immunity herein granted shall apply only to the emergency medical care provider.

(C) Any emergency medical care attendant or technician possessing a valid certificate issued by authorities of the State Board of Health who in good faith renders emergency care or assistance whether in person or by telephone or other means of communication, without compensation, to any injured or ill person, whether at the scene of an accident, fire or any other place, or while transporting such injured or ill person to, from, or between any hospital, or medical facility, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment, or assistance, including but in no way limited to acts or omissions which involve violations of State Department of Health (*or insert appropriate department*) regulations or any other state regulations in the rendering of such emergency care or assistance.

(D) Any person having been attended and successfully completed a course in cardiopulmonary resuscitation, that has been approved by the State Board of Health, who is good faith and without compensation renders or administers emergency cardiopulmonary resuscitation, cardiac defibrillation, or other emergency life-sustaining or resuscitative treatments or procedures which have been approved by the State Board of Health to any sick or injured person, whether at the scene of a fire, an accident, or any other place, or while transporting such person to or from any hospital, clinic, doctor's office or other medical facility, shall be deemed qualified to administer such emergency treatments and procedures; and such individual shall not be liable for acts or omissions resulting from the rendering of such emergency resuscitative treatment or procedures.

(E) For the purpose of Section D, the term, "compensation" shall not be construed to include the salaries of police, fire, or other public officials or emergency service personnel who render such emergency assistance.

(F) Any licensed physician who directs the provision of emergency medical services, as authorized by the State Board of Health, through a communications device shall not be liable for any civil damages for any act or omission resulting from the rendering of such emergency medical services unless such act or omission was the resulting of such physician's gross negligence or willful misconduct.

**Section 3. {Severability Clause.}**

**Section 4. {Repealer Clause.}**

**Section 5. {Effective Date.}**

*Approved by the Health and Human Services Task Force in March 2002.*

## State Medical Licensing Board Act

### *Summary*

The purpose of this Act is to give an authorized state Health Professional Licensing Board clear statutory authority to meaningfully sanction those guilty of consistent malpractice because of inadequate training, negligence, or practicing while mentally impaired because of alcohol or substance abuse. The bill seeks to create objective boards by nominating lay people to serve with physicians.

### *Model Legislation*

**(Title, enacting clause, etc.)**

**Section 1.** This Act shall be known and may be cited as the **State Medical Licensing Board Act**.

**Section 2.** The purpose of this Act is to reform the membership and regulations of the State's Medical Licensing Board so that it may have clear statutory authority to meaningfully and sanction those guilty of consistent malpractice because of inadequate training negligence or practicing while mentally impaired because of alcohol or substance abuse.

**Section 3.** A License or Registration Board created y this article is the successor to the Licensure or Registration Board with the same or similar name created or continued by a statute repealed by this Act.

### **Section 4. {Definitions.}**

(A) "Public member" means a member of the general public who is not a license or registrant under this article, is a resident of this state, is not less than 18 years of age, and does not have a material financial interest in the provision of health services and has not had such an interest within the 12 months before appointment.

### **Section 5. {The Board.}**

(A) The Board shall equally represent licensed health care providers and public sector members. The Board members shall represent an equal geographic distribution of the state.

(B) The board shall consist of 15 (*or insert appropriate number*) voting members.

(1) eight (or insert appropriate number) of whom shall be persons licensed to practice medicine in this state. The physicians appointed to the board shall represent a broad geographical region of the state.

(2)

(3) Seven (or insert appropriate number) of whom shall be public members. Said public members shall not be or ever have been licensed in any health related field; shall not be a member of the immediate family of someone licensed in any health related field; shall not be employed by a company engaged in a directly health related business; and shall not have a material financial interest in the providing of goods and services to persons engaged in the practice of medicine. The public members appointed to the Board should be broadly representative of the geographic regions of the state.

(C) A member of the Board shall:

(1) be 18 or more years of age

(2) be a good moral character;

(3) be a resident of this state for not less than 6 months immediately before appointment and remain a resident of this state through the term of the appointment.

(D) The Governor shall appoint, by and with the advice and consent of the Senate, the members of the Board.

(E) Each term shall be for three years

(F) A member shall not serve for more than two terms.

(G) Any vacancies of the Board shall be filled by the Governor's appointment and such appointments shall be for a term of three years from the date of appointment.

(H) No member of the Board, while serving on the Board, shall be an officer of any professional medical society.

(I) The Governor shall seek nominations from a wide range of sources including professional including professional associations, educational institutions, consumer organizations, health planning agencies, other community health organizations, and the state society when making appointments under his article.

### **Section 6. {Duties of the Board.}**

(A) Meetings of the Board shall be public, and the Board shall maintain minutes of its meetings.

(B) The Board shall elect annually an Executive Director for the Board.



(C) The Board shall investigate through the Executive Director the character of each applicant for certificate to practice medicine to determine whether or not he or she has previously engaged in unprofessional conduct, and whether he or she is physically or mentally capable of engaging in the practice of medicine with safety to the public.

(D) The Board shall investigate through the Executive Director complaints and charges of unprofessional conduct respecting any holder of a certificate to practice medicine.

(E) The Board shall investigate through the Executive Director complaints and charges of the inability of a person to practice medicine with reasonable skill or safety to patients by reason of incompetence, or mental illness, or mental incompetence, or physical illness, including but not limited to deterioration through the aging process, or loss of motor skills, or excessive use of abuse of drugs, including alcohol.

(F) The Board shall investigate through the Executive Director complaints of unauthorized practice of medicine.

(G) The Board shall administer oaths and shall be authorized to compel the attendance of witnesses and the production of documents by the filing of a precipe for a subpoena. Failure to obey a subpoena shall be punishable according to the Rules of the Superior Court;

(H) The Board shall reprimand, ensure or take other appropriate disciplinary action with respect to any person authorized to practice medicine in this State.

**Section 7. {Duties of the Executive Director.}**

(A) It shall be the duty of the Executive Director to investigate either by complaint or, whenever appropriate, upon his or her own or the Board's own motion, cases of unprofessional conduct or inability to practice medicine, unauthorized practice of medicine and medical malpractice; to formulate charges by means of bringing a formal complaint against any person to whom a certificate to practice medicine in this state has been issued if the circumstances warrant; to present all such formal complaints to the Board in accordance with the procedures set forth in this Act.

(B) The Executive Director shall appoint at least one public member of the Board to assist in investigation concerning charges of unprofessional conduct and medical malpractice. The Executive Director shall also appoint investigators from the Division of Professional Regulation (or appropriate department) to participate in said investigations. All such investigations shall be kept within the bounds of the charge being investigated, unless the Executive Director determines that the investigation itself provides good cause for additional investigation. The Executive Director shall report to the Board on investigations and make recommendations as to whether a formal complaint should be issued. The Board may then request that the Executive Director prepare a formal complaint against the person accused.

(C) The Executive Director shall appoint at least one public member of the Board to assist in investigations concerning charges on inability to practice medicine. The Executive Director shall also appoint investigators from the Division of Professional Regulation (or appropriate department) to participate in said investigations. All such investigations shall be kept within the bounds of the charge being investigated, unless the Executive Director determines that the investigation itself provides good cause for additional investigation. The Executive Director, or a designee, shall conduct an examination to determine whether the person to whom a certificate has been issued to practice medicine is fit to practice medicine with reasonable skill and safety to patients, either on a restricted or unrestricted basis. If the Executive Director deems a mental or physical examination necessary, the Executive Director shall order the person to submit to such examination to be conducted by a physician designated by the Executive Director. Any person to whom a certificate has been issued to practice medicine shall, by seeking certification, be deemed to have given consent to submit to mental or physical examination when so directed by the Executive Director, and, further, to have waived all objections to the admissibility of the examination report to the Board on the grounds of privileged communication; the person who administers a diagnostic mental or physical examination as ordered by the Executive Director shall report to the Board and provide a recommendation as to whether a formal complaint should be issued. The Board may then direct the Executive Director to prepare a complaint against the person accused.

**Section 8. {Complaints; Notice of Hearing.}**

(A) Any member of the public, the Board, or the Executive Director may prefer any charge or complaint concerning any aspect of the practice of medicine against an individual to whom a certificate to practice medicine in this State has been issued. Any complaining party shall be entitled to legal representation at such party's expense at any and all stages of proceedings hereunder.

(B) The Executive Director shall investigate all such charges or complaints which appear to be valid and well-founded according to the procedures set forth in this Act.

(C) All complaints against persons to whom a certificate to practice medicine has been issued in this state shall be in writing, signed, and shall set forth the essential facts constituting the alleged unprofessional conduct, medical malpractice, or inability to practice medicine. The Executive Director may maintain the confidentiality of the complaint from the Board. The Executive Director may investigate specific oral charges or complaints at his or her discretion, provided the complaining party is identified.

(D) Each complaint shall describe in detail all allegations upon which it is based; shall inform the respondent of the date, time, and place that the hearing will be held; shall state the law(s) allegedly violated and the statutory or regulatory authority giving the Board authority to act; shall indicate that the respondent has a right to be represented by counsel at the hearing and to present evidence on his or her own behalf; and shall inform the respondent that the Board must base its decision solely upon the evidence receiving at the hearing. The respondent shall have the right to file a written response with the Board within 20 days of service of the complaint.

(E) The attorney General shall provide legal services to the Board, its committees, and the Executive Director.

### **Section 9. {Hearings.}**

(A) After the Board accepts a complaint that has been investigated by the Executive Director in accordance with this Act, it shall appoint a hearing panel, composed of three members of the Board, who shall hear all evidence concerning charges of unprofessional conduct or inability to practice medicine alleged in the complaint. The hearing panel shall convene in executive session to hear the evidence no more than 90 days after the Board accepts a formal complaint unless it, in its discretion, grants a continuance of the hearing date. All evidence at the hearing shall be taken under sworn oath of affirmation, but technical rules of evidence shall make a written statement of its findings of fact and conclusions of law. Only such evidence as was presented at the hearing may be considered by the hearing panel in reaching its findings of fact and conclusions of law. The findings of fact made by the hearing panel shall be binding on the parties appearing before it and shall also be adopted by and binding upon the Board. If the hearing panel finds the allegations made in the complaint are not supported by the evidence, it shall so indicate to the Board together with its recommendation that no further action be taken and that the physician be exonerated of all charges. Should a majority of the members of the Board who consider the matter, excluding any members who participate in the investigation of the complaint or on the hearing panel, or who are otherwise biased, vote to accept the hearing panel's conclusions of law and recommendation, then no further proceeding shall be held before the Board. In such case, the hearing panel's findings of fact shall be binding upon the Board. However, should a majority of the members of the Board who consider the matter, excluding any members who participated in the investigation of the complaint, or on the hearing panel, or who are other biased, vote to reject the hearing panel's conclusions of law and recommendation, then a formal hearing shall be held before the Board to enable the Board to make its own conclusions of law and to determine what discipline, if any, should be imposed.

(B) If the hearing panel finds that any or all of the factual allegations made in the complaint are supported by the evidence it has considered, the Board, excluding members who participated in the investigation, or on the hearing panel, or who are otherwise biased, will consider the statement of the findings of fact and conclusion of law made by the hearing panel at a formal hearing. Such formal hearing is to be held within 60 days after the issuance of the written statement of the hearing panel; provide, however, that if the hearing panel finds that the physician currently presents a clear and imminent danger to the public health by his continued practice of medicine, then the full Board may meet for such formal hearings as soon as possible upon three days written notice of such hearing being provided to the physician or his attorney. A majority but no less than seven Board members who consider the matter shall be necessary in order for any disciplinary action to be taken. Upon reaching its conclusion of law and determining the appropriate disciplinary action, if any, the Board shall issue a written decision.

### **Section 10. {Appeals Procedures.}**

(A) Any person against whom a decision of the Board has been rendered may appeal such decision to the Superior Court in the county in which such person was practicing medicine of at the time of the offense.

(B) The appeal shall be filed within 30 days of the day the written decision and order of the Board is issued.

(C) Any Board action revoking, suspending, or otherwise curtailing an individual's authorization to practice shall not be stayed upon appeal unless so ordered by the Superior Court.

**Section 11. {Providing Information on Malpractice Suits to the Board.}**(Optional section.)

(A) Each insurer providing professional liability insurance to persons licensed by the Board of Medicine, the Board of Osteopathic Medicine and Surgery, the Board of Dentistry, and the hospitals licensed by the state department of public health in this state shall submit the data prescribed in this Section. All data shall be provided with respect to any complaint filed against such insured in any court, if the complaint seeks damages for personal injury claimed to have been caused by the negligence of the insured relating to the insurer's professional services or the performance for a medical result relating to the insured's professional services.

(B)The following data and information shall be furnished to the Board within 30 days of the filing of an answer on behalf of the insured:

- (1) the name and license number of such insured;
- (2) the date of the injury;
- (3) the date of the filing of the complaint;
- (4) the nature of the complaint;
- (5) the disposition of the complaint, including any settlement that has been made; and
- (6) any other information the Board may require.

**Section 12.**

Nothing contained in this Act shall affect any pending investigation or disciplinary action which was commenced prior to its enactment into law.

**Section 13. {Severability Clause.}**

**Section 14. {Repealer Clause.}**

**Section 15. {Effective Date.}**

*Approved by the Health and Human Services Task Force in March 2002.*

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## Uncompensated Care Liability Act

### *Summary*

The purpose of this Act is to encourage the practice of uncompensated care for low-income patients by providing liability immunity. Any licensed physician, any hospital, or any other health care provider who provides medical care to any patient without receiving any direct remuneration or compensation in exchange for rendering care shall not be liable for any civil damages for acts or omissions, unless such acts or omissions were grossly negligent. The provider must first indicate in writing that this care is being administered without any compensation.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the Uncompensated Care Liability Act.

**Section 2.** The legislature hereby finds, determines, and declares that many residents do not receive medical care and preventive health care because they lack health insurance or because of financial difficulties or cost. The legislature also finds that many physicians, hospitals, and other health care providers in this state would be willing to provide medical and allied services without compensation if they were not subject to the high exposure of liability connected with the practice of medicine. The legislature therefore declares that its intention in enacting this Act is to encourage the provision of uncompensated medical care in exchange for a limitation of liability for the physicians, surgeons, hospitals, and other health care providers who provide those services. The legislature further declares that the operation of preventative health screening clinics is beneficial to the citizens of this state and that its intent in enacting this Act is to encourage the use of such clinics by limiting the exposure to liability.

**Section 3.** (A) Any physician licensed under the laws of this state, any hospital licensed pursuant to the laws of this state, or any other health care provider who provides medical care to any patient without receiving any direct remuneration or compensation in exchange for rendering such care shall not be liable for any civil damages for acts or omissions unless such acts or omissions were grossly negligent or were willful and wanton.

(B) The exemption from liability provided under Subsection (A) of this Section shall only apply if, prior to rendering such services, the physician, surgeon, hospital, or other health care provider discloses to the patient, or if a minor, to the minor's parent or legal guardian, in writing that such services are being provided without receiving any direct



remuneration or compensation and that, in exchange for receiving uncompensated medical care, the patient consents to waiving any right to sue for professional negligence expect for acts or omissions that are grossly negligent or are willful and wanton.

**Section 4.** (A) Any organization, including a church, which sponsors, promotes, or organizes a preventative health screening clinic or provides a health screen service to check such indicators as blood pressure or cholesterol levels or other preventative health sings without receiving any direct remuneration or compensation in exchange for the services received shall not be liable for any civil damages for acts or omissions unless such acts or omissions are grossly negligent or are willful and wanton.

(B) The exemption from liability under Subsection (A) of this Section shall only apply if the organization posts in a conspicuous place a notice that in accordance with this Act the organization is not liable for any civil damages for acts or omission expect for those acts omissions that are grossly negligent or are willful and wanton.

**Section 5.** As used in this Act, “direct remuneration or compensation” means direct receipt by the physician, surgeon, hospital, other health care provider, or organization or payment from the patient, or payment or reimbursement from a heath insurance company, health maintenance organization, or nonprofit hospital and health services corporation on behalf of the patient, or payment or reimbursement under medicare, or medicaid, or under the state program for the medically indigent on behalf of the patient. The term “direct remuneration or compensation” shall not include any grant or donation, unless the grant or donation is based on the volume of patients receiving care or treatment.

**Section 6.** {Severability clause.}

**Section 7.** {Repealer clause.}

**Section 8.** {Effective date.}

*1995 Sourcebook of American State Legislation. Ammended by the HHS Task Force in 2002.*

**Commission on Men (Or, Men's Health)**

(Modeled after legislation in Georgia, New Hampshire, and Texas and a Commission on Fatherhood established in Florida.)

NOTE: New Hampshire: HB 587 establishing a commission of the status of men passed the Legislature in April 2002 and was signed into law by Governor Shaheen.

Georgia: HB 1235 establishing a Commission on Men's Health was passed by the Legislature in 2000 and signed into law by Governor Barnes.

Bill Number: \_\_\_\_\_

A BILL TO BE ENACTED

AN ACT

relating to the creation and operation of the Commission on Men.

BE IT ENACTED BY THE LEGISLATION OF THE STATE OF \_\_\_\_\_:

The Legislature makes the following findings:

- (1) There is a silent health crisis affecting the health and well-being of (your state's) men;
- (2) This health crisis is of particular concern to men, but is also a concern for women, and especially to those who have fathers, husbands, sons, and brothers;
- (3) Men's health is likewise a concern for employers who lose productive employees as well as pay the costs of medical care, and is a concern to state government and society which absorb the enormous costs of premature death and disability, including the costs of caring for dependants left behind;
- (4) The life expectancy gap between men and women has steadily increased for one year in 1920 to six years in 2000;
- (5) Men die at higher rates for the top 10 causes of death;
- (6) An estimated 180,000 men will be newly diagnosed with prostate cancer this year alone, of which almost 29,000 will die;
- (7) The incidence of prostate cancer and the resulting mortality rate in African American men is twice as much as white men;

(8) Studies show that women are 100% more likely than men to have regular physician check-ups and obtain preventative screening tests for serious diseases;

(9) Appropriate use of tests such as prostate specific antigen (PSA) exams and blood pressure, blood sugar, and cholesterol screens, in conjunction with clinical exams and self-testing, can result in the early detection of many problems and in increased survival rates;

(10) Educating men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of (your state's) men and its overall economic well-being;

(11) Fatherlessness is a severe social problem and children who have a poor or non-existent relationship with their father are the largest users of state-funded juvenile services;

(12) A Commission on Men (or, Men's Health) is needed to investigate these findings and take such further actions as may be needed to promote men's health in this state.

SECTION \_\_\_\_\_. Subtitle \_\_\_\_\_, Title \_\_\_\_\_, Government Code, is amended by adding Chapter \_\_\_\_\_, to read as follows:

CHAPTER \_\_\_\_\_. COMMISSION ON MEN (or, MEN'S HEALTH)

SUBCHAPTER A. GENERAL AND ADMINISTRATIVE PROVISIONS

Sec. \_\_\_\_\_. 004. DEFINITIONS. (a) In this "chapter," commission means the commission on Men.

Sec. \_\_\_\_\_. 003. COMPOSITION OF COMMISSION. The commission consists of 12 members: four members appointed by the Governor with the advice and consent of the Senate; for members appointed by the presiding officer of the Senate; and four members appointed by the presiding officer of the house of representatives. Each member must be a medical or academic expert or community leader in the area of men's health or family involvement or an active member of an organization active in men's health or family involvement issues.

Sec. \_\_\_\_\_. 004. APPOINTMENT. (a) Appointments to the commission shall be made without regard to the race, color, disability, sex, religion, age, or national origin of the appointees.

(b) Appointments to the commission shall be made so that each geographic area of the state is represented on the commissions.

Sec. \_\_. 005. TERMS. Members of the commission serve terms of two years.

Sec. \_\_. 006. OFFICERS; SUBCOMMITTEES. (a) The commission annually shall elect one of its members as presiding officer.

(b) The presiding officer of the commission may appoint subcommittees for any purpose consistent with the duties of the commission under this chapter.

Sec. \_\_. 007. COMPENSATION; EXPENSES. A member of the commission is not entitled to compensation, but is entitled to reimbursement from commission funds for the travel expense incurred by the member while conducting the business of the commission, as provided by the General Appropriations Act.

Sec. \_\_. 008. MEETINGS; PUBLIC ACCESS. (a) The commission may meet at the times and places that the commission designates.

(b) The commission shall develop and implement policies that provide the public with a reasonable opportunity to appear before the commission and to speak on any issue under the jurisdiction of the commission.

Sec. \_\_. 009. ANNUAL FINANCE REPORT. The commission shall prepare annually a complete and detailed written report accounting for all funds received and disbursed by the commission during the preceding year fiscal year. The annual report must meet the reporting requirements applicable to financial reporting provided in the General Appropriations Act.

(Sections \_\_. 010 - \_\_. 030 reserved for expansion)

#### SUBCHAPTER B. POWERS AND DUTIES; FUNDING

Sec. \_\_. 031. GENERAL POWERS AND DUTIES OF COMMISSION. The commission shall:

- (1) adopt rules as necessary for its own procedures;
- (2) develop strategies and programs, including community outreach and public-private partnerships, designed to:
  - (A) raise public awareness of critical men's issues, including those health problems which disproportionately affect men and boys, and the importance of paternal influence in the family; and
  - (B) encourage the participation of men and boys in healthy behaviors, academic achievement, and family involvement;

(C) develop strategies. Public policy recommendations, and programs, including community outreach and public-private partnerships, that are designed to educate (your state's) men and boys on the benefits of regular physician check-ups, early detection and preventative screening tests, and healthy lifestyle practices;

(3) organize community workshops to identify issues affecting men's health and family involvement;

(4) monitor state and federal policy and legislation that may affect that areas of men's health and family involvement;

(5) recommend assistance, services, and policy changes that will further the goals of the commission; and

(6) submit a report of its findings and recommendations under this chapter to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each year.

Sec. \_\_. 032. DONATIONS, APPROPRIATIONS, AUDIT. The commission may solicit and accept donations, gifts, grants, property, grants, or matching funds from a public or private source for the use of the commission in performing its functions under this chapter.

Sec. \_\_. 033. COMMISSION ON MEN ACCOUNT. The Commission on Men Account is created as an account in the general revenue fund. The commission shall remit all money collected under this chapter to the comptroller for deposit to the credit of the account. Money in the account may be appropriated only to the commission for administration of this chapter.

SECTION 2. The Commission on Men shall be appointed within six months of the effective date of this act.

Section 3. This Act takes effect \_\_\_\_\_, 20\_\_.

*Approved by the Health and Human Services Task Force in 2003.*

**Resolution to Establish the Office of Men's Health**

Resolution to ask Congress to pass S. 1028 and its companion bill H.R. 1734 to **amend the Public Health Service Act to establish an Office of Men's Health** –  
Drafted by Bayer Corporation.

WHEREAS, male morbidity and mortality from preventable causes is substantial, with significant and alarming disparities among subpopulations of men based on race, ethnicity and socioeconomic status; and

WHEREAS, a silent health crisis is affecting the health and well-being of American men; and

WHEREAS, this health crisis is of particular concern to men but is also a concern for women, especially those who have fathers, husbands, sons, and brothers; and

WHEREAS, the National Center for Health Statistics has shown that men have higher age-adjusted death rates than women for each of the top 10 leading causes of death in the United States; and

WHEREAS, men are almost twice as likely as women to die from heart disease and the incidence of stroke is nearly 20% higher in men than in women; and

WHEREAS, men are 50% more likely to die of cancer than women; and

WHEREAS, the life expectancy gap between men and women has steadily increased from one year in 1920 to 6 years in 1990; and

WHEREAS, since women live longer and tend to marry men older than themselves, 7 out of 10 “baby boom” women will outlive their husbands – many of whom can expect to be widows for 15 to 20 years; and

WHEREAS, compared with men, older women are three times more likely to be living alone, are nearly twice as likely to reside in a nursing home, and are more than twice as likely to live in poverty; and

WHEREAS, studies show that the huge disparity between men and women is due in part to a lack of awareness, poor health education and the low number of male-specific health programs. Men are one-half as likely as women to visit a doctor for regular physician check-ups or to obtain preventative screening tests for serious diseases; and

WHEREAS, men's health is also a concern for employers who lose productive employees as well as pay the cost of medical care; and



WHEREAS, men's health is also a concern for Federal and State governments and society which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind; and

WHEREAS, every state has formed a Commission to address women's issues or has established a women's health program, but only seven states have a Commission to address men's issues or a men's health program; and

WHEREAS, educating men, their families and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality of male-specific diseases as well as improve the health of America's men and its overall economic well-being; and

THEREFORE BE IT RESOLVED that the American Legislative Exchange Council (ALEC) advocates Government acknowledgement of Men's Health activities so that existing government health networks can be utilized to increase the health and well being of men; and

BE IT FURTHER RESOLVED that ALEC supports and encourages national, state and local efforts to secure access and remove barriers to healthcare for men and their family members by supporting existing federal legislation (S. 1028 & H.R. 1734) and the passage of state legislation addressing men's health issues.

*Approved by the Health and Human Services Task Force in Winter 2003.*

State Best Practices (Excerpts)

Legislation for the Health of Men and Their Families

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Men's Health As a Public Health Issue

There is a predominantly silent crisis in the health and well-being of American men. Due to a lack of awareness, poor health education, and culturally induced behavior patterns in

their work and personal lives, men's health and well-being are deteriorating steadily. The men's health crisis is seen most dramatically in mortality figures. In 1920, the gap in life expectancy between men and women was only one (1) year. That gap has widened over the years, and by 2000, men were dying six (6) years earlier than women. Over the last thirty years, the rate of male mortality compared to female mortality has increased in every age category.

Simply put, there is a silent crisis in America, a crisis of epic proportions: On average, American men live shorter and less-healthy lives than American women.

Men's health is obviously a concern for men, but it is also a concern for women -- concern for their fathers, husbands, sons and brothers. Men's health is a concern for employers who lose productive employees and pay the costs of medical care, and likewise is a concern for government and society which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind.

### The Weaker Sex:

The stereotype suggesting that men are the stronger gender is not supported by health and mortality data. Males of every age are at higher risk for life-threatening disease, injury, or death. The National Center for Health Statistics has shown that men have higher age-adjusted death rates than women for each of the top 10 leading causes of death in the United States. Men die of heart disease, including heart attacks, at almost twice the rate of women. Men die of cancer at 1.5 times the rate of women and are four times as likely to die of suicide. But physical health is only part of the puzzle. Depression and alienation from family contribute substantially to men's lack of well-being.

**“Excluding pregnancy-related office visits, women make twice as many preventative care visits as men.”**

Utilization of Ambulatory Medical Care by Women: United States, 1997-98, CDC

“Males have a 2.4-fold higher mortality due to accidents and violence,” writes Dr. David Gremillion, a member of MHN's Board of Directors and an Assistant Professor at the University of North Carolina School of Medicine. “Men lead in each of the top 10 causes of death in America, and their life span is 5.7 years shorter than their female counterparts, with an overall age-adjusted mortality 1.6 times greater than that of females. This applies across the diagnostic spectrum, including heart disease, cancer, and chronic liver disease.”

### Prevention:

A recent Centers for Disease Control and Prevention (CDC) study of ambulatory care by women illustrates just how wide the health care gulf between the two sexes is. Among other things, the study found that(ii):

-Excluding pregnancy-related office visits, women make twice as many preventative care

visits as men.

-Among people 65 years of age and over, the rate of visits was fairly similar.

-As would be expected, there are more drug mentions per population among women than there are men, since there are more visits per population.

The study's authors offered several possible explanations for this disparity: Women's self-reported health is worse than men's, on average, which may either reflect more illness or differences in the way health is viewed or discussed by women. Women generally are responsible for their family's health and so may think about health care needs more than men. They are more likely to have a usual source of care, which is a strong predictor of health care utilization. They also tend to use medical care for screening and health education more often than men. Women have been said to also be more likely to report and act on illness, although research has not always borne this out.

#### Socialization:

Men's devotion to the workplace is also partly to blame. Various studies have shown that men are less likely than women to take time off from work for health related issues. Men's reluctance to make timely health care visits, however, is not only a function of work and time, but also of the way our culture socializes boys from earliest age: "big boys don't cry." That attitude extends to the workplace where men feel compelled to ignore their own physical (and mental) health needs and put in a "full 40 hours" ... or more ... knowing that if they take time off for anything less than a true health emergency, they will lose status in the workplace, and, in the case of hourly workers, most probably their job.

"The huge disparity between men and women results partly from a lack of awareness, poor health education, and a paucity of male-specific health programs," explains Dr. Gremillion. "The costs, including the cost of caring for dependents left behind, is enormous."

"More than one-half the elderly widows now living in poverty were not poor before the death of their husbands."  
Meeting the Needs of Older Women: A Diverse and Growing Population,  
The Many Faces of Aging, U.S. Administration on Aging

#### Aging in America:

The poor health habits of men take a toll at early ages but the trend accelerates as men near retirement, causing them to rely on the public health care system (Medicare) sooner than women. The effect of poor health habits is reflected in higher mortality rates among aging men and the male-female ratio.

This higher mortality rate among aging men explains why women are more likely to live

in poverty and rely on public care in their later years. The U.S. Administration on Aging has found that more than one-half the elderly widows now living in poverty were not poor before the death of their husbands. Other data reflect on the poor health and high mortality of aging men and the effect it has on spouses and loved ones:

- 115 males are conceived for every 100 females
  - Male births outnumber female births, 105 to 100
  - More newborn males die than females, 5 to 4
  - Teenage boys die at 2x the rate of girls
  - By age 36, women outnumber men
  - By age 100, women outnumber men 8 to 1
- The Weaker Sex, New York Times Magazine, March 16, 2003

-Compared with men, older women are three times more likely to be living alone, are nearly twice as likely to reside in a nursing home, and are more than twice as likely to live in poverty. (U.S. Administration on Aging)

-Of the more than 9 million older persons living alone, 80% are women (Meeting the Needs of Older Women: A Diverse and Growing Population, The Many Faces of Aging (U.S. Administration on Aging)

-Since women live longer, and tend to marry men older than themselves, 7 out of 10 “baby boom” women will outlive their husbands – many can expect to be widows for 15 to 20 years. (Meeting the Needs of Older Women: A Diverse and Growing Population, The Many Faces of Aging, U.S. Administration on Aging)

#### Possible Solutions:

What can be done to counter this pattern? In a recent article written for *The News and Observer*,” Dr. Gremillion offers some advice(iii):

“Research has shown that women strongly affect the health decisions within families, and this includes emphasis on the health of their spouses and the younger males who are forming attitudes about healthy lifestyles. Women, spouses and others with a male in their life can help them understand the importance of healthy lifestyles and health-seeking behavior. By expressing concern, women give men “permission” to be momentarily weak and honestly express their vulnerabilities and feel more comfortable in the health care setting.

“Another recently study suggests that computers and the Internet offer men an anonymous, private manner of seeking health information in a venue that they feel comfortable with.”

This, coupled with proactive government and workplace health programs, can go a long way toward encouraging healthy behaviors among men and reducing the health disparity

between men and women.

For more health data, and to learn more about the aging population, go to:

MHN Reports: [www.menshealthnetwork.org/reports/reports.html](http://www.menshealthnetwork.org/reports/reports.html)

MHN Library (search by keyword): [www.menshealthnetwork.org/php/mhn\\_lib.php](http://www.menshealthnetwork.org/php/mhn_lib.php)

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i Physician's Weekly, September 3, 2001

ii Utilization of Ambulatory Medical Care by Women: United States, 1997-98, Centers for Disease Control and Prevention (CDC) National Center for Health Statistics Vital and Health Statistics, Series 13, # 149 : July 2001 : pages 12 & 15

iii Men's health needs a heartfelt change, June 17, 2001, The News and Observer, Raleigh, NC

### Government Has A Role

Government has a legitimate role to play in increasing men's awareness of their health care needs and encouraging them to seek regular checkups and timely treatment for their health problems. The budget implications of poor health habits are striking when one considers the burden on society resulting from premature male mortality. That burden is reflected in the economic status of widows and dependents who often must rely on government programs to replace the lost income of a spouse or parent. Widows who fall into poverty after the death of their spouse must rely on food stamps, nursing homes, and other government programs to replace the income and assistance provided by their husbands.

Government policies that focus on prevention, encourage healthy behaviors, lower disability rates, and curb premature mortality are both cost effective and fiscally sound. Minority male disability and mortality, particularly among black men, has striking fiscal implications. While it has been thought that black men, with a life expectancy of 68.6 years, could not expect to receive social security benefits equal to their contribution to the system, recent studies (GAO-03-387, April 2003) add a new twist. Survivor benefits and disability payments to both the individual and dependents combine to provide low income blacks with a disproportionate share of Social Security income.

Government also has a legitimate role in the family life of men by lowering the barriers to father involvement following the dissolution of their families, thus insuring that men remain involved as role models and providers for their children.

-Every state has a Commission on Women, formed to promote awareness of women's health needs and to advance women's role in the workplace and in the family. Only two states have a corresponding Commission on Men (or Men's Health).

-Most states' department of health have advisory councils to guide them in the promotion



of women's health concerns, breast cancer, cervical cancer, osteoporosis, and other diseases which disproportionately affect women. Few state health departments have advisory councils to advise them on men's health needs.

-Breast cancer and prostate cancer kill approximately the same number of people each year. While government has taken a proactive role encouraging screening for breast cancer in women, it has been slow to encourage the same precautions for prostate cancer. According to one health expert, by 1995, 46 states had passed legislation requiring insurance reimbursement for annual breast cancer screening but only two required reimbursement for prostate cancer screening. By 1998, 15 states provided reimbursement for prostate cancer screening, still 31 states short of the number providing reimbursement for breast cancer screening.

-On the federal level, Healthy People 2010, the government's blueprint for the nation's health during the next decade, provides over 30 specific health goals for women, but only one for men. This document is used by state and local departments of health as a guide when designing public health programs, including education and awareness, for the populations they serve.

-The health bill debated in Congress during 1993-1994 (H.R. 3600) provided that girls and women, beginning at puberty, would receive annual screenings for STDs, annual check-ups for female-specific health problems, and every-other-year mammograms beginning at age 50. Men and boys would not be screened for male-specific health problems, would not be checked for STDs, and would not receive even the most basic screening for prostate problems at any age.

-The National Committee for Quality Assurance (NCQA) is not a government agency, but does provide certification for managed health care plans. To score a health plan's performance, NCQA has developed the Health Plan Employer Data and Information Set (HEDIS), "...a set of standardized performance measures designed to...compare the performance of managed health care plans" The HEDIS criteria include several female-specific elements, but no male-specific elements. This means that, for certification, a healthcare plan must meet several specific requirements in the area of women's health, and none in the area of men's health.

If government fails to recognize the health care needs of a segment of the population, it is not surprising that the same segment of the population places little value on the need for health care planning, prevention, or education.

In this publication, we offer samples of positive steps some states have taken to encourage healthy behaviors in men. We also offer samples of state and federal measures that have successfully facilitated father involvement with their children.

Megan Smith  
Director, Project development  
Men's Health Network™

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Health Legislation

Office of Men's Health – Federal

(S 1028 and its companion HR 1734 were introduced in the 108th Congress)

108th CONGRESS

1st Session

S. 1028

To amend the Public Health Service Act to establish an Office of Men's Health.

IN THE SENATE OF THE UNITED STATES

May 8, 2003

Mr. CRAPO introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to establish an Office of Men's Health.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Men's Health Act of 2003'.

SEC. 2. FINDINGS.

Congress finds as follows:

(1) A silent health crisis is affecting the health and well-being of America's men.

(2) While this health crisis is of particular concern to men, it is also a concern for women regarding their fathers, husbands, sons, and brothers.

(3) Men's health is a concern for employers who pay the costs of medical care, and lose productive employees.

(4) Men's health is a concern to Federal and State governments which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind.

(5) The life expectancy gap between men and women has increased from one year in 1920 to almost six years in 2001.

(6) Prostate cancer is the most frequently diagnosed cancer in the United States among men, accounting for 30 percent of all cancer cases in men.

(7) An estimated 180,000 men will be newly diagnosed with prostate cancer this year alone, and over 30,000 will die.

(8) Prostate cancer rates increase sharply with age, and more than 70 percent of such cases are diagnosed in men age 65 and older.

(9) The incidence of prostate cancer is significantly higher in African-American men and the resulting mortality rate is twice that in white men.

(10) An estimated 7,500 men, ages 15 to 40, will be diagnosed this year with testicular cancer, and 400 of these men will die of this disease in 2003. A common reason for delay in treatment of this disease is a delay in seeking medical attention after discovering a testicular mass.

(11) According to the Centers for Disease Control and Prevention, the rate of doctor visits for such reasons as annual examinations and preventive services is 100 percent higher for women more than for men.

(12) Appropriate use of tests such as prostate specific antigen (PSA) exams and blood pressure, blood sugar, and cholesterol screens, in conjunction with clinical exams and self-testing, can result in the early detection of many problems and in increased survival rates.

(13) Educating men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of America's men and its overall economic well-being.

(14) Recent scientific studies have shown that regular medical exams, preventive screenings, regular exercise, and healthy eating habits can help save lives.

(15) Establishing an Office of Men's Health is needed to investigate these findings and take such further actions as may be needed to promote men's health.

### SEC. 3. ESTABLISHMENT OF OFFICE OF MEN'S HEALTH.

(a) IN GENERAL- Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by adding at the end the following:

#### OFFICE OF MEN'S HEALTH

SEC. 1711. The Secretary shall establish within the Department of Health and Human Services an office to be known as the Office of Men's Health, which shall be headed by a director appointed by the Secretary. The Secretary, acting through the Director of the Office, shall coordinate and promote the status of men's health in the United States.

(b) REPORT- Not later than two years after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the Office of Men's Health, shall submit to the Congress a report describing the activities of such Office, including findings that the Director has made regarding men's health.

###

#### Commission on Men (or, Men's Health)

(Modeled after legislation in Georgia, New Hampshire, and Texas and a Commission on Fatherhood established in Florida)

NOTE: New Hampshire: HB 587 establishing a commission on the status of men passed the Legislature in April 2002 and was signed into law by Governor Shaheen.

Georgia: HB 1235 establishing a Commission on Men's Health was passed by the Legislature in 2000 and signed into law by Governor Barnes.

Bill Number: \_\_\_\_\_

A BILL TO BE ENTITLED

AN ACT

relating to the creation and operation of the Commission on Men.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF \_\_\_\_\_:

The Legislature makes the following findings:

- (1) There is a silent health crisis affecting the health and well-being of (your state's) men;
- (2) This health crisis is of particular concern to men, but is also a concern for women, and especially to those who have fathers, husbands, sons, and brothers;
- (3) Men's health is likewise a concern for employers who lose productive employees as well as pay the costs of medical care, and is a concern to state government and society which absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind;
- (4) The life expectancy gap between men and women has steadily increased from one year in 1920 to six years in 2000;
- (5) Men die at higher rates for the top 10 causes of death;
- (6) An estimated 180,000 men will be newly diagnosed with prostate cancer this year alone, of which almost 29,000 will die;
- (7) The incidence of prostate cancer and the resulting mortality rate in African American men is twice that in white men;
- (8) Studies show that women are 100% more likely than men to have regular physician check-ups and obtain preventive screening tests for serious diseases;
- (9) Appropriate use of tests such as prostate specific antigen (PSA) exams and blood pressure, blood sugar, and cholesterol screens, in conjunction with clinical exams and self-testing, can result in the early detection of many problems and in increased survival rates;
- (10) Educating men, their families, and health care providers about the importance of early detection of male health problems can result in reducing rates of mortality for male-specific diseases, as well as improve the health of (your state's) men and its overall economic well-being;
- (11) Fatherlessness is a severe social problem and children who have a poor or non-existent relationship with their father are the largest users of state-funded juvenile services;
- (12) A Commission on Men (or, Men's Health) is needed to investigate these findings and take such further actions as may be needed to promote men's health in this state.

SECTION \_\_. Subtitle \_\_, Title \_\_, Government Code, is amended by adding Chapter \_\_ to read as follows:

## CHAPTER \_\_. COMMISSION ON MEN (or, MEN'S HEALTH)

### SUBCHAPTER A. GENERAL AND ADMINISTRATIVE PROVISIONS

Sec. \_\_.001. DEFINITIONS. In this chapter, "commission" means the Commission on Men.

Sec. \_\_.003. COMPOSITION OF COMMISSION. The commission consists of 12 members: four members appointed by the Governor with the advice and consent of the Senate; four members appointed by the presiding officer of the Senate; and four members appointed by the presiding officer of the house of representatives. Each member must be a medical or academic expert or community leader in the area of men's health or family involvement or an active member of an organization active in men's health or family involvement issues.

Sec. \_\_.004. APPOINTMENT. (a) Appointments to the commission shall be made without regard to the race, color, disability, sex, religion, age, or national origin of the appointees.

(b) Appointments to the commission shall be made so that each geographic area of the state is represented on the commission.

Sec. \_\_.005. TERMS. Members of the commission serve terms of two years.

Sec. \_\_.006. OFFICERS; SUBCOMMITTEES. (a) The commission annually shall elect one of its members as presiding officer.

(b) The presiding officer of the commission may appoint subcommittees for any purpose consistent with the duties of the commission under this chapter.

Sec. \_\_.007. COMPENSATION; EXPENSES. A member of the commission is not entitled to compensation, but is entitled to reimbursement from commission funds for the travel expense incurred by the member while conducting the business of the commission, as provided by the General Appropriations Act.

Sec. \_\_.008. MEETINGS; PUBLIC ACCESS. (a) The commission may meet at the times and places that the commission designates.

(b) The commission shall develop and implement policies that provide the public with a reasonable opportunity to appear before the commission and to speak on any issue under the jurisdiction of the commission.

Sec. \_\_.009. ANNUAL FINANCIAL REPORT. The commission shall prepare annually a complete and detailed written report accounting for all funds received and disbursed by the commission during the preceding fiscal year. The annual report must meet the



reporting requirements applicable to financial reporting provided in the General Appropriations Act.

(Sections \_\_.010 - \_\_.030 reserved for expansion)

#### SUBCHAPTER B. POWERS AND DUTIES; FUNDING

Sec. \_\_.031. GENERAL POWERS AND DUTIES OF COMMISSION. The commission shall:

- (1) adopt rules as necessary for its own procedures;
- (2) develop strategies and programs, including community outreach and public-private partnerships, designed to:
  - (A) raise public awareness of critical men's issues, including those health problems which disproportionately affect men and boys, and the importance of paternal influence in the family; and
  - (B) encourage the participation of men and boys in healthy behaviors, academic achievement, and family involvement;
  - (C) develop strategies, public policy recommendations, and programs, including community outreach and public-private partnerships, that are designed to educate (your state's) men and boys on the benefits of regular physician check-ups, early detection and preventive screening tests, and healthy lifestyle practices;
- (3) organize community workshops to identify issues affecting men's health and family involvement;
- (4) monitor state and federal policy and legislation that may affect the areas of men's health and family involvement;
- (5) recommend assistance, services, and policy changes that will further the goals of the commission; and
- (6) submit a report of its findings and recommendations under this chapter to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each year.

Sec. \_\_.032. DONATIONS; APPROPRIATIONS; AUDIT. The commission may solicit and accept donations, gifts, grants, property, grants, or matching funds from a public or private source for the use of the commission in performing its functions under this chapter.

Sec. \_\_.033. COMMISSION ON MEN ACCOUNT. The Commission on Men Account

is created as an account in the general revenue fund. The commission shall remit all money collected under this chapter to the comptroller for deposit to the credit of the account. Money in the account may be appropriated only to the commission for administration of this chapter.

SECTION 2. The Commission on Men shall be appointed within six months of the effective date of this act.

SECTION 3. This Act takes effect \_\_\_\_\_, 20\_\_.

*Legislation for the Health of Men and Their Families: June 2003.*

*Approved by the Health and Human Services Task Force in 2003.*

Obtained and released by:  
SUNSHINE  
The Center for Common Cause and  
The Center for Media and Democracy

## **Organ Donation Tax Deduction Act**

### ***Model Legislation***

**Section 1. Title.** This Act may be cited as the “Organ Donation Tax Deduction Act.”

**Section 2. Purpose.** The purpose of the “Organ Donation Tax Deduction Act” is to create an individual income tax subtract modification for certain individuals who donate a human organ.

### **Section 3. Scope and Definitions.**

- A. Subject to the conditions in this paragraph, an individual may subtract up to \$10,000 from federal adjusted gross income if he or she, while living, donates one or more of his or her human organs to another human being for human organ transplantation, as defined in **{insert section}**, except that in this paragraph, “human organ” means all or part of a liver, pancreas, kidney, intestine, lung, or bone marrow. A subtract modification that is claimed under this paragraph may be claimed in the taxable year in which the human organ transplantation occurs.
- B. An individual may claim the subtract modification under Paragraph A only once, and the subtract modification may be claimed for only the following unreimbursed expenses that are incurred by the claimant and related to the claimant’s organ donation:
- 1) Travel expenses.
  - 2) Lodging expenses.
  - 3) Lost wages.
- C. The subtract modification under Paragraph A may not be claimed by a part- year resident or a nonresident of this state.

**Section 4. Initial Applicability.** The creation of **{insert section}** of the statutes first applies to taxable years beginning on January 1 of the year in which this subsection takes effect, except that if this subsection takes effect after July 31, the creation of **{insert section}** of the statutes first applies to taxable years beginning on January 1 of the year following the year in which this subsection takes effect.

**Section 5. {Severability Clause}**

**Section 6. {Repealer Clause}**

*Passed by the Health and Human Services Task Force on December 10, 2005.*

SUNSHINE  
Obtained and released by:  
Common Cause and  
The Center for Media and Democracy  
VIEW

## **Resolution Supporting Organ Donation Education**

**WHEREAS**, the medical breakthrough of organ donation has given new life to over 230,000 Americans and greatly enhanced the life of countless others; and

**WHEREAS**, new prescription drugs recently introduced on the market have proven so effective that over 80 percent of those receiving organ transplants live beyond the one-year benchmark for success, and the long term success rates of organ donation have steadily improved every year; and

**WHEREAS**, there are over 77,000 citizens who are currently awaiting transplants in the United States; and

**WHEREAS**, currently on average, 15 persons in this country die every day awaiting an organ transplant who could have lived productive lives if the necessary organ with the proper tissue type was available; and

**WHEREAS**, recent polls show that over 93 percent of Americans support an increase in organ donation; and

**WHEREAS**, the state of Wisconsin has passed legislation to create the most comprehensive organ donation education program in the nation; and

**WHEREAS**, the Wisconsin program includes such basic education in the Drivers' Education and Health classes and has prepared the most extensive educational documents including videos, workbooks and slides explaining the benefits of organ donation and removing the myths of organ donation; and

**WHEREAS**, as a result of Wisconsin's hard work and visionary attitude in creating the organ donation education program, the people of Wisconsin have seen dramatic results in the number of organs donated.

**NOW THEREFORE BE IT RESOLVED**, that the American Legislative Exchange Council recognizes the life-saving benefits of increasing organ donor awareness.

**BE IT FURTHER RESOLVED**, that (insert state) seek to implement a life-saving organ donor awareness program via its driver's education curriculum.

*Approved by the Health and Human Services Task Force in Summer 2001.*

## Medical Treatment Decision Act

### *Model Legislation*

(Title, enacting clause, etc.)

**Section 1.** The legislature finds that a competent adult has been traditionally reorganized as having the right to accept or reject medical treatment concerning his person. The legislature also finds that recent advances in medical technology have made it possible to prolong dying through the use of extraordinary, extreme, or radical medical or surgical procedures. The use of such medical or surgical procedures often involves patients who are unconscious or otherwise incompetent to accept or reject medical treatment. Therefore, the Legislature finds that the right to accept or reject medical treatment should be available to an adult while he is competent, notwithstanding the fact that such medical or surgical treatment may be offered or applied when he is suffering from a terminal condition and is unconscious or otherwise incompetent to decide whether such medical or surgical treatment should be accepted or rejected.

**Section 2.** As used in this Act, the following terms have the following meanings:

- (A) “Adult” means any person eighteen years or age or older.
- (B) “Attending physician” means the physician, whether selected by or assigned to a patient, who has primary responsibility for the treatment and care of said patient.
- (C) “Court” means the District Court of the county in which the declarant having a terminal condition is located at the time of commencement of a proceeding pursuant to this Act.
- (D) “Declarant” means a mentally competent adult who executes a declaration.
- (E) “Declaration” means a written document, voluntarily executed by a declarant, in accordance with the Requirements of Section 3.
- (F) “Life-sustaining procedure” means any medical procedure or intervention that, if administered to a qualified patient, would serve only to prolong the dying process. “Life sustaining procedure” shall not include any medical procedure or intervention to nourish the qualified patient, or considered necessary by the attending physician to provide comfort or alleviate pain.
- (G) “Qualified patient” means a patient who has executed a declaration in accordance with Section 3 of this Act and who has been certified by the attending physician and two other physicians to be in a terminal condition.



(H) "Terminal condition" means an incurable or irreversible condition for which the administering of life-sustaining procedures will serve only to postpone the moment of death.

### **Section 3.**

(A) Any competent adult may execute a declaration directing that life-sustaining procedures be withheld or withdrawn if at some future time, he is in a terminal condition and either unconscious or otherwise incompetent to decide whether any medical procedure or intervention should be accepted or rejected. It shall be the responsibility of the declarant or someone acting for him to submit the declaration to the attending physician for inclusion in the declarant's medical record.

(B) A declaration executed before two witnesses by any competent adult shall be legally effective for purposes of this Act regardless of form. In the event that the declarant is physically unable to sign the declaration it may be signed by some other person in the declarant's presence and at his direction. Such other person shall not be:

- (1) The attending physician or any other physician; or
- (2) An employee of the attending physician or a health care facility where the declarant is a patient; or
- (3) A person who has a claim against any portion of the estate of the declarant at the time of his death at the time the declaration is signed; or
- (4) A person who knows or believes that he is entitled to any portion of the estate of the declarant upon his death either as a beneficiary of a will in existence at the time the declaration is signed or as an heir at law.

(C) The declaration shall be signed in the presence of two witnesses. Said witnesses shall not include any person specified in Paragraphs (1) through (4) of Subsection B.

**Section 4.** In the case of a declaration of a qualified patient known to the attending physician to be pregnant, the declaration shall be given no force or effect.

### **Section 5.**

(A) In the event that an attending physician is presented with an unrevoked declaration executed by a declarant whom the physician believes has a terminal condition, the attending physician shall cause the declarant to be examined by two other physicians. If all three physicians find that the declarant has a terminal condition, they shall certify such fact in writing and enter such in the qualified patient's medical record together with a copy of the declaration.

(B) If the attending physician has actual knowledge of the whereabouts of the qualified patient's spouse, any of his adult children, a parent, a brother, or sister, or attorney-in-fact

under a durable power of attorney, the attending physician shall immediately make a good faith effort to notify at least one of said persons, in the order names, that certificate of terminal condition has been signed.

(C) If no action to challenge the validity of a declaration, in accordance with Section 6 of this Act, has been filed within seventy-two hours after the certification is made by the physicians, the attending physician shall withdraw or withhold all life-sustaining treatment pursuant to the terms of the declaration.

#### **Section 6.**

(A) Any person who is the spouse, adult child, parent, brother or sister, or attorney-in-fact under a durable power of attorney of the qualified patient may challenge the validity of a declaration in the appropriate Court of the county in which the qualified patient is located. No other person or group shall have standing to challenge the validity of a declaration under this Act.

(B) Upon the filing of a petition to challenge the validity of a declaration and notification to the attending physician, a temporary restraining order shall be issued until a final determination of validity shall be made.

(C)(1) In proceedings pursuant to this Section, the Court shall appoint a guardian ad litem shall take such action as he deems necessary and prudent in the best interest of the qualified patient, and shall present to the Court a report of his actions, findings, conclusions, and recommendations.

(2) Unless the Court for good cause shown provides for a different method of time to notice, the petitioner, at least five days prior to the hearing, shall cause notice of the time and place of the hearing to be given to the qualified patient's guardian or conservator, if any; to the Court appointed guardian ad litem; and to such other parties as the Court shall direct.

(3) The Court may require such evidence, including independent medical evidence, as it deems necessary.

(4) Upon the determination of the validity of the declaration, the Court shall enter any appropriate order.

**Section 7.** A declaration may be revoked by the declarant either orally, in writing, or by burning, tearing, canceling, obliterating, or destroying said document.

#### **Section 8.**

(A) With respect to any declaration which appears on its face to have been executed in accordance with this Act:

(1) Any physician may act in compliance with such declaration in the absence of actual notice of revocation, fraud, misrepresentation, or improper execution;

(2) No physician signing a certificate of terminal condition or withholding or withdrawing life-sustaining procedures in compliance with a declaration shall be subject to civil liability, criminal penalty, or licensing sanction therefore;

(3) No hospital or person acting under the direction of a physician and participating in the withholding or withdrawing of life-sustaining procedures in compliance with a declaration shall be subject to civil liability, criminal penalty, or licensing sanction therefore.

**Section 9.**

(A) The existence of a declaration shall not affect, impair, alter, or modify any existing contract of life insurance or annuity or be the basis for any delay in issuing or refusing to issue any annuity or policy of life insurance or any increase in the premium therefore.

(B) No insurer or provider of health care services shall require a person to execute a declaration as condition of being insured or receiving health care services; nor shall the failure to execute a declaration be the basis for any increased or additional premium for a contract or policy for health insurance.

**Section 10.** Nothing in this Act shall be construed as altering or amending the standards of the practice of medicine, or as condoning, authorizing, or approving euthanasia, or mercy killing, nor as permitting any affirmation or deliberate act or omission to end life except as provided by this act, or to permit the withholding of any medical procedure or intervention to nourish the qualified patient.

**Section 11.** An attending physician who refuses to comply with the terms of a declaration valid on its face shall transfer the care of the declaration to another physician who is willing to comply with the declaration. Failure of a physician to comply with the terms of a declaration valid on its face or to transfer the care of the declarant to another physician who is willing to comply with the declaration shall constitute unprofessional conduct as defined by the laws of this State.

**Section 12. {Severability Clause.}**

**Section 13. {Repealer Clause.}**

**Section 14. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1990.*

## **Prevention of Assisted Suicide Act**

### ***Model Legislation***

(Title, enacting clause, etc.)

**Section 1.** [Short title.] This act may be cited as the **Prevention of Assisted Suicides Act**. [An amendment to the state criminal code.]

**Section 2.** [Assisted suicide—Unlawful act.] A person shall be guilty of a [name of serious felony] who intentionally, knowingly, or willfully:

(A) Aids, abets, assists, advises, or encourages another to commit suicide;  
or

(B) Provides to, deliveries to, or procures for another any drug or instrument with knowledge that the other may attempt to commit suicide with the drug or instrument.

**Section 3.** [Failure to commit not a defense.] Failure of another to commit suicide shall not be a defense to a person charged with committing an act under Section 2.

**Section 4.** [Wrongful death.] Any person who aids and abets the suicide of another may be civilly liable for the wrongful death of the suicide victim.

**Section 5.** {Severability Clause.}

**Section 6.** {Repealer Clause.}

**Section 7.** {Effective Date.}

*Approved by the Health and Human Services Task Force in 1987.*

**Resolution on Maintaining Confidentiality of Patient-Identifiable Information**

**WHEREAS**, recent developments in the area of information technology have stimulated public concern over confidentiality of patient-identifiable medical information; and

**WHEREAS**, the federal Health Insurance Portability and Accountability act (HIPAA) requires the development of detailed federal standards with respect to the privacy of individuality identifiable health information; and

**WHEREAS**, confidentiality requirements should be comprehensive in assuring patients that information identifying them and their medical condition or predisposition to any specific condition is confidential information; and

**WHEREAS**, state and federal policies must accomplish twin objectives of protecting the privacy of individual patients, while also protecting the continued viability of research and the coordination of health care research to promote improved quality of health care for all patients; and

**WHEREAS**, patients benefit from improved health care interventions, including early detection and timely preventive services, as well as the many new medicines which have been brought to the market this past year, new weapons against HIV/AIDS, several new anti-cancer drugs, a new anti-depressant and a new anti-psychotic drug, new treatments for chronic diseases such as diabetes and asthma, and for many other deadly and debilitating diseases; and

**WHEREAS**, continued progress of this magnitude depends on aggressive, multifaceted research, including:

- Basic science that allows us to understand disease processes,
- Practical research and development that finds the right way to combat the disease,
- Clinical trials required by law to demonstrate the safety and efficacy for potential products,
- Large-scale epidemiological research and health services research that helps to determine how a product performs in realistic applications and to detect rare side-effects and unsuspected benefits that may not show up in relatively unsuspected benefits that may not show up in relatively limited trails, and
- Outcomes research and economic studies to permit the evaluation for the cost-effectiveness of modern medical interventions; and

**WHEREAS**, innovations in medical science, in combination with developments in genomic technologies are revolutionizing medical research and the future of health care as they begin to reveal the molecular basis of human illnesses; and

**WHEREAS**, legislation aimed at preserving the confidentiality of patient medical information should be carefully crafted to allow the continuation of vital medical research and the provision of high quality health care applying the knowledge gained from such research; and

**WHEREAS**, genetic information cannot be scientifically or practically separated from other medical information and should not be regulated individually either, and

**WHEREAS**, establishing ownership of medical information and samples is not an appropriate mechanism for protecting privacy, and instead will hinder research, potentially deprive patients of the opportunity to participate in clinical trials, create potential conflicts with the certification and licensure requirements applicable to providers and practitioners and hinder their ability to provide high quality care.

**NOW THEREFORE BE IT RESOLVED** that any state or federal legislation to protect the confidentiality of individually identifiable medical information should ensure that vital medical research is encouraged and facilitated, should protect the current practice of storing tissue samples and medical information which is critical to medical research and the legal operation of health care institutions and the delivery of quality health care, and should not require the destructions of medical information and samples; and

**FURTHER, BE IT RESOLVED** that establishing ownership of medical information and samples is not an appropriate mechanism for protecting privacy.

*Approved by the Health and Human Services Task Force in 1997.*



## Clinical Trial and Results Registries Act

### *Model Legislation*

**Section 1. Short Title.** This Act shall be known as the “Clinical Trial and Results Registries Act.”

**Section 2. Summary.** This bill establishes an agreement for {insert state} to adopt and abide to federal legislation for Clinical Trial and Results Registries (CTRR).

**Section 3. Background.** In 1997, the FDA Modernization Act (FDAMA), Section 113 (“FDAMA 113”) mandated the posting of Phase II to Phase IV industry-sponsored clinical trials conducted under an Investigational New Drug (IND) application for serious and life-threatening illnesses onto a public registry, maintained by the National Library of Medicine within the National Institute of Health. The intent was to provide patients with information on clinical trials and provided a means for those patients to contact participating physicians.

On September 28, 2007, the FDA Amendments Act (FDAAA) (“the Amendment”) was signed by President George W. Bush with an effective date of October 1, 2007. Title VIII of the Amendment extended the mandate for clinical trial sponsors (public or private) to register all Phase II to Phase IV trial information and subsequent results information, regardless of clinical trial outcome. The intent of sharing results is to foster the scientific enterprises’ knowledge around human clinical trials, with an understanding that even failed clinical trials that do not produce the expected results can add value to science and medicine.

A number of respected bodies have adapted their own position around clinical trial and results registries, including the World Health Organization (WHO) and the International Committee of Medical Journal Editors (ICMJE).

Since the original FDAMA 113 mandate, a number of individual states have proposed, and in some instances (for example, Maine) passed into legislation additional requirements above and beyond federal legislation. In some instances, the additional requirements were value-adding for patients and health care providers, because the additional information required to publicly post provided useful decision-making information. However, these state-specific proposals/requirements often overlap with federal mandates and/or confuse the clinical trial enterprise (private and public) about what is required due to different terminology, timelines and expectations.

### **Section 4. Legislation.**

A. So that {insert state} can have the most value-adding impact to its constituents, it is proposed that {insert state}:

1. Determine if the FDAAA Regulation, Title VIII, includes appropriate information for {insert state}’s patients and health care providers to make meaningful medical decisions. In instances where it is determined that additional information should be included in the clinical trial or result public registry (based on the federal legislation),

{insert state} shall participate and provide comment to the FDAAA legislation, as appropriate.

B. {Insert state} shall not propose or enact CTRR requirements specific to {insert state}, nor shall {insert state} preempt the federal legislation.

C. If {insert state} would like to provide CTRR information to its constituents, {insert state} must agree to provide a link to the federal databases so as to ensure patients and health care providers have access to timely and consistent information.

**Section 5. Definitions.** As used in this Act, the following definitions from Title 21 of the Code of Federal Regulations and/or the FDA Amendments Act of 2007 apply:

A. “Clinical trial” means a controlled clinical investigation; other than a Phase I investigation, of a drug.

B. “Sponsor” means a person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization.

**Section 6. Applicability and Scope.**

A. Provisions of this Act shall apply to all states where clinical research is conducted by public or private sponsors.

B. {Severability Clause.}

C. {Repealer Clause.}

D. {Effective Date.}

**Endnotes**

A. Gulmezoglu M., Pang, T., Horton R., Dickersin K. WHO Facilitates International Collaboration in Setting Standards for Clinical Trial Registration. The Lancet, 2005. 365:1829-1831.

B. Deangelis C., Drazen J.M., Frizelle F.A., Haug C., Hoey J., Horton, R., et al. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. Ann. Intern. Med. 2004; 141:477-8. Sept. 2004. (published electronically Sept. 2004: [www.icmje.org](http://www.icmje.org)).

C. World Health Organization. International Clinical Trials Registry Platform (ICTRP). [www.who.org](http://www.who.org).

D. Joint Industry Position on the Disclosure of Clinical Trial Information. [www.phrma.org](http://www.phrma.org). Jan. 2005.

E. FDA Amendments Act of 2007 (FDAAA). [www.fda.gov](http://www.fda.gov).

*Passed by the Health and Human Services Task Force on December 8, 2007.*

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## **Drug Liability Act**

### *Summary*

This Act establishes in statutory form certain clear limitations with the respect to the imposition of liability in actions for damages alleged to have been caused by certain drugs.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Drug Liability Act**.

**Section 2.** The legislature finds and reports that there is a need for remedial legislation to establish in statutory form certain clear limitations with respect to the imposition of liability in actions for damages alleged to have been caused by certain drugs. The legislature also finds and declares that the lack of such limitations has severely harmed the public interest by creating disincentives for the research and development of new pharmaceutical products and by delaying or preventing the introduction into the market of products that could prolong or even save the lives of individuals suffering from severe illnesses, including AIDS and human immunodeficiency virus infection.

**Section 3.** The manufacturer or seller of a drug is not liable for punitive damages if the drug alleged to cause harm either:

(A) Was manufactured and labeled in relevant and material respects in accordance with the terms of an approval or license issued by the Federal Food and Drug Administration under the Food, Drug, and Cosmetic Act (21 United States Code Section 301, et seq.) or the Public Health Service Act (42 United States Code Section 201 et seq.) or

(B) Is generally recognized as safe and effective pursuant to conditions established by the federal Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

**Section 4.** Notwithstanding Section 2, punitive damages may be awarded if the plaintiff proves, by clear and convincing evidence, that the defendant, either before or after making the drug available for public use, knowingly, in violation of applicable federal Food and Drug Administration regulations, withheld from or misrepresented to the Administration information known to be material and relevant to the harm which the plaintiff allegedly suffered.

**Section 5. {Severability clause.}**

**Section 6. {Repealer clause.}**

**Section 7. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1993.*

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## Drug Re-Importation Liability Act

**To amend Chapter {\_\_\_} of Title {\_\_\_} of the Official Code of {insert state} Annotated, relating to general provisions of torts, so as to provide for limited liability for physicians and pharmaceutical companies from claims for damages incurred pursuant to prescriptions filled with products from outside of the United States or its territories.**

BE IT ENACTED BY THE GENERAL ASSEMBLY OF {insert state}

Chapter {\_\_\_} of Title {\_\_\_} of the Official Code of {insert state} Annotated, relating to general provisions for torts, is amended by adding at the end thereof of a new Code section, to be designated Code Section {\_\_\_}, to read as follows:

Notwithstanding any other provision of law or rule of civil procedure, a physician licensed under Chapter {\_\_\_} of Title {\_\_\_} or a pharmaceutical company shall not be subject to civil liability in an action for damages caused by the plaintiff filling a prescription with a product from outside the United States or its territories and in violation of the Federal Food, Drug, and Cosmetic Act (Title 21 of the U.S. Code of Federal Regulations), unless the plaintiff pleads specific facts which, if proven, amount to negligence of such physician and/or pharmaceutical company.

*Approved by the Health and Human Services Task Force on May 1, 2005.*



## **Drug Utilization Review Board Act**

### ***Summary***

In accordance with the Federal Omnibus Budget Reconciliation Act of 1991, all states are required to establish a Drug Utilization Review Board for their Medicaid programs by January 1, 1993. Failure to create such a Board could result in the loss of funding for Medicaid programs. Despite this regulation, less than a dozen states have DUR boards. Since the establishment of Boards is mandated, those states that do not legislate their creation will be subject to the regulatory creation of such a Board by the appropriate state agency. Alec's legislation creates the most fair and cost efficient DUR Boards, provides the duties of that Board, and provides guidelines for a drug approval program.

### ***Model Legislation***

**{Title, enacting clause, etc.}**

#### **Section 1. Definitions.**

As used in this Act:

- (A) "Provider" means health professionals licensed to prescribe and/ or dispense medicine in this state.
- (B) "Board" means the Drug Utilization Review Board created in Section 2.
- (C) "Compendia" means resources widely accepted by the medical profession in the efficacious use of drugs, including "American Hospital Formulary Services Drug Information," "U.S. Pharmacopoeia— Drug Information." "A.M.A. Drug Evaluations," and peer-re-viewed medical literature.
- (D) "Counseling" means the activities conducted by a pharmacist to inform Medicaid recipients about the proper use of drugs, as required by the Board under this Act.
- (E) "Criteria" means those predetermined elements developed by health professionals used to measure drug use on an ongoing basis in order to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.
- (F) "Drug-disease contradictions" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.
- (G) "Drug-interactions" means that the two or more drugs taken by the recipient lead to clinically significant toxicity that is characteristic of one of any of the drugs present, or leads to interference with the effectiveness of one or any of those drugs.

(H) “Drug Utilization Review” or “DUR” means the program designed to measure and assess, on a retrospective and perspective basis, the use of outpatient drugs against predetermined criteria and standards.

(I) “Intervention” means a form of communication utilized by the Board with a prescriber or pharmacist about optional drug use to maximize health care outcomes.

(J) “Medically accepted indication” means any use for a covered outpatient drug that is approved under the federal Food, Drug and Cosmetic Act, that appears in peer-reviewed medical literature, and that is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, American Medical Association-Drug Evaluations, and the U.S. Pharmacopeia-Drug Information.

(K) “Overutilization” or “underutilization” means the use of a drug in such quantities that the desired therapeutic goal is not achieved.

(L) “Pharmacist” means a person licensed in (insert state) to engage in the practice of pharmacy.

(M) “Physician” means a person licensed in (insert state) to practice medicine and surgery.

(N) “Prospective DUR” means that part of the drug utilization review program that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy problems based on explicit and predetermined criteria and standards.

(O) “Retrospective DUR” means that part of the drug utilization review program that assess or measures drug use based on an historical review of drug use data against predetermined and explicit criteria and standards, on an ongoing basis with professional input.

(P) “Standards” means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the Medicaid recipient database.

(Q) “SURS” means the Surveillance Utilization Review System of the Medicaid program.

(R) “Therapeutic appropriateness” means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.

(S) “Therapeutic duplication” means prescribing and dispensation the same drug or two or more drugs from the same therapeutic class where periods of drug administration overlap and where that practice is not medically indicated.

## **Section 2. DUR Board – Creation and Membership.**

(A) There is created a 12 member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.

(B) The members of the DUR Board shall be appointed by the governor who shall appoint each member to a three year term. Persons appointed to the Board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms. The membership shall be comprised of the following.

- 1) Four physicians who are actively engaged in the practice of allopathic or osteopathic medicine in this state, to be selected from a list of nominees provided by the (insert state) Medical Associations;
- 2) One physician who is actively engaged in academic medicine in this state, to be selected from a list of nominees provided by the (insert state) Medical Association;
- 3) Three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the (insert state) Medical Association;
- 4) One pharmacist who is actively engaged in academic pharmacy in this state, to be selected from a list of nominees provided by the (insert state) Pharmaceutical Association;
- 5) One person who shall represent consumers in this state, to be selected from a list of nominees provided by the (insert state);
- 6) One dentist licensed to practice in this state, who is actively engaged in the practice of dentistry, nominated by the (insert state) Dental Association.

(C) Physician and pharmacist members of the Board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.

(D) Appointments to the Board shall be made so that the length of the terms are staggered. In making the appointments, the state shall provide for geographic balance in representation on the Board.

(E) The Board shall elect a chair from among its members who shall serve a one year term, and may serve consecutive terms.

**Section 3. DUR Board – Responsibilities.**

The Board shall:

(A) Develop policies necessary to carry out its responsibilities as defined in this Act;

(B) Oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this Act, indulging responsibility for approving DUR

provisions of contractual agreements between the Medicaid program and any other entity that would process and review Medicaid drug claims and profiles for the DUR program in accordance with this Act;

(C) Develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the Board shall reflect the local practices of physicians in order to monitor:

- 1) Therapeutic appropriateness;
- 2) Overutilization or underutilization;
- 3) Therapeutic duplication;
- 4) Drug-diseases contradictions;
- 5) Drug-drug interactions
- 6) Incorrect drug doses or duration of drug treatment; and
- 7) Clinical abuse and misuse

(D) Develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive and nature, in order to improve the quality of care;

(E) Disseminate information to physicians and pharmacists to ensure that they are aware of the Board's duties and powers;

(F) Provide written, oral, or electronic reminders of patient-specific or drug specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;

(G) Utilize face-to-face discussions between the experts in drug therapy and a prescriber or pharmacist who has been targeted for educational interventions;

(H) Conduct intensified reviews or monitoring of selected prescribers or pharmacists;

(I) Create and educational program using data provided through DUR to provide active and ongoing education outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;

(J) Provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;

(K) Publish an annual report, subject to public comment prior to its issuance, and submit that report to the United States Department of Health and Human Services by December 1 of each year. That report shall also be submitted to legislative leadership, the executive director, and the president of the (insert state) Medical Association by December 1 of each year. The report shall include:

- 1) An overview of the activities of the board and the DUR program;
- 2) A description of interventions used and their effectiveness, specifying whether the intervention was a result of underutilization or overutilization of drugs, without disclosing the identities of individual physicians, pharmacists or recipients;
- 3) The costs of administering the DUR program;
- 4) Any fiscal savings resulting from the DUR program;
- 5) An overview of the fiscal impact to the DUR program to other areas of the Medicaid program such as hospitalization or long term care costs;
- 6) A quantifiable assessment of whether DUR has improved the recipient's quality of care;
- 7) A review of the total number of prescriptions, by drug therapeutic class;
- 8) An assessment of the impact of educational programs or interventions on prescribing or dispensing practices; and
- 9) Recommendations for DUR program improvement;

(L) Develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;

(M) Establish a grievance process for physicians and pharmacists under this act;

(N) Publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:

- 1) Fraud, abuse, gross overuse, inappropriate, medically unnecessary care among physicians, pharmacists, and recipients;
- 2) Potential and actual server adverse reaction to drugs;

- 3) Therapeutic appropriateness;
- 4) Overutilization or underutilization;
- 5) Appropriate use of generics;
- 6) Therapeutic duplications;
- 7) Drug-disease contradictions;
- 8) Drug-drug interactions;
- 9) Incorrect drug dosage and duration of drug treatment;
- 10) Drug allergy interactions; and
- 11) Clinical abuse and misuse.

(O) Develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:

- 1) The name and description of the medication;
- 2) The administration, form, duration of therapy;
- 3) Special direction and precautions for use;
- 4) Common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;
- 5) Techniques for self monitoring drug therapy;
- 6) Proper storage;
- 7) Prescription refill information; and
- 8) Action to be taken in the event of a missed dose.

(P) Establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this Act. The recorded information shall include:

- 1) The name, address, age, and gender of the recipient;



- 2) Individual history of the recipient where significant including disease state, known allergies and drug reactions, and comprehensive list of medications and relevant devices;
- 3) The pharmacist's comments on the individual's drug therapy;
- 4) Name of prescriber; and
- 5) Name of drug, dose, duration of therapy , and direction for use.

**Section 4. Confidentiality of records**

(A) Patient-related information obtained under this Act shall be treated as confidential or controlled information.

(B) The Board shall establish procedures ensuring that the information described is held confidential by a pharmacist, being provided to patient's physician only upon request.

(C) The Board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the Board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The Board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the Board. The Board may release cumulative nonidentifying information for research purposes.

**Section 5. Drug Prior Approval Program.**

Any drug prior approval program approved or implemented by the Board shall meet the following conditions:

(A) No drug may be placed on prior approval for other than medical reasons;

(B) The Board shall hold a public hearing at least 90 days prior to placing a drug on prior approval

(C) The Board shall provide evidence that placing a drug class on prior approval will not impede quality of recipient care and that the drug class is subject to clinical abuse or misuse;

(D) No later than nine months after any drug class is placed on prior approval, it shall be reconsidered;

(E) The program shall provide either telephone or facsimile approval or denial at least Monday through Friday, within 24 hours after receipt of the prior approval request;

(F) The program shall provide for the dispensing of at least a 72-hour supply of the drug in an emergency situation or on weekends;

(G) The program may not be applied to prevent acceptable medical use for the appropriate off-label indications; and

(H) Any drug class placed on prior approval shall receive a majority vote by the board for that placement, after meeting the requirements described in Subsections (A) through (G).

**Section 6. Advisory committees.**

The Board may establish advisory committees to assist it in carry out its duties under this Act.

**Section 7. Retrospective and prospective DUR.**

(A) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(B) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (D) and (E).

(C) The retrospective DUR program shall be based on guidelines established by the Board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to: Identify patters of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and

1) Assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:

- a) Therapeutic appropriateness;
- b) Overutilization or underutilization;
- c) Therapeutic duplications;
- d) Drug-disease contradictions;
- e) Drug-drug interactions;
- f) Incorrect drug dosage and duration of drug treatment; and
- g) Clinical abuse and misuse.

(D) The prospective DUR program shall be based on guidelines established by the Board and shall provide that, before a prescription is filled or delivered, a review will be

conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from

- 1) Therapeutic duplication;
- 2) Drug-drug interactions;
- 3) Incorrect dosage or duration of treatment;
- 4) Drug-allergy interactions; and
- 5) Clinical abuse or misuse.

(E) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

**Section 8. Penalties.**

Any person who violates the confidentiality provisions of this Act is guilty of a class B misdemeanor.

**Section 9. Immunity.**

There is no liability on the part of and no cause of action of any nature arises against any member or the board, its agents, or employees for any action or omission by them in effecting the provisions of this part.

**Section 10. {Severability Clause.}**

**Section 11. {Repealer Clause.}**

**Section 12. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1992.*

## **Good Samaritan Drug and Medical Supply Donation Act**

### *Summary*

The purpose of this Act is to encourage the donation of medical supplies and drugs by the private sector to nonprofit organizations for distribution to needy individuals without the threat of liability. The Act protects a person, corporation, partnership, organization, association, or governmental entity from the civil or criminal liability arising from the nature, age, packaging, or condition of drugs or medical supplies that the entity donates in good faith to a nonprofit organization for ultimate distribution to needy individuals. The immunity would not apply to an injury to or death of a recipient that shall result from an act or omission of the donor constituting gross negligence or intentional misconduct.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This subsection may be cited as the **Good Samaritan Drug and Medical Supply Donation Act**.

**Section 2. {Definitions.}**

(A) "Donate" means to give without requiring anything of significant monetary value from the recipient. The term shall include giving by a nonprofit organization to another nonprofit organization where the donor organization has charged a nominal fee to the donee organization, and distribution by a nonprofit organization to an ultimate recipient who has been required to pay a nominal fee to the nonprofit organization.

(B) "Drug" means:

- (1) any article recognized in the official United States Pharmacopoeia, or the official National Formulary, or any supplement to them; or
- (2) any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man, or
- (3) any article other than food intended to affect the structure or any function of the human body; but does not mean medical supply as defined in this Subsection.

(C) "Gross negligence" means conduct by a person with knowledge, at the time of the conduct, that the conduct is harmful to the health or well-being of another person.

(D) “Intentional misconduct” means conduct by a person with knowledge, at the time of the conduct, that the conduct is harmful to the health or well-being of another person.

(E) “Medical supply” means any instrument, apparatus, implement, contrivance, implant, in vitro reagent, or other similar or related article including any component, part, or accessory, which is:

- (1) recognized in the official National Formulary, or the official United States Pharmacopoeia, or any supplement to them,
- (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease in humans; or
- (3) intended to affect the structure of any function of the human body, and which does not achieve any of its principal intended purposes through chemical action within or on the human body and which is not dependent upon being metabolized for the achievement of any of its principal intended purposes.

(F) “Nonprofit organization” means an incorporated or unincorporated entity that:

- (1) is operating for religious, charitable, or educational purposes; and
- (2) does not provide net earnings to, or operate in any other manner that insures to the benefit of, any office employee, or shareholder of the entity. As used in this paragraph, earning shall not include employee compensation.

(G) “Person” means an individual, corporation, partnership, organization, association, or governmental entity including but not limited to a drug manufacturer, medical supply manufacturer, retail pharmacy, hospital pharmacy, wholesaler, clinic, physician, nurse, hospital, dentist, outpatient health facility, nursing home, home health care entity, or nonprofit drug or medical supply distributor. In the case of a corporation, partnership, organization, association or government entity, the term includes as officer, director, partner, deacon, elder, pastor, rabbi, trustee, council member, or other elected or appointed individual responsible for the governance of the entity.

### **Section 3. {Liability for Damage from Donated Drug or Medical Supply.}**

A person shall not be subject to any civil or criminal liability arising from the nature, age, packaging, or condition of drugs or medical supplies that the person donates in good faith to a nonprofit organization for ultimate distribution to needy individuals, except that this paragraph shall not apply to an injury to or death or an ultimate user or recipient of the drug or medical supply that results from an act or omission of the donor constituting gross negligence or intentional misconduct.

### **Section 4. {Partial Compliance.}**

If some or all of the donated drugs or medical supplies do not meet all quality and labeling standards imposed by federal, state, and local laws and regulations, the person who donates the drug or medical supply shall not be subject to civil or criminal liability in accordance with this Subsection of the nonprofit organization that receive the donated drug or medical supply:

- (1) is informed by the doctor of the distressed or defective condition of the donated drug or medical supply and
- (2) agrees to take necessary measures to comply with all relevant quality standards imposed by federal, state, and local laws and regulations prior to distribution of the donated drug or medical supply; and
- (3) is made knowledgeable as to the quality standards applicable to the donated drug or medical supply under federal, state, and local laws and regulations.

**Section 5. {Conclusion.}**

This Act shall not be construed to create any liability.

**Section 6. {Severability Clause.}**

**Section 7. {Repealer Clause.}**

**Section 8. {Effective Date.}**

*Approved by the Health and Human Services Task Force in March 2002.*



## **Medicaid Reimbursement for Drugs Act**

### ***Summary***

This Act repeals the ability of current or future state Medicaid programs to restrict access to drugs with closed formularies. Specifically, the legislation states that no state department, division, or agency shall maintain a drug formulary that restricts a physician's ability to treat a patient with a drug that has been approved and designated as safe and effective by the federal Food and Drug Administration.

### ***Model Legislation***

**{Title, enacting clause, etc.}**

**Section 1.** This Act may be cited as the **Medicaid Reimbursement for Drugs Act**.

**Section 2.** A practitioner may prescribe legend drugs in accordance with this chapter that, in the practitioner's professional judgment and within the lawful scope of the practitioner's practice, the practitioner considers appropriate for the diagnosis and treatment of the patient. No state department, division, or agency shall maintain a drug formulary that restricts a physician's ability to treat a patient with a drug that has been approved and designated as safe and effective by the federal Food and Drug Administration, except drugs for cosmetic purposes, by any method including any prior or retroactive approval process for reimbursement. A state department, division or agency may reimburse for multi-source legend drugs in the generic form, in accordance with state and federal law, unless an exception has been made by the prescribing practitioner.

**Section 3. {Severability Clause.}**

**Section 4. {Repealer Clause.}**

**Section 5. {Effective Date.}**

*Approved by the Health and Human Services Task Force.*

## Principles Regarding Prescription Drug Benefits

The federal government is considering the addition of a prescription drug benefit to the Medicare program to address growing concerns about access to and affordability of prescription drugs. In addition, given the present absence of federal action, many states are crafting or have already created benefit programs for their citizenry. Numerous proposals have been offered with regard to these proposed benefits, many of which directly contradict the Jeffersonian principles of limited government, individual choice, and free markets upon which our nation was founded. Alarming, many of these proposals provide a new entitlement for a class of our citizenry. The Health and Human Services Task Force of the American Legislative Exchange Council is committed to the implementation of a prescription drug benefit that does not violate Jeffersonian principles. To that end, and to serve as a foundation for its work, the Task Force has adopted a model set of Principles Regarding Prescription Drug Benefits. These principles include, but are not limited to:

**Flexibility.** The Task Force supports a benefit that affords the states the greatest degree of flexibility in implementation. While the Task Force would prefer to have a prescription drug benefit funded using block grants, its principles apply to both a federally implemented and a state-implemented benefit. The Task Force rejects any unfunded mandates imposed by the federal government and will oppose any movement by the federal government to shirk its financial responsibility with regard to overall Medicare reform. In addition, any federal legislation must contain the necessary provisions to permit states to continue operation of their existing plans without penalizing proactive states through maintenance of effort provisions.

**A targeted benefit.** A very small number of seniors, only 4% in 1999, spent more than \$2,000 per year on out-of-pocket prescription drug expenses. Seniors with the highest expenses and the lowest incomes are those to whom a prescription drug benefit must be targeted. If a drug benefit is enacted to extend to the entire Medicare population, or the entire citizenry, it will result in the creation of another broad entitlement. The creation of such an entitlement in our nation's social policy is irresponsible and will foster unintended consequences by distorting markets, putting extraordinary burdens on taxpayers to fund this entitlement, and ultimately injecting damaging government controls. What is needed is a sense of ownership in meeting a need rather than a sense of entitlement.

**Free-Market Supremacy.** A key to the success of any health care reform, including the addition of a prescription drug benefit, is the ability of the private sector to meet the needs of the population. The federal and state governments should seek innovative partnerships with the private sector to provide prescription drugs for its citizens. Though a drug benefit will utilize public funding, the private sector is best able to deliver this benefit, as it may negotiate appropriate discounts and keep overall spending in check.

**Individual Freedom and Choice.** Our nation is founded upon these two bedrock principles, which are all too often ignored by policymakers, particularly in the health care arena. A prescription drug benefit must allow its beneficiaries affordable access to all necessary pharmaceuticals, whether name brands, generics, or some non-prescription over-the-counter drugs. Allowing such access protects the sanctity of the patient-provider relationship, which the Task Force acknowledges and respects.

At the same time, the Task Force recognizes the difficult choices to be made given the constraint of limited economic resources. Thus, while the Task Force supports the greatest degree of freedom possible for patients, it also recognizes that access to pharmaceuticals is not without boundaries. Accordingly, the Task Force supports allowing the states to exercise the greatest degree of freedom when it comes to making crucial decisions on issues such as formularies, cost sharing, and disease management. The Task Force further supports drug benefit plans that promote personal responsibility, encouraging beneficiaries to recognize the costs of their coverage and the consequences associated therewith.

Regardless, beneficiaries must have some level of choice with regard to a prescription drug benefit so as to encourage market-oriented behaviors. Beneficiaries must be able to choose between competing, private sector plans in order to make their own determinations, as “one size fits all” does not apply in the health care arena.

**Market-Dictated Pricing.** Government entitlement programs inevitably lead to price controls. When price controls are imposed on any industry, they reduce return on investment, and the ability of producers to fund new, innovative research or continued development, or increase production. The most damaging effect of price controls on pharmaceuticals is that they will discourage manufacturers from developing additional life-saving drugs because they will not be able to recoup the costs of research and development. History has proven time and again that mandated price controls do not work; in fact, one truism of public policy is that price controls on goods and services lead to shortages of those goods. It is tragically ironic that a proposal intended to expand access to medication through price controls will result in restricting patient access.

*Approved by the Health and Human Services Task Force on August 3, 2001.*

### **Prior Authorization Resolution**

This resolution was developed by the Health Care Task Force for state legislators to show support for open access to pharmaceuticals as an effective method of containing costs in the total Medicaid budget. This resolution also states opposition to restrictive measures such as drug formularies and prior authorization programs.

**WHEREAS** prescription medicines are vitally important to ensuring good health and quality of life for Medicaid recipients; and

**WHEREAS** the cost-effectiveness of pharmaceuticals contribute to improved overall health care is exemplified by a reduction in emergency room visits, in-hospital days, physician visits, unnecessary surgeries, as well as avoidance of medical complications, increased speed in recovery, improved patient compliance, and quality of life through reduced pain and suffering; and

**WHEREAS** the American Legislative Exchange Council has supported open access to pharmaceuticals as a cost-effective method of containing costs in the total Medicaid budget; and

**WHEREAS** the American Legislative Exchange Council opposes restrictive measures such as restrictive formularies and prior authorization systems; and

**WHEREAS** the enactment of the Omnibus Budget Reconciliation Act of 1990 (HR 5835) provides for significant cost savings to all state Medicaid programs through the mandated drug manufacturer rebated to Medicaid; and

**WHEREAS**, HR 5835 also allows state Medicaid programs to continue or institute prior authorization programs, in which physicians must seek and obtain approval from the state to prescribe the medicines which they believe are the most appropriate for their patients; and

**WHEREAS** prior authorization systems have been used in more than 20 states to deny effective therapy to the poor and disabled, creating a two-tier system of medical care; and

**WHEREAS** research has demonstrated that substitution resulting from restricted formularies negates any potential cost savings, and;

**WHEREAS** 10 states are now required under federal law to eliminate their restrictive Medicaid drug formularies; and

**WHEREAS** officials of several states have indicated their intent to employ the newly allowable prior authorization systems as a de facto restrictive formulary, despite the mandated manufacturer rebates; and

**WHEREAS** such use of prior authorization would represent a distortion of the legislative intent of the Congress of the United States, and would subvert the goal of quality care for Medicaid patients; and

**WHEREAS** the American Legislative Exchange Council believes that the goal of reducing expenditures in the Medicaid drug program has been attained through adoption of the manufacturer rebate provisions of HR 5835;

**NOW, THEREFORE, BE IT RESOLVED** that the American Legislative Exchange Council is opposed to any further attempts by state Medicaid officials to hamper access to prescription medicines; and

**FURTHER, BE IT RESOLVED** that the American Legislative Exchange Council urge the governors and the governors-elect of the 50 states, and the state Medicaid directors, to eliminate prior authorization systems, and preserve access to important prescription medicines for America's indigent population.

*Approved by the Health and Human Services Task Force in 1993.*



## **Resolution concerning the Prohibition of Imported Prescription Drugs**

**WHEREAS**, the use of safe and legal prescription drugs improves the quality of care and helps patients live healthier, longer, and more productive lives while keeping them out of more costly acute care settings in the long term, and

**WHEREAS**, the Food, Drug, and Cosmetic Act (FDCA) governs the manufacture, sale, and distribution of drugs in interstate commerce, and under the FDCA, every new drug must be approved by the Food and Drug Administration (FDA) prior to marketing, and also under the FDCA, approvals are specific to each product, and all prescription drugs must be accurately labeled and may not be dispensed without an order from a licensed practitioner, and

**WHEREAS**, virtually all prescription drugs imported into the United States, other than those imported by the original manufacturer, pose serious safety concerns and violate these provisions of the federal law; such as those recently uncovered by a U.S. Customs and FDA investigation, which found that 88% (1,019 of 1,153) contained unapproved drugs, such as mislabeled, misbranded, expired, and mishandled drugs that might cause patient health problems, and

**WHEREAS**, the importation of drugs from foreign countries opens the currently secured distribution system established by the FDCA, thereby increasing the likelihood that counterfeit drugs, dangerous narcotics and deliberately contaminated material would endanger the health of U.S. citizens, and

**WHEREAS**, national pharmacy groups with a focus on patient health and safety have stated that the safety of imported drugs cannot be guaranteed and may result in patient harm, and

**WHEREAS**, the FDA's Personal Importation policy, which merely states as a matter of FDA enforcement discretion, an individual may import small quantities of drugs which are intended for serious conditions and which are not available domestically, does not alter the requirements of the federal law, and

**WHEREAS**, consumers victimized by imported drugs have included the most vulnerable patients including seniors, children, and the underserved.

**NOW, THEREFORE, BE IT RESOLVED** that the American Legislative Exchange Council supports the FDA's efforts to ensure the safety and quality of prescription drugs and opposes the illegal importation of non-FDA approved prescription drugs because of safety concerns.



*Approved by the HHS Task Force by a vote of 52-0 on May 1, 2004.*

Obtained and released by:  
Common Cause and  
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SUNSHINE VIEW

## **Resolution on Federalism in Recycling Narcotics**

**WHEREAS**, The federal Centers for Medicare and Medicaid Services estimates that more than \$1 billion in unused prescription drugs—including Schedule II controlled substances and other narcotics—are improperly disposed of each year, and;

**WHEREAS**, Unused prescription drugs disposed of in the sewage system flow into rivers, lakes, oceans, and are spread onto farm fields as sludge, and;

**WHEREAS**, Unused prescription drugs disposed of in the trash can be scavenged by identity thieves, poison children and animals, and seep through landfills into groundwater, and;

**WHEREAS**, The poor, uninsured, and underinsured can benefit from the use of recycled narcotics as long as the medication is in its original, unopened container and a licensed pharmacist has determined that the contents are not expired, unadulterated, or misbranded, and;

**WHEREAS**, There is a growing movement in many states to enact drug repository legislation, and this legislation does not include the use of recycling narcotics, and;

**WHEREAS**, Although many state statutes do not preclude or prohibit the return of narcotics, it is the understanding of the {insert legislative body here} that federal agencies have prohibited the return of controlled substances—after they have been dispensed to patients—to physicians' offices, pharmacies, hospitals, hospices, health clinics, long-term care facilities, or similar state repositories for any purpose; and

**WHEREAS**, {insert legislative body here} recognizes that, in the absence of bad faith, any donor, participant, provider, or pharmaceutical manufacturer shall not be liable for any claim or injury arising from participation in a drug repository program.

**THEREFORE BE IT RESOLVED THAT** The {insert appropriate legislative body here} memorializes the federal government to work with states in establishing recycling and redistribution programs for narcotics in health care facilities and other established state drug repositories.

**THEREFORE BE IT FURTHER RESOLVED THAT** Copies of this resolution be sent to the President of the United States, the United States Congress, and the appropriate leadership of the United States Department of Health and Human Services, the United States Food and Drug Administration, the United States Office of National Drug Control Policy, the United States Drug Enforcement Administration, and the United States Pharmacopeia.

*Approved by the Health and Human Services Task Force on December 9, 2006.*

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SUMMERVIEW

## **Resolution on Negative Impacts of Pharmaceutical Price Controls**

**WHEREAS**, the current US health insurance industry is tied to the U.S. tax code by the percentage of tax deductibility for health insurance contributions whereby employers receive 100% tax deductibility for employee health insurance contributions, and the self-employed and individual purchasers of health insurance receive a certain percentage of tax deductibility for their health insurance contributions; and

**WHEREAS**, the US health care industry is not a pure market system, because it separates the payment for healthcare through taxes and/or contributions from consumption of medical services; and

**WHEREAS**, consumers are left with little or no basis with which to compare the quantity, quality, cost, or value of the services they utilize and because they are unaware of the total cost of medical services, they have a natural incentive to over-utilize medical care; and

**WHEREAS**, many employer-sponsored insurance plans cover a portion of the cost for prescription medicines, thus enabling consumers to be aware of the cost of medications, since they must pay a larger share of out-of-pocket expense for medications; and

**WHEREAS**, consumers are led to believe that increasing prescription prices of medicines are a leading cause of health care cost escalation, although outpatient prescription medicines account for only 7.2 percent of total 1993 U.S health spending; and yet pharmaceuticals save millions of dollars in reduced hospital and physician expenses; and

**WHEREAS**, in 1998 US Pharmaceutical companies invested \$24 billion of their revenues into research and development of innovative medications. The pharmaceutical industry improves American health care, through effective research and development of new drug entities; and

**WHEREAS**, when price controls are imposed on any industry, they reduce returns on investments, and the ability of producers to fund new, innovative research or continued development, or increase in production. The most damaging effect of price controls on pharmaceuticals is that they will discourage manufacturers from developing additional life-saving drugs because they will not be able to recoup the costs of research and development process; and

**WHEREAS**, price controls encourage manufacturers to shift resources from research and development to marketing existing drugs, because investing money in experimental research and development would not be cost-effective.

**THEREFORE BE IT RESOLVED**, that government-mandated price controls on pharmaceuticals negatively impact the quality of health care by increasing consumer's price for medicines, curtail price competition and stifle manufacturer's ability to research and develop life-saving medicines which result in the substitution of costlier medical procedures.

**BE IT FURTHER RESOLVED**, that *{insert state}* encourages Members of Congress to consider that consumers would benefit from genuine market-based, consumer-oriented health care reforms, which simultaneously would control costs, improve quality, and expand access to health care for all Americans.

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S. House of Representatives.

*The Health and Human Services Task Force unanimously passed this Resolution at its August 12, 1999 meeting.*

## Resolution on Prescribing Data

**WHEREAS**, The American Medical Association (AMA) maintains a Physician Masterfile that includes current and historical data on individual physicians (whether or not the physicians are members of the AMA), but does not include physician prescribing data; and

**WHEREAS**, The AMA licenses Physician Masterfile data to health care information organizations, which in turn match physician prescribing data, obtained from pharmacies and other sources, to Physician Masterfile data; and

**WHEREAS**, Health care information organizations market the matched data to government agencies, academic institutions, and pharmaceutical manufacturers for a wide range of research and commercial purposes, which benefit patients, physicians, and other health care stakeholders by delivering reliable, evidence-based insights about drug safety issues as well as the quality and cost of care; and

**WHEREAS**, Some physicians have expressed a desire that their prescribing data not be released to pharmaceutical sales representatives, and the AMA has responded by instituting a Prescribing Data Restriction Program (PDRP) to enable such physicians to withhold such access to their prescribing data; and

**WHEREAS**, The PDRP appropriately accommodates the desire of individual physicians to withhold such access to their prescribing data while preserving the public benefits associated with use of the matched data marketed by healthcare information organizations and avoiding legislatively-mandated restrictions that could have unintended consequences.

**THEREFORE BE IT RESOLVED THAT** The state of {insert state} commends the AMA for instituting the PDRP and urges the {insert name of state medical society} to inform all physicians licensed by the state about the PDRP.

*Adopted by the Health and Human Services Task Force at the States and Nation Policy Summit on December 9, 2006. Approved by the ALEC Board of Directors January 8, 2007.*



## **Resolution on State Use Tax on Prescription Drug Samples**

### *Summary*

Many states currently impose a state use tax on prescription drug samples, while at the same time exempting the sale of prescription drugs from this tax. Free drug samples give patients the opportunity to try new therapies and begin treatment immediately. This Resolution requests that states pass legislation providing a tax exemption on prescription drug samples.

### *Model Resolution*

**WHEREAS**, eighteen states impose a use tax on prescription drug samples; and

**WHEREAS**, in the process of imposing a use tax, many states have also specifically exempted the sale of prescription drugs, pursuant to a written prescription by a licensed prescriber, from this tax; and

**WHEREAS**, revenue officials have taken the position that since the statutes refer to a written prescription, drug samples provided free of charge without a written prescription are not exempt from the tax, even though the sale of these products in a retail pharmacy would not be subject to the tax; and

**WHEREAS**, the availability of free samples provides an opportunity for the patient to gain experience with a new therapy and to begin treatment immediately, an important consideration when a patient does not have convenient access to a retail pharmacy; and

**WHEREAS**, the availability of samples allows patients with no source of payment for prescription drugs to have access to free prescription drugs; and

**WHEREAS**, many physicians have found prescription drug samples to be an important source of private subsidy for uninsured patients.

**NOW, THEREFORE BE IT RESOLVED**, that legislation must be passed in the affected states to provide a clear and unambiguous exemption for the manufacture, use, storage, consumption or distribution of free drug samples provided to a licensed prescriber.

*Approved by the Health and Human services Task Forces in Summer 1996, amended  
May 1999.*

## **Resolution Urging Health Insurance Coverage of Experimental Drugs**

### *Summary*

This resolution calls on insurance companies to reimburse patients for the limited number of experimental drugs available from the FDA. Coverage for experimental medication is usually in the insurance company's best interest, since drug therapy is less expensive than alternative treatments. This resolution not only helps suffering patients to afford experimental medication, but also sends a political message to the FDA. The message is clear: experimental drugs reduce costs and help suffering patients who are desperate for treatment.

**WHEREAS**, health costs have been adversely impacted by human immunodeficiency virus (HIV), cancer, leukemia, and other diseases, because their victims require expensive hospitalization and treatment; and

**WHEREAS**, accelerated research efforts in the past few years have resulted in the development of various drugs which can reduce the severity of symptoms and prolong life, or at least suspend the progression of viral infection; and

**WHEREAS**, most new drugs, however, are expensive and are not covered by health insurance primarily because they are still experimental and the licensing process is slow; and

**WHEREAS**, because sufferers of these illnesses are desperate for a remedy, many have turned to unlicensed, illegal, and possibly unsafe drugs from overseas; and

**WHEREAS**, there are dozens that have been proven to be effective in the laboratory but are now undergoing tests on humans at research centers throughout the country; and

**WHEREAS**, if these drugs are indeed effective in combating HIV, cancer, leukemia, and other diseases, treatment by the administration of such drugs would probably be less expensive in the long run and would decrease the need for lengthy hospitalization;

**NOW THEREFORE BE IT RESOLVED**, that the health insurance industry is encouraged to provide coverage for experimental drugs, where such drugs have already been approved by the Food and Drug Administration (FDA) for other indications, and where peer review research and scientific literature support their use in FDA no-indicated uses; and

**BE IT FURTHER RESOLVED**, that certified copies of this resolution be transmitted to all health insurers licensed by the state.

*Approved by the Health and Human Services Task Force in March 2002.*

SUNSHINE  
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VIEW

## Resolution on Transparency in Health Care

**WHEREAS, {Insert state}** finds that consumers are becoming more value conscious when making decisions about their personal health care and financing of such health care and as a result are seeking greater transparency in health care information; and

**WHEREAS, {Insert state}** finds that greater access to information about cost and quality of health care is particularly critical for the growing number of consumers enrolled in “consumer-driven health plans” such as health savings accounts, health reimbursement arrangements, flexible spending accounts, etc. which offer consumers unprecedented opportunity to determine how their health care dollars are spent; and

**WHEREAS, {Insert state}** finds that increased transparency in cost and quality data has been shown to drive positive change in health care including greater cost containment for consumers engaged in promoting quality and controlling overall health costs; and

**WHEREAS, {Insert state}** finds that voluntarily, the private sector has developed and implemented successful transparency programs that provide valuable information about the cost and quality of care; and

**WHEREAS, {Insert state}** has a great interest in the quality and cost of health care provided to all residents including state employees and beneficiaries of state-funded health programs.

**THEREFORE BE IT RESOLVED THAT {Insert state legislative body}** supports a system of health care transparency which ensures that:

- Consumers are provided with relevant, useful, accurate, actionable, and understandable information about the quality and cost of health care; and
- The private sector is encouraged to build upon its effective ongoing voluntary efforts to enhance transparency; and similarly, that private sector innovations are not sidetracked or otherwise discouraged by the imposition of burdensome and costly mandates; and
- Providers are encouraged to collect quality and cost data and to make it available to patients, health plans, and others who are working toward greater quality and cost savings in health care.

**BE IT FURTHER RESOLVED THAT {Insert state}** demonstrates and underscores its commitment to increased transparency in health care by making quality and cost data

related to state-funded health programs available to state employees and beneficiaries of publicly-funded programs.

*Approved by the Health and Human Services Task Force on July 27, 2007.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy  
SUMMERVIEW

## **Discount Medical Plan Organization Model Act**

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### **Model Legislation**

**Section 1. Short title.** This Act may be cited as the “Discount Medical Plan Organization Act.”

**Section 2. Purpose.** The purpose of the “Discount Medical Plan Organization Act” is to regulate the promotion, offer, sale, and use of discount medical plans and to facilitate the detection of and reduce the occurrence of discount medical plan organization fraud.

**Section 3. Definitions.** As used in this act, unless the context indicates otherwise, the following definitions apply:

- A. “Administrator” means a person or entity who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on these coverages.
- B. “Affiliate” means a person or entity that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
- C. “Commissioner” means the Commissioner of Insurance.



- D. “Control” or “controlled by” or “under common control with” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person.
- E. “Discount Medical Plan” means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration, offers access for its members to providers of health care services and the right to receive discounts on health care services provided under the discount medical plan from those providers. The term does not include a stand alone pharmacy discount program.
- F. “Discount medical plan organization” means an entity that:
- 1) Has established a discount medical plan; and
  - 2) Contracts with providers, provider networks and other discount medical plan organizations to provide access for discount medical plan members to receive medical services at a discount and determines the charge to the purchaser.
- G. “Health care provider” means a physician, facility or other health care practitioner who is licensed, accredited or certified to perform specified medical services consistent with state law.
- H. “Health insurance issuer” means any entity that offers health insurance coverage through a plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. A “health insurance issuer” shall also include a health maintenance organization as defined in this state. **{insert reference to appropriate sections in state law}**
- I. “Marketer” means a person or entity that markets, promotes, sells or distributes a discount medical discount plan, including a private label entity that places its name on and markets or distributes a discount medical discount plan pursuant to a marketing agreement with a discount medical discount plan organization.
- J. “Network of health care providers” means two or more health care providers who are contractually obligated to provide services in accordance with the terms and conditions applicable to a discount medical plan.
- K. “Preferred provider organization company” means a company that contracts with health care providers for lower fees than those customarily charged by the health care

provider for services and contracts with health insurance issuers, administrators, or self-insured employers to provide access to those lower fees to a particular group of insureds, subscribers, participants, beneficiaries, members, or claimants.

- L. “Service area” means the area within a 60-mile radius of the home or place of business of a discount medical plan purchaser.

**Section 4. Applicability and Scope.** This Act applies to all discount medical plan organizations doing business in this state.

**Section 5. Registration Requirements.** A discount medical plan organization may not market, promote, sell, or distribute a discount medical plan in this state unless the organization holds a certificate of registration as issued by the commissioner.

- A. An application to the commissioner for a certificate of registration must be accompanied by a nonrefundable application fee of \$100. The commissioner shall issue the certificate unless the commissioner determines that the organization or its affiliates or a business formerly owned or managed by the organization or an officer or manager of the organization has had a previous application for a certificate of registration denied, revoked, suspended, or terminated for cause or is under investigation for or has been found in violation of a discount medical plan statute or regulation in another jurisdiction within the previous 5 years.
- B. A discount medical plan organization shall renew its certificate of registration annually. The certificate is renewed upon payment by the organization of a nonrefundable renewal fee of \$100 and expires on the anniversary of its issuance if the renewal fee is not paid before that date. Once issued or renewed, the certificate continues in effect for 1 year unless suspended, revoked, or terminated; and
- C. An administrator that is authorized to do business in this state and that provides access to discounted medical care as part of a self-funded group health plan to residents who are members of a self-funded group health plan administered by that administrator is not required to obtain a certificate of registration pursuant to this section.
- D. This section does not excuse a discount medical plan organization that is also an insurer from full compliance with the Insurance Code.
- E. Nothing in this section requires a provider who provides discounts to his or her own patients to obtain and maintain a license under this Act as a discount medical discount plan organization.

**Section 6. Surety Bond or Deposit Requirements.** Each registered discount medical plan organization shall maintain in force a surety bond in its own name in an amount not less than \$35,000 to be used in the discretion of the commissioner to protect the financial interest of members who may be adversely affected by the insolvency of a discount medical plan organization. The bond shall be issued by an insurance company licensed to do business in this state.

- A. In lieu of the bond specified in Subsection A, a licensed discount medical plan organization may deposit and maintain deposited with the commissioner, or at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to the commissioner with at all times have a market value of not less than \$35,000.
- B. All income from a deposit made under Subsection B shall be an asset of the discount medical plan organization.
- C. Except for the commissioner, the assets or securities held in this state as a deposit under Subsection A or B shall not be subject to levy by a judgment creditor or other claimant of the discount medical plan organization.
- D. Properly licensed insurers and their affiliates who hold a certificate of registration under this act are exempt from Section 6, Subsections A and B.

**Section 7. Right of Return.** A discount medical plan issued for delivery in this state is returnable or cancelable, within 30 days of the date of delivery of the card or a longer period if provided in the purchase agreement, by the purchaser or user for any reason, and the user must receive a full refund of all fees, except nominal fees associated with enrollment costs, that were part of the cost of the card.

- A. A discount medical plan organization may not charge or collect a fee, including a cancellation fee, after a purchaser or user has given the organization notice of the person's intention to return or cancel the plan
- B. A discount medical plan organization shall ensure that each purchaser or user receives with the card a notice stating the terms under which the discount medical plan may be returned or cancelled as provided in subsections (1) and (2). A discount medical plan returned or cancelled in accordance with this section is void from the date of purchase.

**Section 8. Prohibited Activities.**

- A. A discount medical plan organization or a marketer that markets, promotes, advertises, or distributes a discount medical plan in this state:

- 1) May not make misleading, deceptive, or fraudulent representations regarding:
    - a) the discount or range of discounts offered by a discount medical plan;
    - b) the access to any range of discounts offered by a discount medical plan; or
    - c) another medical care service provided in connection with a discount medical plan;
  - 2) May not lead a prospective purchaser or user of a discount medical plan to believe that the discount medical plan being offered is an insurance product. This section does not preclude a discount medical plan organization from offering insurance products to prospective members;
  - 3) Shall provide to a prospective purchaser or user, before purchase, access to a list of health care providers, including the name, city, state, and provider type in the prospective purchaser's or user's service area; and
  - 4) Shall make continuously available to each discount medical plan user, through a toll-free telephone number, the Internet, or in writing upon request, the name, address, telephone number, and provider type of all health care providers in the user's service area who are bound by contract to provide services in accordance with the terms and conditions applicable to the card.
- B. A discount medical plan organization that markets, promotes, advertises, or distributes a discount medical plan in this state shall state, on all advertisements for discount medical plans, in bold and prominent type, and on all cards themselves in clear and conspicuous type, that the card is not insurance.
- C. The discount medical plan shall disclose to discount medical plan users that contracts with plan providers may be direct, or through indirect contract arrangements, like preferred provider networks.

#### **Section 9. Fraud.**

- A. A person that willfully operates as, or aids and abets another operating as, a discount medical plan organization in violation of Section 5 of this Act commits insurance fraud and shall be subject to **{insert classifications for misdemeanor and felony penalties in the state insurance code for insurance fraud}**, as if the unregistered discount medical plan organization were an unauthorized insurer,

and the fees, dues, charges or other consideration collected from the members by the unregistered discount medical plan organization or marketer were insurance premiums.

- B. A person that collects fees for purported membership in a discount medical plan, but purposefully fails to provide the promised benefits commits a theft and upon conviction is subject to **{insert classifications for misdemeanor and felony penalties that match provisions in the state's criminal code for theft offenses}**. In addition, upon conviction, the person shall be ordered to pay restitution to persons aggrieved by the violation of this Act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

**Section 10. Waiver of Requirements for Preferred Provider Organizations.** The commissioner may waive the requirements of Sections 5 and 6 for any preferred provider organization company. The factors taken into account in granting a waiver include but are not limited to whether the company:

- A. Has contracts in place with health care providers residing in this state;
- B. Has contracts in place with users and purchasers of health care services residing in this state who use the discount medical plan in conjunction with a self-funded or fully insured health plan;
- C. Is primarily in the preferred provider organization business; and
- D. Was in business in this state prior to **{insert effective date of the act}**.

**Section 11. Penalties.** If, after notice and hearing, the commissioner finds that the discount medical plan organization has violated a provision of this act, the commissioner may do any of the following:

- A. Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; or
- B. Impose a monetary penalty of not less than \$100 for each violation, but not to exceed an aggregate penalty of \$50,000; or
- C. Suspend or revoke the certificate of registration.

**Section 12. Regulations.** The commissioner may adopt regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with

**{insert statutory citation providing for administrative rulemaking and review of regulations}.**

**Section 13. Severability.** If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

**Section 14. {Repealer Clause.}**

**Section 15. {Effective Date.}**

*Passed by the Health and Human Services Task Force on December 10, 2005.*



## **Group Coverage Discontinuance and Replacement Model Regulation**

### ***Model Legislation***

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the Group Coverage Discontinuance and Replacement Model Regulation. (This bill is intended to be introduced with the Health Insurance Reform Act for Small Business Coverage.)

### **Section 2.** Authority.

These rules and regulations are adopted and promulgated by *(title of supervisory authority)* pursuant to Section *(insert applicable section)* of the *(insert state)* Insurance Code.

### **Section 3. Scope.**

This regulation is applicable to all insurance policies and subscriber contracts issued or provided by an insurance company or nonprofit service corporation on a group or group-type basis covering persons as employees of employers or as member of unions or association.

### **Section 4. Definition.**

The term “group-type basis” means a benefit plan other than “salary budget” plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

- (A) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.
- (B) The coverage is not available to the general public and can be obtained and maintained only because of the covered person’s membership in or connection with the particular organization or group.
- (C) There are arrangements for bulk payments of premiums or subscription charges to the insurer or nonprofit service corporation.
- (D) There is sponsorship of the plan by the employer, union, or association.

### **Section 5. Effective Date of Discontinuance for Non-Payment of Premium or Subscription Charges.**

- (A) If a policy or contract subject to these rules and regulations provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.
- (B) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period, such as by continuing in force beyond the end of the grace period, such as by continuing to recognize claims subsequently incurred, the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policy holder or other entity responsible for making payment or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled workday after the date upon which the notice is delivered.

### **Section 6. Requirements for Notice of Discontinuance.**

- (A) Any notice of discontinuance so given by the carrier shall include a request to the group policyholder or other entity involved to notify employees covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise, in an instance in which the plan involves employee contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.
- (B) The carrier shall prepare and furnish to the policyholder or other entity at the same time a supply of notice forms to be distributed to the employees or members concerned, indicating such discontinuance and the effected date thereof, and urging the employees or members to refer to their certificates or contracts in order to determine what right, if any, are available to them upon such discontinuance.

### **Section 7. Extension of Benefits.**

- (A) Every group policy or other contract subject to these rules and regulations hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract, as required by the following Subsections of this Section
- (B) In the case of a group life plan that contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability), the discontinuance of the group policy shall not operate to terminate such extension.
- (C) In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy

during a disability shall have no effect on benefits payable for that disability or confinement.

- (D) In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered “reasonable” if it provides an extension of at least 12 months under “major medical” and “comprehensive medical” type coverages, and under other types of hospital or medical expense coverages providing either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event which occurred while coverage was in force (e.g., an accident).
- (E) Any applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the policy or contract’s regular benefit limits.

### **Section 8. Continuance of Coverage in Situations Involving Replacement of One Carrier by Another**

- (A) This Section shall indicate the carrier responsible for liability in those instances in which one carrier’s contract replaces a plan of similar benefits of another.
- (B) {Liability of prior carrier.} The prior carrier remains liable only to the extent of its accrued liabilities and extension of benefits. The position of the prior or other entity secures replacement coverage from a new carrier, self-insures, or forgoes the provision of coverage.
- (C) {Liability of succeeding carrier.}
  - 1) Each person who is eligible for coverage in accordance with the succeeding carrier’s plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier’s plan of benefits
  - 2) Each person not covered under the succeeding carrier’s plan of benefits in accordance with paragraph (1) above must nevertheless be covered by the succeeding carrier accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding carrier’s plan. Any reference to the individual carrier’s coverage becomes effective.
    - a) The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier’s plan reduced by any benefits payable by the prior plan
    - b) Coverage must be provided by the succeeding barrier until at least the earliest of the following dates:
      - I. the date the individual becomes eligible under the succeeding carriers plan as described in paragraph (1) above;

- II. for each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage (such as at termination of employment or ceasing to be an eligible dependent);
- III. in the case of an individual who is totally disabled, and in the case of a type of coverage for which Section 6 requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by Section 6, or if the prior carrier's policy or contract is not subject to that Section, would have been required of that carrier had its policy or contract been subject to Section 6 at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.
- 3) In the case of preexisting conditions limitations included in the succeeding carrier plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this paragraph during the period of this time limitation applies under the new plan shall be the lesser of:
- a) The benefits of the new plan determined without application of the preexisting conditions limitation, or
  - b) The benefits of the prior plan.
- 4) The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the ninety (90) days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.
- 5) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of Section 7, benefits, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination shall be made as if coverage has not been replaced by the succeeding carrier.

**Section 9. {Severability Clause.}**

**Section 10. {Repealer Clause.}**

**Section 11. {Effective Date.}**

These rules and regulations shall take effect on (insert a date at least 120 days after promulgation).

*Approved by the Health and Human Services Task Force in 1993.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

SUNSHINE VIEW

## Health Care Choice Act for States

### *Model Legislation*

A. The **{insert state legislative body}** recognizes the need for individuals, employers, and other purchasers of health insurance coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. Therefore, the **{insert state legislative body}** seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in selected states to issue accident and sickness policies in **{insert state}**.

B. The selected out-of-state insurers shall not be required to offer or provide state-mandated health benefits required by **{insert state}** law or regulations in health insurance policies sold to **{insert state}** residents.

C. Each written application for participation in an out-of-state health benefit plan shall contain the following language in boldface type at the beginning of the document:

1. “This policy is primarily governed by the laws of **{insert state where the master policy is filed}**; therefore, all of the rating laws applicable to policies filed in this state do not apply to this policy, which may result in increases in your premium at renewal that would not be permissible in a **{insert state}**-approved policy. Any purchase of individual health insurance should be considered carefully since future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a **{insert state}**-approved policy, please consult your insurance agent or the **{insert state Department of Insurance or similar agency}**.”

D. Each out-of-state health benefit plan shall contain the following language in boldface type at the beginning of the document:

1. “The benefits of this policy providing your coverage are governed primarily by the laws of a state other than **{insert state}**. While this health benefit plan may provide you a more affordable health insurance policy, it may also provide fewer health benefits than those normally included as state mandated health benefits in policies in **{insert state}**. Please consult your insurance agent to determine which state-mandated health benefits are excluded under this policy.”

E. The **{insert title of state insurance commissioner}** shall be authorized to conduct market conduct and solvency examinations of all out-of-state companies seeking to offer health benefit plans in this state or who have been given approval to offer health benefit plans in this state. Such examinations shall be conducted in the same manner and under the same terms and conditions as for companies located in this state.



F. The **{insert title of state insurance commissioner}** shall adopt rules and regulations necessary to implement this chapter, including, but not limited to, determining which health insurance companies located in other states shall be authorized to offer plans to **{insert state}** residents and determining the manner of approving the health benefit plans offered by such companies.

*Approved by the Health and Human Services Task Force on July 27, 2007.*

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VIEW

## **The Health Insurance Reform Act for Individual Coverage**

### *Summary*

The purpose of this Act is to reform the individual health insurance market and, therefore, make individual and family medical insurance more available to people without group coverage. The bill accomplishes this by establishing predictable rate regulation standards for over-regulated state markets. Such regulatory reform encourages insurers to re-enter the individual insurance market with competitive pricing to reach portions of the uninsured population.

ALEC's bill would allow an insurer to guarantee the payment of a certain percentage of its premium income in benefits to policy holders. This percentage would be negotiated with state regulators. If total payout on claims at the end of a year fall short of the guaranteed percentage, policyholders would be refunded the difference. If payout exceeded the guarantee, the insurer would lose the difference, but could adjust its rates to avoid future losses and guard against insolvency. Refunds of less than \$10.00 would be aggregated by the insurer and paid to the State Insurance Department. Refunds above \$10.00 would be sent directly to the policy holders.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Health Insurance Reform Act for Individual Coverage**.

**Section 2.** The legislature finds that there is a shortage of affordable major medical insurance for individuals and their dependents not covered by group insurance plans. The legislature further finds that there is a proper and necessary role for the State Insurance Department to continue, under its current authorization, in the regulation of individual health insurance rates and in the monitoring of the solvency of health insurance companies doing business in this state.

The legislature further finds that, for a competitive market for affordable individual health insurance to develop, it is necessary that rates be regulated according to predictable and clear objective standards. Therefore, it is the intent of the legislature to encourage an increase in supply and competition in the individual health insurance market by establishing more predictable standards for rate regulations.

**Section 3.** Rates on a particular individual health insurance policy form shall be deemed reasonable in relation to the premium and shall be deemed approved upon filing with the

Commissioner which meets the requirements of this Act. Benefits shall continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer of the insurer, and must contain at least the following:

(A) A recitation of the anticipated loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(B) A guarantee that the actual loss ratios in the state for the experience period in which the new rates take effect and for each experience period thereafter until new rates are filed shall meet or exceed the loss ratio standards referred to in subparagraph (A) above. If the annual earned premium volume in this State under the particular policy form is less than \$1,000,000 and therefore not actuarially credible, the loss ratio guarantee shall be based on the actual nationwide loss ratio for the policy form. If the aggregate earned premium for all states is less than \$1,000,000, the experience period shall be extended until the end of the calendar year in which \$1,000,000 earned premium is attained;

(C) A guarantee that the actual loss ratio results for the state (or national results, if applicable) for the experience period at issue shall be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Commissioner not later than June 30 following the date for filing the applicable Accident and Health Policy Experience Exhibit.

(D) A guarantee that if the actual loss ratio during an experience period is less than the anticipated loss ratio for that period, then policyholders in this state shall receive a proportional refund based on premium earned. The total amount of the refund will be calculated by multiplying the anticipated loss ratio by the applicable earned premium during the experience period and subtracting from that result the actual incurred claims during the experience period. If nationwide loss ratios are used, then the total amount refunded in this state shall equal the total refund, as calculated above, multiplied by the total earned premium during the experience period from all policyholders in this state who are eligible for refunds and divided by the total earned premium during that period in all states on the policy form.

The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal \$10.00 or more. The refund will include interest, at the then-current accident and health reserve interest rate established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment.

Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due.

(E) A guarantee that refunds of less than \$10.00 will be aggregated by the insurer and paid to the Insurance Department of this state.

(F) As used herein, the term "loss ratio" means the ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.

(G) As used herein, the term "experience period" means, for any given rate filing for which a loss ratio guarantee is made, the period beginning on the first day of the calendar year during which the rates first take effect and ending on the last day of the calendar year during which the insurer earns \$1,000,00 in premium on the form in question in this state or, if the annual premium earned on the form in this state is less than \$1,000,000, nationally. Successive experience periods shall be similarly determined beginning on the first day following the end of the preceding experience period.

(H) As used herein, the term "claims" means only those amounts paid, or to be paid, to satisfy policy benefits.

**Section 4. {Severability clause.}**

**Section 5. {Repealer clause.}**

**Section 6. {Effective date.}**

*Approved by the Health and Human Services Task Force in 1991, March 2002.*

## **Health Insurance Reform Act for Small Business Coverage**

### *Summary*

The purpose of this Act is to reform the small group health insurance market so as to ensure small employers' access to health insurance at more predictable and affordable rates. Currently, over 50 percent of the working, uninsured are employed by firms with fewer than 25 people. ALEC's proposal contains three critical components necessary to reform the small group insurance market. This legislation would make small group insurance portable, renewable, and affordable.

Portability guarantees that, once employees have entered the health insurance system, they cannot be canceled even if employment is changed. This means that employees would be guaranteed the right to convert to a permanent individual health insurance plan if they leave their place of employment. Renewability guarantees that no small group could be singled out for termination due to health, claim costs, or length of coverage. Furthermore, it guarantees that no small group could be singled out for abusive rate increases for high claim costs. This safeguards against the negating of coverage due to health conditions, a problematic occurrence in the small group market. Lastly, this bill achieves affordability by eliminating expensive mandated benefits and enforcing stable rate increases. By enforcing stable rates, the model would discourage practices known as "low balling" and "tier rating." These practices involve charging extremely low rates to new groups attract new customers and then giving large rate increases in the second or subsequent years.

ALEC's small group act does not contain community rating or guaranteed issue provisions, two measures which are often included in small group insurance reform. Guaranteed issue requires private carriers to sell coverage to anyone at anytime, regardless of their health status. Community rating requires private carriers to charge everyone identical premium rates. Under this approach, about 75 to 90 percent of the insured population will pay more so that 10 to 25 percent can pay less. The Health Insurance Reform Act for Small Business Coverage excludes both provisions.

### *Model Legislation*

{Title, enacting clause, etc.}

**Section 1.** This Act may be cited as the **Health Insurance Reform Act for Small Business Coverage**.

**Section 2. {Definitions.}** As used in this Act:

(A) The term "insurer" means an entity subject to the laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or healthcare services.

An insurance company, insurance service, or insurance organization, including a health maintenance organization, which is licensed in the business of insurance in this state and which is subject to state law which regulates insurance.

(B) The terms "small employer" and "employer" mean a business that, during the most recent calendar year, employed at least 2 and not more than 50 employees who are eligible for coverage under a health benefit plan on at least 50 percent of that business' working days.

(C) The term "employee welfare benefit plan" has the same meaning as that term is given by the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.).

(D) The terms "health benefit plan" and "plan" mean any employee welfare benefit plan that is issued by an insurer and that provides medical, surgical, or hospital care or benefits to employees of a small employer and their dependents. The terms shall exclude any individual major medical policy that is renewable at the option of the insured except for reasons set forth in paragraphs 3(A) or 3(C) of this Act or if the insurer non-renews all policies issued on the same policy form in this state. These terms also exclude any policy of group insurance that is not designed, administered, or marketed as a health benefit plan to be provided by an employer for its employees.

(E) The term "similar plans" means plans that do not materially differ from one another in any of the following respects:

- (1) the set of services covered;
- (2) utilization management provisions;
- (3) managed care network provisions;
- (4) the criteria used by the insurer in underwriting coverage under a plan where variations in such criteria may reasonably be expected to produce substantial variation in the claims costs incurred under the plan.

(F) The term "case characteristics" means demographic and other relevant characteristics as determined by the insurer that are considered by the insurer in the determination of premium rates for a small employer but excluding:

- (1) claims experience;



- (2) health status; and
- (3) duration of coverage since date of issue.

**Section 3. {Non-renewal.}**

(A) No insurer providing coverage under a small employer health benefit plan shall fail to renew such plan except for any of the following reasons:

- (1) nonpayment of required premium;
- (2) fraud or misrepresentation on the part of the plan sponsor;
- (3) noncompliance with provisions of the plan including provisions regarding minimum numbers of or percentages of insured employees;
- (4) non-renewal upon 180 days written notice with respect to all small employers in the state;
- (5) movement outside the service area;
- (6) membership of an employer in a bona fide association ceases where health insurance coverage is made exclusively in the state through one or more bona fide associations.

(B) An insurer that exercises its right of non-renewal as provided in paragraph 2(a)(4) may not accept any new small employer business for a period of five years beginning on the date of the discontinuance of the last insurance coverage not so renewed;

**Section 4. {Experience Rating.}**

(A) The premium rate charged in connection with a small employer health benefit plan shall be the same for all small employers with similar case characteristics covered under similar plans. Notwithstanding the foregoing, an insurer may adjust the premium charged to an employer in connection with the plan based upon that employer's claims experience, the health of persons covered under the plan, and the duration of coverage since the date of issue, provided that the total premium shall not exceed two times the lowest premium charged to an employer with similar case characteristics.

(B) Subject to the limitations set forth in paragraph 4(A), the percentage increase in the premium rate charged to a small employer may not exceed the sum of:

- (1) the percentage change in the new business premium rate for employers with similar case characteristics as measured between the first day of the calendar year in which the new rates take effect and the first day of the prior calendar year; plus

(2) an adjustment not to exceed 15 percent annually based on claims experience, health status, or duration of coverage; plus

(3) any adjustment due to changes in the coverage provided or changes in the case characteristics of the employer.

**Section 5. {No Excluded Occupations.}**

No insurer may refuse to offer coverage under a health benefit plan to employees of a small employer based solely on the nature of the employer's business. An insurer may charge an additional premium based on the nature of the employer's business, but the total premium may not exceed 150 percent of the lowest premium that would be charged to that employer under Section 4 of this Act without regard to the nature of the employer's business.

**Section 6. {No Mandated Benefits.}**

No statute or regulation that mandates the provision of specified health insurance benefits or that prohibits or limits the use of managed care shall be construed to apply to any small employer health benefit plan or any conversion policy provided in accordance with Section 5 of this Act.

**Section 7. {Conversion Privilege.}**

(A) Any person who has been continuously covered for at least 90 days under a small employer health benefit plan and who thereafter loses such coverage by reason of any of the following:

- (1) termination of employment;
- (2) reduction of hours;
- (3) divorce;
- (4) attainment of any age specified in the plan;
- (5) expiration of any continuation of coverage available as required by state or federal law;
- (6) cancellation of the plan by the employer or non-renewal thereof due to failure to pay required premium unless within 31 days thereafter the employer provides coverage to any employee under any employee welfare benefit plan which provides medical, surgical, or hospital care or benefits; or
- (7) non-renewal of the plan as set forth in paragraph 3(a)(4) of this Act; shall upon written request to the insurer, be entitled to receive an individual conversion policy. Such

request shall be made within 31 days of loss of coverage. The premium for any given period shall not exceed 135 percent of the rate that would have been charged with respect to that person had the person been covered as an employee under the plan during the same period. When the plan under which such person was covered has been canceled or not renewed, the rates shall be based on the rate that would have been charged to such person had the plan continued in force as determined by the insurer in accordance with standard actuarial principles.

(B) Benefits provided under such conversion policy shall not be less than the benefits provided under the plan. The insurer may apply any benefits paid under the plan against the benefits limits of the conversion policy provided that if it does so, it shall also credit the insured with any waiting period, deductible, and coinsurance to the extent credited under the plan.

### **Section 8 {Prohibiting Discrimination.}**

A health benefit plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health-status related factors in relation to the individual or a dependent of the individual:

- (A) health status;
- (B) physical or mental medical condition;
- (C) claims experience;
- (D) receipt of health care;
- (E) medical history;
- (F) genetic information;
- (G) evidence of insurability;
- (H) disability.

Nothing herein shall require a health benefit plan to provide particular benefits other than those provided under the terms of such plan or coverage or to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

### **Section 9. {Severability Clause.}**

### **Section 10. {Repealer Clause.}**

### **Section 11. {Effective Date.}**

*(This legislation should be accompanied by the Group Coverage Discontinuance and Replacement Model Regulation [page 102].)*

*Approved by the Health and Human Services Task Force in 1991, amended in 2002.*

Obtained and released by:  
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SUMMERVIEW

## Independent External Review for Health Benefit Plans Act

### *Model Legislation*

{Title, enacting clause, etc.}

#### Section I. Title

This Act may be cited as the Independent External Review for Health Benefit Plans Act

#### Section II. Definitions:

(A) “Enrollee” means an individual covered under a health benefit plan. In the case of a minor child, the term includes the parent or legal guardian of the child, and in the case of an incapacitated or partially incapacitated person, the legal guardian of the person.

(B.1.) “Health benefit plan” means individual or group hospital or medical insurance coverage plan, a not for profit hospital or medical service, a prepaid health plan, a health maintenance organization, or preferred provider plan that requires utilization review. A health benefit plan shall not include indemnity health insurance policies, including those using a contract or provider network, so long as the policy does not require certification for appropriateness of care, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, specified disease, hospital indemnity confinement, limited benefit health insurance, worker’s compensation or similar insurance, or automobile medical payment insurance.

#### ***Or Alternative definition of “health benefit plan:”***

(B.2.) Health benefit plan” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer which:

(1) either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with or employed by the health insurance issuer; and

(2) requires utilization review.

A health benefit plan shall not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a

supplement to liability insurance, specified disease, hospital indemnity confinement, limited benefit health insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

(C) "Independent external review" means a review by an independent external review entity of a decision by a health benefit plan to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit.

(D) "Independent external review entity" means an individual or an organization certified by the {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency} to conduct external reviews.

(E) "Internal review" means procedures established by the health benefit plan for an internal reevaluation of an initial decision to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit and a determination by the health benefit plan to grant or deny coverage or reimbursement.

(F) "Expert reviewer" means an individual employed by or under contract with the independent external review entity to conduct independent external review.

### **Section III. Request for Independent External Review**

(A) An enrollee shall have the right to request an independent external review to examine the health benefit plan's coverage decision if the enrollee meets the following criteria:

- (1) The enrollee has been denied coverage based on a determination that the service or treatment which would otherwise be a covered benefit does not meet the definition of "medical necessity" set forth in the enrollee's evidence of coverage and the service or treatment is not considered experimental or investigational;
- (2) The enrollee is a member of the health benefit plan in good standing or is otherwise eligible to receive covered benefits under the health benefit plan;
- (3) The enrollee has exhausted the internal review, if any, except that the health benefit plan and the enrollee may jointly agree to waive this requirement; and
- (4) The cost of the service or treatment for the coverage at issue would require the health benefit plan to incur {insert amount, i.e. \$1,000 or \$2,500} or more expenditure to cover such treatment or service.  
{Drafting note: This paragraph is optional, and the threshold should be determined by each state. This may be waived in the case of life threatening situations.}

(B) A health care provider shall have the right to request an external review on behalf of an enrollee if:

- (1) The enrollee provides the health care provider with a written authorization that



specifies the service or treatment that is the subject of the independent external review;

(2) The enrollee provides the health benefit plan with a written authorization to release the enrollee's medical records to the independent external review entity;

(3) The health care provider delivers to the health benefit plan a copy of the enrollee's written authorization concurrently with the request for review.

(C) The health benefit plan shall have written policies describing the independent external review process. The health benefit plan shall disclose the availability of the independent external review process and how enrollees may access the process in the health benefit plan's evidence of coverage or other disclosure forms.  
{Drafting note: Section III (C) is optional.}

#### **Section IV. Independent External Review Process**

(A) The health benefit plan shall notify eligible enrollees in writing of the opportunity to request the independent external review at the time of the final internal review decision to deny coverage. The enrollee may file a request for independent external review with the health benefit plan no later than sixty (60) calendar days after receiving such notification.

(B) The enrollee shall pay a one-time fee of {insert amount e.g. one hundred dollars (\$100)} toward the cost of the independent external review, payable at the time of the request. In the case of a hardship where conditions which are terminal or in the case of an employed person who no longer meet the definition of actively at work, the fee shall be waived. Whenever the expert reviewer finds in favor of the enrollee fee shall be refunded.

(C) The health benefit plan shall be responsible for the remaining costs incurred by the independent external review entity.

(D) The health benefit plan shall contract with only those independent external review entities certified for inclusion on the list maintained by the {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency}.

(E) The health benefit plan shall provide to the independent external review entity a copy of the following documents within five (5) business days of the health benefit plan's receipt of a request for an independent external review:

{Drafting note: The duration can be extended for more than five business days if necessary. In the case of emergencies and life-threatening conditions, an expedited review may be necessary prior to and after the filing date of an independent external review. This may include certification by the doctor of the emergency, with information exchanges to be completed within 24 to 48 hours via facsimile, e-mail, or overnight communication, and the decision should be made within a reasonable number of hours.}

(1) Any information that was submitted to the health benefit plan by or on behalf of the enrollee in support of the enrollee's request for coverage; and

(2) A copy of the contract or evidence of coverage provisions upon which denial of coverage was based, any other relevant documents used by the health benefit plan in determining whether the proposed service or treatment is a covered benefit, and any statement by the health benefit plan explaining the reason for the health benefit plan's decision to deny coverage for the service or treatment.

(F) The independent external review entity shall notify the enrollee and the enrollee's physician of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under paragraph E of this section. The health benefit plan shall be notified of this request. The enrollee and the enrollee's physician shall submit the additional information, or an explanation of why the additional information is not being submitted, to the independent review entity and the health benefit plan within five (5) business days of the receipt of such a request. The health benefit plan may, at its discretion, determine that the additional information provided by the enrollee or the enrollee's physician justifies a reconsideration of its coverage denial. A subsequent decision by the health benefit plan to provide coverage shall terminate the independent external review upon notification to the independent review entity.

(G) The independent external review entity shall submit the expert reviewer's determinations to the health benefit plan and the enrollee within thirty (30) business days of receipt of the request for review, except that for life-threatening conditions, as determined by the enrollee's physician, the determinations shall be submitted within {insert timeframe, i.e. 72 hours or seven (7) days} of the receipt of the request for review. At the request of the expert reviewer, the deadline shall be extended by up to five (5) business days for the consideration of additional information requested under paragraph (E) of this section.

{Drafting note: the deadline of five business days may be extended}

(1) The expert reviewer's determination shall be in writing and shall state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage.

(2) The expert reviewer's shall make determinations based on the applicable coverage documents, including any defined terms, and shall not expand the contractually agreed upon coverage.

(3) The expert reviewer's determination shall specifically cite the relevant provisions in the evidence of coverage, the enrollee's specific medical condition, and the relevant documents pursuant to paragraph (D) of this section, to support the expert reviewer's decision.

(H) Coverage for the services required under this section shall be provided subject to the

terms and conditions generally applicable to benefits under the evidence of coverage under the health benefit plan. Nothing in this subdivision shall be construed to require the health benefit plan to pay for the services of a non-contracting physician, that are not otherwise covered pursuant to the evidence of coverage under the health benefit plan. {Drafting note: Language may be added that would allow payment of out-of network services providers if the network provider refused to perform a service that a patient paid for out of their own pocket, but which was later determined should have been covered. }

## **Section V. Qualifications of the Independent External Review Entity**

(A) The {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency} shall certify and maintain a list of certified independent external review entities.

(B) The independent external review entities shall meet the following requirements for certification:

(1) Independent external review entities shall employ or contract with expert reviewers who meet the following requirements to conduct independent external reviews:

(a) Expert reviewers shall be physicians or other appropriate providers who are expert in the treatment of the enrollee's medical condition, and knowledgeable about the recommended service or treatment;

(b) Expert reviewers shall hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical board in the area(s) appropriate to the subject of review; and

(c) Expert reviewers shall have no history of disciplinary actions or sanctions (including, but not limited to loss of staff privileges or participation restriction) taken or pending by any hospital, government or regulatory body.

{Drafting note: For the expert's history of disciplinary actions or sanctions, refer to the state's medical records and/or the National Provider Databank. }

(2) The independent external review entity shall not be a subsidiary of, nor in any way owned or controlled by, a health benefit plan, a trade association of health benefit plans, a health care provider or a professional association of health care providers.

(3) Neither the expert reviewer, nor the independent external review entity, shall have any material professional, familial, or financial conflict of interest with any of the following:

(a) The health benefit plan whose coverage decision is the subject of the independent external review;

- (b) Any officer, director, or management employee of the health benefit plan;
- (c) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment;
- (d) The institution at which the service or treatment would be or was provided;
- (e) The developer or manufacturer of the drug, device, procedure, or other therapy proposed or used for the enrollee whose treatment is under review; and
- (f) The enrollee or the enrollee's guardians or representatives.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical research center, provides health services to health benefit plan enrollees, except as subject to the requirement of paragraph (3)(d) of this section; affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting provider of the health benefit plan.

(5) Any independent review entity that has received accreditation by a national recognized private accrediting entity, with established and maintained standards shall be deemed to meet the requirements of this section.

#### **Section VI. Quality Assurance of Independent External Review**

The independent review entity shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the expert reviewers, and the confidentiality of medical records and review materials.

#### **Section VII. Outcome of Independent External Review**

(A) The determination of the independent external review entity is binding on the health benefit plan and the enrollee. In this Act, binding shall mean that access to the independent external review process by the health benefit plan or enrollee shall be limited to one independent external review for each denial of coverage.

(B) A decision of the independent external review entity in favor of the enrollee shall be final and binding on the health benefit plan. The health benefit plan shall provide appropriate coverage according to the decision without delay and shall be immune from liability for abiding by such decision.

(C) A determination by the independent external review entity in favor of a health benefit plan shall create a rebuttable presumption in any subsequent legal action that the health benefit plan's prior determination was appropriate.

(D) Nothing in this Act shall render the health benefit plan liable for monetary damages

arising from any act or omission of the independent external review entity.

(E) An independent external review entity and an expert reviewer assigned by the entity to conduct a review under this Act is not liable for damages arising from the determinations made pursuant to this Act. This paragraph does not apply to an act or omission of the independent review entity that is made in bad faith or that involves gross negligence.

### **Section VIII. Annual Independent External Review Entity Reporting Requirements**

(A) The independent external review entity shall report to the {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency} and to the state legislature the following information on an annual basis:

- (1) the number of independent review decisions in favor of enrollees;
- (2) the number of independent review decisions in favor of health carriers;
- (3) the average turnaround time for an independent review decision;
- (4) the number of cases in which the independent review entity did not reach a decision in the time frame specified in statute or regulation and reasons for delay;
- (5) the number of resolutions reached prior to an independent external review.

**Section IX. {Severability Clause.}**

**Section X. {Repealer Clause}**

**Section XI. {Effective Date.}**

*The Health and Human Services Task Force passed this bill at its August 12, 1999 meeting.*

## **Renewability of Individual Health Insurance Act**

### ***Summary***

The purpose of this Act is to reform the individual health insurance market to prevent insurance companies from canceling individual policies due to illness or high-risk health conditions once they have been under-written.

### ***Model Legislation***

#### **Section 1. {Definitions}**

(A) The term "insurer" means any entity which provides health insurance in this state.

(B) The term "individual health benefit plan" means any plan which is insured by an insurer and which provides medical, surgical, or hospital care or benefits to a resident of this state. The term does not include non-renewable plans with a duration of 6 months or less, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or employee welfare benefit plans.

#### **Section 2. {Non-renewal}**

(A) No insurer providing coverage under an individual health benefit plan shall non-renew such plan except for the following reasons:

- (1). Nonpayment of required premium;
- (2). Fraud or misrepresentation on the part of the individual;
- (3). Non-compliance with provisions of the plan;
- (4). Non-renewal upon ninety (90) days written notice with respect to all persons insured under a particular individual health plan in the state.

(B) An insurer that exercises its right on non-renewal as provided in paragraph 2A.4. may not accept any new individual health business for a period of five (5) years, after it provides notice of such non-renewal.

#### **Section 3. {Severability Clause.}**



**Section 4. {Repealer Clause.}**

**Section 5. {Effective Date.}**

*Approved by the health and Human Services Task Force in 1995.*

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## Resolution on Expanding Access to Health Insurance

**WHEREAS, {insert state legislative body here}** finds that access to health insurance is important to its citizens; and

**WHEREAS, {insert state legislative body here}** finds that the citizens of **{insert state here}** should be able to choose from a wide variety of plans that ensure health insurance is affordable; and

**WHEREAS, {insert state legislative body here}** finds that many citizens of **{insert state here}** either do not have access to health insurance or can not afford to purchase it; and

**WHEREAS, {insert state legislative body here}** finds that state legislators can have a profound impact on the affordability, accessibility, and availability of health insurance; and

**WHEREAS, {insert state legislative body here}** finds that a free market in health insurance:

- Provides consumers with a broad range of affordable health insurance options,
- Promotes competition,
- Keeps health insurance premium rates low, and
- Helps the uninsured get and keep health insurance; and

**WHEREAS, {insert state legislative body here}** finds that legislators can help consumers find affordable health insurance by promoting free-market solutions, including:

- Health savings accounts which have helped millions of the uninsured find an affordable health insurance product,
- Small group premium subsidies which help very small businesses provide insurance to employees,
- List billing which allows employees to purchase individual health insurance through payroll deductions,
- Underwriting which allows health insurers to price risks appropriately,

- High risk pools which provide access to insurance for individuals with chronic conditions,
- Mandate-lite health insurance which provides consumers with an affordable health insurance option,
- Plan design freedom which allows health insurers to design plans that meet consumer needs like limited benefit plans or innovative plan designs,
- Tax deductions which can help make insurance more affordable, and
- Health insurance vouchers which allow the working poor to choose their own benefit plans rather than a government-designed, one-size-fits-all approach; and

**WHEREAS, {insert state legislative body here}** finds that many states have increased health insurance costs by instituting policies that harm consumers, including:

- Requiring health insurers to include numerous expensive mandated benefits in policies sold to consumers,
- Instituting price controls like community rating which raise overall health insurance rates for everyone,
- Limiting consumer options in the individual market by limiting the ability of health insurers to design health insurance plans, and
- Requiring health insurance companies in the individual market to accept all applicants which raises health insurance costs; and

**WHEREAS, {insert state legislative body here}** finds that many well-intentioned reforms have actually harmed consumers in several ways, including:

- Contributing to health insurance premiums that are unaffordable to many Americans,
- Eliminating consumer choice, and
- Increasing the number of citizens who are uninsured.

**THEREFORE BE IT RESOLVED THAT {insert state legislative body here}** finds free-market-based solutions, unfettered by burdensome government regulation, are the best way to provide consumers with access to innovative and affordable health insurance options, which both reduce the number of the uninsured and alleviate the dependence of our most vulnerable members of society on one-size-fits-all, government-subsidized health care programs.

*Approved by the Health and Human Services Task Force on December 9, 2006.*

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## **Resolution on Federal Health Insurance Reform Legislation**

### *Summary*

This Resolution helps prevent Congress from passing federal legislation that would impose restrictions such as guaranteed issue and community rating, or give the Secretary of Health and Human Services unnecessary authority over state health reform programs, clearly violating the states' own rights to regulate their own health programs.

### *Model Resolution*

**WHEREAS**, the states have been at the forefront of the health reform debate by aggressively leading the charge to make health care coverage portable and renewable to citizens, and

**WHEREAS**, the states have discovered that reforms such as guaranteed issue and community rating do not result in universal coverage but instead drive up the cost of health insurance and drive healthy people out of the insurance market, and

**WHEREAS**, the U. S. Congress is considering legislation which would impose restrictions such as guaranteed issue on states and give the U.S. Secretary of Health and Human Services authority over state health reform programs, power which would clearly interfere with the states' historical ability to regulate their own health insurance programs.

**NOW THEREFORE BE IT RESOLVED**, that the legislature of the state of [State] urges Congress not to institute federal review, oversight, or preemption of state health insurance laws nor to impose guaranteed issue in the individual and group health insurance plans, and

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S. House of Representatives.

*Approved by the Health and Human Services Task Force in 1996.*

## Resolution on Stop-Loss Insurance

### *Summary*

This Resolution encourages state legislators not to support legislation or regulation which would impose arbitrary limits on stop-loss coverages issued to self-funded plans. By guarding against such legislation, the preservation of a free-market, voluntary employer-based health benefit system is maintained.

### *Model Resolution*

**WHEREAS**, one of five, or 51 million Americans, are enrolled in self-funded health benefit plans, and

**WHEREAS**, three of four self-funded employers purchase stop-loss coverage for their health benefit plans, and these plans protect consumers by paying in excess of \$100 billion in health benefits to employees and their families, and

**WHEREAS**, one of three small business establishments with fewer than 100 employees self-fund their health benefit plans, which are covered under the Employee Retirement Income Security Act (ERISA), and

**WHEREAS**, impairment of a free-market, voluntary employer-based health benefit system would potentially result in higher benefit plan costs for employers and higher costs and reduced coverage for employees and their families, and

**NOW THEREFORE BE IT RESOLVED**, that the American Legislative Exchange Council (ALEC) encourages state legislators not to support state legislation or regulations that would hurt employees and their families by imposing arbitrary limits on stop-loss coverages issued to self-funded plans, and

**BE IT FURTHER RESOLVED**, that ALEC believes in the preservation of a free-market, voluntary employer-based health benefit system in which employers prudently choose to self-fund health benefits for their employees and their families at financially viable risk retention levels.

*Approved by the Health and Human Services Task Force in 1996.*



## The Small Business Health Care Act

### *Model Legislation*

(Title, Enacting clause, etc.)

**Section 1.** The legislature finds that the rising cost of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees. The legislature further finds that the policy of mandating health care benefits has had an adverse impact on the cost of such coverage. It is therefore the intent of the legislature to reduce costs by authorizing the development of basic hospital and medical coverage for small groups.

### **Section 2.**

(A) A basic group disability insurance policy may be offered to employers of fewer than one hundred employees. Such a basic group disability policy shall provide coverage for hospital expenses and services rendered by a physician licensed by this State, but is not subject to the requirements of {INSERT ALL MANDATED BENEFIT STATUTES}.

(B) Nothing in this Section shall prohibit an insurer from offering, or a purchaser from seeking, benefits in excess of the basic coverage authorized herein. Nothing in this Section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(C) All forms, policies, and contracts shall be submitted for approval to the Insurance Commissioner, and the rates of any plan offered under this Section shall be reasonable in relation to the benefits thereto.

**Section 3. (Severability Clause.)**

**Section 4. (Repealer Clause.)**

**Section 5. (Effective Date.)**

*Approved by the Health and Human Services Task Force in 1993.*

## Children's Health Insurance Program Act

### *Model Legislation*

#### [STATE] CHILDREN'S HEALTH INSURANCE PROGRAM ACT

**Section 1.** This Act may be cited as the [State] Children's Health Insurance Program.

**Section 2. Purpose.** The purpose of this Act is to create a State Health Insurance Program eligible for Payment under Section 2105 of the Social Security Act (43 U.S.C.). The program will expand the health insurance options of targeted low-income children through the service of private health insurers meeting the requirement of Section 5 and 7 of this Act that contract with the department to provide targeted low-income children with health insurance coverage.

**Section 3. Definitions.** As used in this Act:

- A. "Child" means a natural person less than 19 years of age who is a resident of this state.
- B. "Creditable health coverage" has the meaning given the term "creditable coverage" under section 2701 c) of the Public Health Service Act (42 U.S.C 300gg c) and includes coverage that meets the requirements of section 2103 of the Social Security Act (42 U.S.C.) provided to a targeted low-income child under this Act or under a waiver approved under section 2105 c) 2) B) of the Social Security Act (42 U.S.C.) (relating to a direct service waiver.)
- C. "Department" means Department of Insurance.
- D. "Group health plan" has the meaning given such term under section 2791 of the Public Health Service Act (42 U.S.C.300gg-91).
- E. "Health Insurance coverage" has the meaning given under section 2791 b) 1) of the Public Health Service Act (42 U.S.C 300gg-91).
- F. "Low Income child" means a child whose family income is below the 200 percent of poverty.
- G. "Participating insurer" means any entity licensed to provide health insurance in this state that as contracted with the Department to offer health insurance coverage to targeted low-income children pursuant to this Act.
- H. "Poverty" has the meaning given such term in section 673 2) of the Community Service Block Grant act (42 U.S.C 9902 2)), including any revision in such section.
- I. "Preexisting condition exclusion" has the meaning given such term in section 2701 b) 1) A) of the Public Health Service Act (42 U.S.C 300gg b) 1) A)).

- J. “Qualified child health plan” means health insurance coverage provided by a participating insurer consistent with Section 7 of this Act.
- K. “State Medical Office” means the [state] office responsible for administrating Title XIX of the United States Code.
- L. “Target low-income child” means a child, except as provided by paragraph 4) of this subscription, who:
- 1) Has been determined eligible by this State under this Act:
    - a) is a low-income child, or
    - b) is a child whose family income exceeds the Medicaid-applicable income level of [state] by not more than 50 percentage points, and
  - 3) is not found to be eligible for Medicaid or covered under a group health plan or under health insurance coverage. (This does not include a health insurance coverage program offered by [state] that receives no federal funds and that has been in operation since before July 1, 1997.).
  - 4) Such term does not include—
    - a) a child who is an inmate of a public institutions or a patient in an institution or a patient in an institution for mental diseases; or
    - b) a child who is a member of a family that is eligible for health benefits coverage under a State employee health benefits plan.

#### Section 4. Program Administration and Financing

- A) The State shall prepare a State Children Health Insurance Program or submission to the Secretary of the U.S Department of Health and Human Services within\_\_ of the date of enactment of this Act.
- B) The Department shall enter into contract with at least two insurers and at least two health maintenance organizations that offer a qualified child health plan.
- C) The State Medicaid office shall be responsible for certifying the eligibility of children for the State Children’s Health Insurance Program. (DRAFTING NOTE: Some sates may have another agency better equipped to certify eligibility.)
- D) Upon notice of enrollment of a targeted low-income while in a qualified child health plan, the Department shall forward the annual negotiated cost of insuring each targeted low-income child to the appropriate participating insurer.
- E) No event shall more than 10 percent of the federal and state funds be used for
- 1) Other children’s health programs for targeted low-income children:
  - 2) initiatives for improving the health of children (including targeted low-income and other low-income children):
  - 3) outreach activities that inform families of children who are likely to be eligible for this program or other public or private health insurance programs, and

- 4) other reasonable costs incurred by the State to administer the program.

### **Section 5. Insurer Provisions.**

- A. To be eligible for the state payment, a participating insurer shall offer a qualified health plan to eligible children without regard to health status and without the imposition of preexisting condition exclusion, except that a preexisting condition exclusion may be applied if the qualified health plan is provided through a group health plan or group health insurance coverage, consistent with the limitations on the imposition of preexisting condition exclusions in connection with such coverage under State and federal law.
- B. Premium and cost-sharing amounts are limited to the following:
  - 1) No deductibles, co-insurance or other cost-sharing is permitted with respect to Benefits for well-baby and well-child care including age-appropriate immunizations.
  - 2) For children whose family income is at or below 150% of poverty:
    - a) Premiums, enrollment fees or similar charges may not exceed the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) of the Social Security Act, (42 U.S.C. 201 et seq.) and
    - b) Deductibles and other cost sharing shall not exceed an amount that is nominally consistent with standards provided under Section 1916(a)(3) of the Social Security Act (42 U.S.C) 301 et. seq.), as adjusted.
  - 3) For children whose family income is more than 150% of poverty, premiums, deductibles, and other cost-sharing may be imposed on a sliding scale related to income, provided that a total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this Act shall not exceed 5% of such family's income for the year involved.
- C. Existing health insurance sales and marketing methods, including the use of agents and payment commissions, shall be utilized to inform families of the availability of the [state] Children's Health Insurance Program and assist them in obtaining coverage for children under the program.

### **Section 6. Eligibility Provisions**

- A. Targeted low-income children shall be eligible for coverage with a participating insurer regardless of health status.
- B. Eligible children shall be allowed to change enrollment between participating insurers upon the annual coverage renewal date, provided the at least six months notice of an election to change enrollment is provided to the participating insurer with which the child is currently enrolled. The notice provision shall be reduced

to 60 days if the child has changed residence to an area outside the geographic service area of the participating area insurer with which the child is currently enrolled.

## **Section 7. Scope of Benefits**

A qualified health plan shall contain benefits consistent with either A) B) or C). However, nothing in this Act shall be construed to prevent a qualified child health from offering a category of benefits that are not specified herein.

- A. Health insurance coverage equivalent to one of the following:
1. the standard Blue Cross/Blue Shield preferred provider option under the Federal employees health benefit plan (5 U.S.C. 8903.1), or
  2. a health benefits coverage plan that is offered and generally available to State employees, or
  3. health insurance coverage offered by health maintenance organizations that has the largest insured commercial, non-Medicaid enrollment of covered lives in the State.
- B. 1) Health insurance coverage that has an aggregate actuarial value at least equivalent to A) 1), 2) or 3) and that includes coverage for the following basic services:
- a) inpatient and outpatient hospital services;
  - b) physicians' surgical and medical services;
  - c) laboratory and x-ray services' and
  - d) well-baby and well-child care, including age-appropriate immunizations.
- 2) Health insurance coverage based in actuarial equivalence for basic services as described in paragraph 1) of this subsection may provide the following additional services if the coverage for such services has an actuarial value of least 75% of the actuarial value of the coverage provided in that category of services in such package:
- a) coverage of prescription drugs;
  - b) mental health services;
  - c) vision services;
  - d) hearing services;
- C. Upon application by this State, any other health insurance coverage that has been approved by the U.S Secretary of Health and Human Services.

**Section 8. {Severability Clause.}**

**Section 9. {Repealer Clause.}**

**Section 10. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1997.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

**SUNSHINE VIEW**



## Medicaid Consumer-Directed Care Act

### *Summary*

The purpose of this Act is to allow consumers to be in charge of directing their own care. In the existing system, disabled Medicaid beneficiaries have very little control over the long term care services they receive. This legislation is designed to provide consumers more independence, flexibility, and choice in determining and arranging their care. It challenges the notion that all Medicaid recipients are incapable of managing their own care effectively and responsibly. The Medicaid Consumer Directed Care Act is designed to provide control to eligible persons so that they might purchase the kind of services that are best for them.

### *Model Legislation*

#### **Section 1. Title.**

The Act may be cited as the Medicaid Consumer Directed Care Act

#### **Section 2. Definitions.**

(A) "Eligible Medicaid beneficiaries" means the following:

- (1) Frail elders (ages 60+) who are receiving 1915(c) Medicaid waiver services;
- (2) Adults with physical disabilities (ages 18-64) who are receiving Medicaid home and community based waiver services;
- (3) Children (ages 3-17) with developmental disabilities who are receiving Medicaid home and community based waiver services; and
- (4) Adults (ages 18-64) with developmental disabilities who are receiving Medicaid home and community based waiver services.

(B) "Eligible services" means care received in the home or in the community by eligible Medicaid beneficiaries that meets the long-term care needs that would otherwise make them at risk for institutional placement.

#### **Section 3.**

The Department of Health and Human Services shall establish within Medicaid this program to allow eligible Medicaid beneficiaries, as defined above, to receive a cash allowance or control of a specific budget so that they might purchase the long term care services of their own choosing.

The Department of Health and Human Services will provide a case manager/consultant to assist the participant. The Department of Health and Human Services will assess the participant's needs and establish the budget.

**Section 4. {Severability Clause.}**

**Section 5. {Repealer Clause.}**

**Section 6. {Effective Date.}**

*Approved by the Health and Human Services Task Force in Summer 2002.*

## **Resolution on Federal Medicaid and Welfare Block Grants**

### *Summary*

A Resolution supporting the adoption of Federal Medicaid and Welfare Block Grants which would transfer both the financial authority and decision making power to the states to operate the programs as they so desire.

### *Model Resolution*

**WHEREAS**, the growth in federal spending of the Medicaid and welfare entitlements are astronomical and spiraling, significantly increasing the federal budget costs, and

**WHEREAS**, this growth will never be controlled unless the states have autonomous management of the programs, free from Federal mandates regarding individual entitlement, eligibility groups, benefits, payment rates, and financing structures to allow most citizens of the states to benefit from the Medicaid and welfare programs, and

**WHEREAS**, the states will be able to design and develop innovative, efficient and productive Medicaid and welfare programs that will meet the needs of the residents within the state of [insert State]'s budget capacity, and

**NOW THEREFORE BE IT RESOLVED**, that the legislature of the state of [insert State] urges Congress to pass federal funds on to States via block grants to be used for public welfare and Medicaid purposes, and

**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S. House of Representatives.

*Approved by the Health and Human Services Task Force in 1996.*

## **Resolution Supporting Private Market Initiatives For Children's Health Insurance Programs**

**WHEREAS**, the U.S Congress passed a provision in the 1997 Budget Agreement allocating \$24 billion over the next five years to the states in order to provide health insurance for low-income, uninsured children: and

**WHEREAS**, the states are required to contribute a Medicaid matching rate, which is estimated will cost the states an additional \$10 over the next five years; and

**WHEREAS**, the states must now determine how best to use the allocated funds, based on the guidelines of the federal legislation, which allows states to either expand existing state Medicaid programs, or to provide coverage through group or individual health plans with a benefits package actuarially reflecting one of the several specified preexisting plans; and

**WHEREAS**, on October 1, 1997 the US Department of Health and Human Services will make said funds available to the states; and

**WHEREAS**, the expansion of Medicaid in an inefficient method of delivering cost-effective, timely health care; and

**WHEREAS**, Medicaid has become one of the most expensive items in many state budgets, in part, as a result of the fraud, abuse and bureaucracy endemic to such large entitlement program; and

**WHEREAS**, private health insurance initiatives have been proven to be significantly less expensive than the operation of state Medicaid programs; and

**WHEREAS**, 24 states are working with private organizations to provide children with private health insurance, and;

**WHEREAS**, in a system where private health insurance is made available, the consumer is able to chose the plan that best suits his/her family needs, both economically and medically,

**THEREFORE BE IT RESOLVED**, that the implementation of children's health insurance programs should allow for families to enroll in private health plans of their choice, such as a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Provider Service Networks (PSN), traditional fee-for-service policies, and Medical Savings Accounts (MSAs).

*Adopted by the Health and Human Services Task Force and approved by the ALEC Board of Directors in 1997.*

SUNSHINE  
Obtained and released by:  
Common Cause and  
The Center for Media and Democracy  
VIEW

## **Resolution Urging congress to Create Private Financing of the Medicare Program**

### *Summary*

The Resolution urges Congress to enact legislation that would amend the Medicare program so as to authorize the use of Private Individual Medical Accounts to assist individuals in saving the resources necessary to pay for their health care needs in retirement.

### *Model Resolution*

**WHEREAS**, it is widely agreed that the Medicare program is in need of major structural changes if it is to remain a viable alternative for the health care needs of future generations; and

**WHEREAS**, in 1996 Medicare expenditures made up twelve percent (12%) of the federal budget, more than double the level in 1975; and

**WHEREAS**, the Congressional Budget Office estimates that at the current rate, by 2006 Medicare will consume eighteen percent (18%) of the federal budget -- more than the United States' education, crime, and defense budgets combined; and

**WHEREAS**, during the lifetime of the next generation, Medicare's income will only cover sixty percent (60%) of its expenditures; and

**WHEREAS**, the existing method of funding Medicare by taking an ever increasing payroll tax out of the paychecks of working Americans to pay for the medical benefits of retired Americans, is a pyramid scheme which cannot be maintained in future years; and

**WHEREAS**, in 1998 there are four workers to pay taxes to support each Medicare beneficiary, by the year 2030 there will only be two workers for each beneficiary; and

**WHEREAS**, in the 1996 Annual Report of Trustees of the Federal Hospital Insurance Trust Fund, the Medicare Trustees predicted that the Medicare program would be depleted by the year 2001.

**NOW THEREFORE BE IT RESOLVED**, that the State/Commonwealth of {Insert State/Commonwealth Name} urges the U.S. Congress to enact legislation amending the Medicare program to allow for the creation of a system of Individual Medical Accounts wherein individuals will build a fund over their working careers that will provide the resources to pay for their health care needs in retirement.



**BE IT FURTHER RESOLVED**, that copies of this resolution will be distributed to all Governors and members of the U.S. Senate and the U.S House of Representatives.

*Approved by the Health and Human Services Task Force in 1996.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

**SUNSHINE VIEW**

## Earned Income Tax Credit for Parents

### *Summary*

This act provides for a refundable tax in the amount of four percent of the taxpayers earned income for one or more dependent child under the age of 18, and additional four percent of the taxpayers earned income if any dependent child is under the age of five at the end of the taxable year, and an additional four percent of the taxpayers earned income of the taxpayer is lawfully married to a dependent spouse. This amount shall not exceed \$12,500.

### *Model Legislation*

**Section 1. {Title.}** This Act may be cited as the Earned Income Tax Credit for Parent Act.

**Section 2.** (A) Section (in appropriate Section) of the Internal Revenue Code is amended by redesignating (insert section) as section (insert) and by inserting after (insert section) the following revenue section: (redesignated section). In the case of an individual there is allowed as a refundable credit an amount equal to the earned income tax credit amount for the taxable year.

(B) For the purpose of this section:

(1) the earned income tax credit amount for the taxable year is an amount equal to the sum of the applicable credit percentages of so much of the taxpayer's earned income as does not exceed \$12,500.

(2) for the purposes of Paragraph (1) the applicable credit percentage is:

(a) Four percent if the taxpayer has one or more dependent child, and

(b) An additional four percent if any dependent child of the taxpayer is under age five at the end of the taxable year; and

(c) An additional four percent if the taxpayer is lawfully married to a qualified dependent spouse.

(C) For the purpose of this Section, the term "qualified dependent child" means any individual:

- (1) who is a dependent (as defined in section 152 of the Internal Revenue Code) of the taxpayer;
- (2) who is a child (as defined in section 151 (c)(3) of the Internal Revenue Code) of the taxpayer; and
- (3) who has not attained the age of 18 at the close of the calendar year in which the taxable year of the taxpayer begins.

Such term does not include any dependent of an individual receiving aid or assistance under Part A or Part E of Title IV of the Social Security Act.

(D) For purposes of this section the term, “qualified dependent spouse” means any individual who is:

- (1) lawfully married to the taxpayer; and
- (2) who is a dependent spouse as defined in section (insert) of the Internal Revenue Code. The taxpayer shall receive no credit for a qualified dependent spouse unless a credit is received for a qualified dependent child.

(E) In the case of an individual who is legally married, this section shall apply only if a joint return is filed for the taxable year.

(F) Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allowed under this section in the case of a taxable year covering a period of less than 12 months.

(G)(1) The amount of the credit allowed by this section shall be determined under tables prescribed by (insert appropriate agency).

- (2) The tables prescribed under Paragraph (B)(1) shall reflect the provisions of Subsections (A) and (B) and shall have income brackets of no greater than {insert amount} each for earned income between \$0 and the amount of earned income at which the credit is phased down to the amount applicable under subsection (B)(3)(c).

(H)(1) In the case of any taxable year beginning after {insert year}, the \$12,500 and the \$16,000 amounts in Subsection (B) shall be increased by an amount equal to:

- (a) such dollar amount, multiplied by
- (b) the cost of living adjustment determined for the calendar year in which the taxable year begins.

(2) If the increase in (B)(1) is not a multiple of \$10, such increases shall be rounded to the nearest multiple of \$10.

**Section 3. {Severability Clause.}**

**Section 4. {Repealer Clause.}**

**Section 5. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1995.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

**SUNSHINE VIEW**

## Health Care Tax Relief Equity Act

### *Summary*

The purpose of this Act is to provide state tax credits for both the purchase of individual health insurance policies and out-of-pocket medical expenses. This bill restores tax equity to the health care system. Currently, only employers are allowed to purchase health insurance with pre-tax dollars. This is not only unfair to individuals, the self-employed, and their families, but it also fosters a dependence on employer provided health care. With tax credits, individuals would be encouraged to shop around for the best plan to meet their needs. Purchasers would become more sensitive to the price and utilization of insurance and, in effect, would spur stronger competition within the health care industry, helping to keep costs under control.

ALEC's bill would grant taxpayers a state tax credit for the purchase of health insurance, covering medical care for the taxpayer, the taxpayer's spouse, or a dependent. The bill would also allow taxpayers to use the credit for out-of-pocket medical care expenses for the taxpayer, the taxpayer's spouse, or a dependent, which were not reimbursed by insurance.

### *Model Legislation*

**Section 1.** This Act may be cited as the **Health Care Tax Relief and Equity Act**.

**Section 2.** Persons filing state income tax returns shall be permitted to apply a credit against their tax liability of (insert appropriate percentage, amount, or scale), calculated upon:

(A) Amounts paid by the persons for expenses incurred for medical care, and not reimbursed by insurance or otherwise, for the person, the person's spouse, or the person's dependents. This calculation shall exclude any amount paid by an employer and not reported as income.

(B) Amounts paid by the person for expenses incurred for health insurance for the person, the person's spouse, or the person's dependents. This calculation shall exclude any amount paid by an employer and not reported as income.

**Section 3.** {Severability Clause.}

**Section 4.** {Repealer Clause.}

**Section 5.** {Effective Date.}

*Approved by the Health and Human Services Task Force in 1991. Amended by the Health and Human Services Task Force in March 2002.*

## Young Child Tax Credit Act

### *Summary*

This act provides for a tax credit in the amount of five percent of the taxpayers earned income for dependents under the age of five, and five percent of the taxpayers earned income for a dependent spouse, not exceeding \$10,000.

### *Model Legislation*

{Title, enacting clause, etc.}

#### **Section 1.**

(A) Section (insert section and all appropriate chapters and subchapters) of the Revenue Code is amended by redesignating (insert section) as Section (insert new section) and by inserting (insert Section) after the following new Section: (redesignated section) in the case of an individual, there is allowed as a credit against the tax imposed by the subtitle for the taxable year an amount equal to the dependent tax credit amount for the taxable year.

(B) For the purpose of this Section:

(1) The young child tax credit amount for the taxable year is an amount equal to the sum of the applicable credit percentages of so much of the taxpayer's earned income as defined in Section (B)(2) for such year as does not exceed \$10,000.

(2) For the purpose of Subsection (B)(1), the applicable credit percentage is:

- (a) Five percent for any one qualified dependent child of the taxpayer;
- (b) Five percent for a second qualified dependent child of the taxpayer other than the qualified dependent taken into account under Subparagraph (a); and
- (c) Five percent for a qualified dependent spouse.

(3) In the case of the taxpayer whose earned income for the taxable year exceeds \$30,000, the amount determined under Subsection (B)(1) shall be reduced by an amount equal to the sum of the applicable phaseout percentages of such excess.

(4) For the purpose of Subsection (B)(3) the applicable phase-out percentage is:



(i) \$5 for each \$100 of income that exceeds the amount specified in Paragraph (3)(a) for any qualified dependent; and

(ii) \$5 for each \$100 that exceeds the amount specified in Paragraph (3)(a) for each additional qualified dependent taken into account in Paragraph (B)(2)(b).

(C) For the purpose of this Section, the term “qualified dependent” means any individual:

(1) who is a dependent (as defined in section 152 of the Internal Revenue Code) of the taxpayer;

(2) who is a child (as defined in section 151(c)(3) of the Internal Revenue Code) of the taxpayer; and

(3) who has not attained five years of the age at the close of the calendar year in which the taxable year of the taxpayer begins.

Such term does not include any dependent of an individual receiving aid or assistance under Part A or Part E of Title IV of the Social Security Act.

(D) For the purpose of this Section the term “qualified dependent spouse” means any individual who is a dependent spouse (as defined in the Internal Revenue Code) of the taxpayer.

(E) No taxpayer shall receive any credit amount as defined under Paragraph (B)(1) for a qualified dependent spouse unless the taxpayer also claims a credit for at least one dependent child.

(F) In the case of an individual who is legally married, this section shall apply only if a joint return is filed for the taxable year.

(G) Except in the case of a taxable year closed by reason of the death of a taxpayer, no credit shall be allowable under this section in the case if a taxable year covering a period of less than 12 months.

(H)(1) The amount of the credit allowed by this section shall be determined under tables prescribed by (insert appropriate agency).

(2) The tables prescribed under paragraph (H)(1) shall reflect the provisions of Subsections (A) and (B) and shall have income brackets of not greater than (insert amount) each for earned income between \$0 and the amount of earned income at which the credit is phased down to the amount applicable under subsection (B)(3)(c).

(I)(1) In the case of any taxable year beginning after (insert year), the \$10,000 and the \$30,000 amounts in subsection (B) shall be increased by an amount equal to:

(a) such dollar amount, multiplied by

(b) the cost-of-living adjustment determined for the calendar year in which the taxable year begins.

(2) If any increase determined under paragraph (I)(1) is not a multiple of \$10, such increase shall be rounded to the nearest multiple of \$10.

**Section 2. {Repealer Clause.}**

**Section 3. {Severability Clause.}**

**Section 4. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1995.*

## **Kinship Care Act**

### ***Summary***

Families are the best welfare program for children. Parents are the first source of support for children. Where parental resources are inadequate but voluntary support for the kinship network of family members is available to meet the child's needs, there is no justification for displacing the family and creating dependency upon government welfare programs.

### ***Model Legislation***

**Section 1. Title:** This Act may be cited as the "Kinship Care Act."

### **Section 2. Purpose.**

The main purpose of the Kinship Care Act is to change the current welfare eligibility criteria so that an applicant's eligibility is not based exclusively on the ability of that person to support one or more dependents, but is also determined by the ability and willingness of relatives to provide safe support for the dependents, as determined by an appropriate certification process.

### **Section 3. Legislative Declarations.**

The legislature of {the State} hereby finds and declares that:

- (A) Welfare programs are intended to provide temporary economic sustenance for individuals while they seek to enter the work force and eventually extricate themselves, and their dependents, from poverty.
- (B) Welfare programs have fallen short of this goal and the failure to escape poverty often persists through generations as children of welfare families go onto welfare rolls as adults, resulting in a needless waste of human potential as well as economic and other costs to society.
- (C) A primary cause of intergenerational welfare dependency is the adverse impact of the welfare environment upon children.
- (D) Reducing intergenerational welfare dependency requires, where possible, the avoidance of a welfare environment and the rearing of children in family settings that will be conducive to rejection of the welfare career.
- (E) Prior welfare programs lacked measures that would assist in the elimination of intergenerational welfare dependency and, indeed, actually encouraged such dependency

by ignoring the availability of non-welfare alternatives for dependent children.

(F) It is therefore in the public interest to amend the welfare laws to eliminate the encouragement of intergenerational welfare dependency and to promote the rearing of children in non-welfare environments more conducive to an economically and socially productive adulthood.

(G) One of the best opportunities for reducing welfare dependency lies in the revision of eligibility criteria to better identify which children are actually in need of welfare assistance. In the past, eligibility criteria for most welfare programs have considered only the cash income of the single custodial parent without regard to the availability of voluntary kinship or extended family assistance.

(H) Kinship Care, the practice of looking to capable and willing family members as an alternative to welfare dependency, recognizes both that a functioning extended family provides the child's best welfare safety net and that government programs can not and should not displace a willing, functioning family.

(1) Accordingly, the legislature for {the State} finds and declares that it is contrary to the best interests of the child to create welfare dependency where voluntary kinship care resources are available to meet the child's need without resort to government welfare programs.

#### **Section 4. Legislation Modification.**

Section {#} of the Code of {the State}, is hereby [amended or added] as follows:

No person shall be eligible to receive benefits under this program by reason of the need of that person to support one or more dependents unless the administrator [or agency or other appropriate official] has certified, after undertaking diligent efforts, that there are no relatives of such child who are fit and willing to provide for the needs of the child without resorting to welfare dependency. Such certification shall be required prior to initial entry into the program and, thereafter, upon periodic annual reviews of eligibility. An applicant's preference for welfare payments rather than family assistance shall not be a basis for granting welfare eligibility unless the administrator [or agency or other appropriate official] has certified, after making diligent investigation, that family assistance will be detrimental to the safety of the child.

#### **Section 5. {Severability Clause.}**

#### **Section 6. {Repealer Clause.}**

#### **Section 7. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1996.*

## **Learnfare Act**

### ***Summary***

The Learnfare Act requires that all teenagers who are included in grant of public assistance who are parents or who are residing with a natural or adoptive parent and who have not graduated from high school or received a high school equivalency diploma, attend school.

### ***Model Legislation***

**{Title, enacting clause, etc.}**

**Section 1.** The purpose of this Act is to provide rules for the administration of LEARNFARE, a program that requires that all teenagers who are included in grant of public assistance who are parents or who are residing with a natural or adoptive parent and who have not graduated from high school or received a high school equivalency diploma, attend school.

**Section 2.** As used in this Act the following terms have the following meanings:

- (A) "Ceased to attend" means that a teenager has 20 consecutive full school days of unexcused absences;
- (B) "Dropout" means a teenager who has ceased to attend school, continues to reside in the school district, does not attend another school, does not participate in a home schooling program, has not graduated from high school or received a high school equivalency diploma, and does not have an acceptable excuse under Section 6;
- (C) "Excused absence" means that the reason for the absence meets the school district's definition of a valid reason for a teenager not attending school;
- (D) "Full day" means the entire school day as defined by the school district;
- (E) "High school equivalency diploma" means a certificate of educational achievement issued under (insert appropriate statute);
- (F) "Home schooling program" means a valid home schooling program as authorized under (insert appropriate statute);

(G) "LEARNFARE" means a program established under this Act that requires that all teenagers who are included in a grant of public assistance, who are parents or who are residing with a natural or adoptive parent and who have not graduated from high school or received a high school equivalency diploma, attend school;

(H) "Monthly attendance requirement" means that a teenager have no more than two full days of unexcused absences in a calendar month;

(I) "School" means:

(1) a public school as described in {insert appropriate statute};

(2) a private school as described in {insert appropriate statute};

(3) a vocational, technical or adult education school pursuant to {insert appropriate statute};

(4) the course of study meeting the standards established by the Department of Education under {insert appropriate statute} for the granting of a high school equivalency diploma;

(J) "School district" means the territorial unit for school administration as described in {insert appropriate statute};

(K) "Teenager" means a person who is 13 to 19 years of age, and who is a parent or residing with his or her natural or adoptive parent;

(L) "Unexcused absence" means that the reason for the absence does not meet the school district's definition of a valid reason for the teenager not to attend school.

**Section 3.** (A) A teenager shall attend school full or part time, except that a teenager who is participating in a home schooling program, has graduated from high school or received a high school equivalency diploma, is exempt from the school attendance requirement under this Act.

(B) a teenager who is required to participate in LEARNFARE under this Act shall be considered to be meeting the school attendance requirements under the following circumstances:

(1) A teenager who is required to attend school shall be considered to have met the attendance requirement by having fewer than ten full days of unexcused absences from school during the most recently completed school semester;

(2) a teenager who has ten or more full days of unexcused absences from school during the most recently completed school semester or was a dropout and returned to school during the semester under review or who is unable to verify previous attendance shall comply with the monthly attendance requirement;



(3) if the school that the teenager is currently enrolled in does not keep daily attendance records, the teenager shall be considered to be meeting the monthly attendance requirement if the school verifies the continuing enrollment of the teenager in the semester under review;

(4) the teenager is not required to comply with attendance requirements when the school the teenager is attending is not in regular session, including during the summer.

(C) Either the teenager or his parent shall cooperate in providing information needed to verify enrollment information or good cause under Section 6 of this Act. If neither one cooperates, the teenager shall be ineligible for aid as provided under {insert appropriate statute}.

**Section 4.** (A) The Department of Public Welfare {or insert appropriate department} shall review school attendance information at all initial eligibility determinations and at all reviews under {insert appropriate statute}.

(B) The signature of an applicant on an application for Aid to Families with Dependent Children (AFDC) or General Relief constitutes permission for the release of school attendance records for that individual or for any teenager residing with that individual.

(C) (1) The Department shall request information from the teenager's school district about the teenager's attendance in the school district's most recently completed semester of attendance. (2) If information about the teenager's previous school attendance is not available or cannot be verified, the Department shall require the teenager to meet the monthly attendance requirement for one semester or until the information is obtained.

(D) The Department shall use the attendance information provided by a school district to verify attendance for a teenager.

(E) The Department shall review a teenager's claim that he or she has a good cause under Section 6 of this Act for not attending school.

**Section 5.** (A) A school district shall provide information to the Department about the attendance of a teenager who is enrolled in a public school in the district within five working days of the receipt of a written request for such information from the Department.

(B) The school district shall define how many hours of attendance count as a full day and shall provide that information, upon request, to the Department.

(C) In reporting attendance, the school district may not add partial day's absence together to constitute a full day's absence.

**Section 6.** (A) A teenager who is required to attend school to meet LEARNFARE participation requirements under this Act shall comply except when there is good cause which shall be demonstrated by any of the following circumstances:

- (1) the teenager is the caretaker of a child less than 90 days old; or
- (2) the Department determines that child care services are necessary for the teenager to attend school and there is no child care available. Child care shall be considered unavailable if there is no space available for the child in a licensed day care center within reasonable time and distance, or if the cost of the care where space is available is excessive in the judgment of the Department; or
- (3) the department determines that transportation to and from child care is necessary for the teenager's child and there is no public or private transportation available; or
- (4) The teenager is prohibited by the school district from attending school and an expulsion is pending. This exemption no longer applies once the teenager has been expelled;
- (5) The teenager failed to attend school for one or more of the following reasons:
  - (a) illness, injury, or incapacity of the teenager or a member of the teenager's family. For purposes of this Paragraph, "member of the teenager's family" means a spouse, child, parent, or other dependent relative who lives with the teenager;
  - (b) court-required appearances or temporary incarceration;
  - (c) medical or dental appointments for the teenager or his or her child;
  - (d) death of a relative or friend;
  - (e) observance of a religious holiday;
  - (f) family emergency;
  - (g) breakdown in transportation;
  - (h) suspension;
  - (i) any other circumstance beyond the control of the teenager.

**Section 7.** (A) Upon determination that a teenager has failed without good cause to attend school as required, the Department shall provide written notice to the teenager or his parents (whoever is the primary recipient of aid) which specifies:

(1) that the teenager will be removed from the AFDC or General Relief grant in the next possible payment month because the teenager required to attend school has failed to meet attendance requirements. If the teenager is the only child in the grant, the notice shall state that the entire grant will be discontinued;

(2) the beginning date of the sanction, and the teenager to whom the sanction applies;

(3) the right of the teenager or his parents (whoever is the primary recipient of aid) to request a fair hearing under Subsection (B) of this Section.

(B) The teenager or his parents (whoever is the primary recipient of aid) may request a fair hearing on the Department's determination that the teenager has not been attending school.

(C) If the teenager or his parents do not request a fair hearing under Subsection (B) of this Section, or if, after a fair hearing has been held, the hearing officer finds that the teenager without good cause has failed to meet the monthly attendance requirement, the Department shall discontinue or deny aid to the teenager in the next possible payment month.

(D) A sanction applied under Subsection (C) of this Section shall be effective for one month for each month that the teenager failed to meet the monthly attendance requirement. In the case of a dropout, the sanction shall remain in force until the teenager provides written proof from the school district that he or she has re-enrolled and met the monthly attendance requirement for one calendar month. Any month in which school is in session for at least ten days during the month may be used to meet the attendance requirement under this Subsection. This includes attendance at summer school. The sanction shall be removed the next possible payment month.

**Section 8. {Severability Clause.}**

**Section 9. {Repealer Clause.}**

**Section 10. {Effective Date.}**

*1995 Sourcebook of American State Legislation*

## **Minors on Welfare Residency Act**

### ***Summary***

There is a higher rate of welfare dependency by teenage, single parents who set up their own residence than those who remain at home. This Act requires that single, teenage parents live at home in order to receive TANF benefits. By continuing adult supervision in the young parent's life, the family unit is thereby strengthened.

### ***Model Legislation***

**{Title, enacting clause, etc.}**

**Section 1.** Notwithstanding the provisions of any other law to the contrary, no Temporary Assistance for Needy Families (TANF) grant payment shall be made on behalf of a minor under the age of eighteen who has never married and who has a child or is pregnant unless such minor resides with a parent, legal guardian, or other adult relative, or in a foster home, maternity home, or other adult-supervised living arrangement.

**Section 2.** Exceptions to this Act shall be allowed in accordance with requirements of the Federal Family Support Act of 1988 as in any of the following circumstances:

(A) the individual has no parent or legal guardian who is living or the whereabouts of the individual's parent or legal guardian are unknown; or

(B) the state determines that the physical health or safety of the individual or his or her child would be jeopardized; or

(C) the individual has lived apart from his or her parent or legal guardian for a period of at least one year prior to the birth of the child or applying for benefits.

**Section 3. {Severability Clause.}**

**Section 4. {Repealer Clause.}**

**Section 5. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1996.*

## **Privatization of Welfare-To-Work Programs Act**

### ***Model Legislation***

**Section 1. Title.** This Act shall be known and cited as the "Privatization of Welfare-to-Work Programs Act."

**Section 2. Definitions.** As used in this Act:

A. "Welfare-to-Work" program means the employment and job training program for families with dependent children who are recipients of the Temporary Assistance for Needy Families (TANF).

B. "Workfare Agency" means the private organization that is contracted by the Department to administer the Welfare-to-Work program.

C. "Employment" is used as defined in TANF.

D. "Department" means appropriate state human services department.

E. "Benefits" mean appropriate cash benefits and food stamp benefits.

F. "Competitive contracting" means the state Department will choose the private providers from which it will purchase related services.

### **Section 2. Work-Not-Welfare Program.**

A. The Department shall contract for the delivery, administration, and management of employment and job training program using the federal block grant assistance provided to the states through the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*.

B. The Department shall require able individuals who are 18 to 60 years of age who are not employed participants in a Welfare-to-Work program, except as listed in Section 2 (C), to participate in the employment and job training program.

C. Exemptions to the work requirement include:

1) The Department may not require an individual who is a recipient under the food stamp program and is the caretaker of a child who is under the age of 12 weeks to participate in an employment and job-training program

*Drafting Note: Federal law requires MDP*

D. The Department may distribute benefits on a pay-for-performance level. *Drafting note: refer to ALEC's Pay for Performance Act.*

### **Section 3. Agency Contracts.**

A. The Department may award a two-year contract, on the basis of a competitive contracting process approved by the secretary of administration, to any person to administer the Welfare-to-Work Program in a geographical area determined by the Department. *Drafting note: Refer to ALEC's Competitive Contracting of Public Services for competitive contracting process.*

B. The Department shall contract with a county to administer the Welfare-to-Work Program county, if the county has met the TANF requirements with dependent children caseload performance standards established by the Department.

C. When the contract expires, a county may apply for a new contract under the competitive contracting process.

D. The Workfare Agency's contract will only be renewed if the Agency has placed a pre-determined percentage of TANF recipients in employment for {insert time frame, i.e.3-6 months.} The Department must establish this percentage at the beginning of each contract.

### **Section 4: Agency Requirements.**

The Agency must, but is not limited to:

A. Advise program participants on employment and job activities;

B. Identify and encourage employers to provide permanent jobs for persons who are eligible for trial jobs or community service jobs;

C. Create, and encourage others to create subsidized jobs for persons who are eligible for trial jobs or community services jobs;

D. Create, and encourage others to create, on-the-job training sites for persons who are eligible for trail jobs or community services jobs;

E. Foster and guide the entrepreneurial efforts of participants who are eligible for trial jobs or community service;

F. Provide mentors, both from membership and recruitment of members from the community, to provide job-related guidance to persons who are eligible for trial jobs or community services jobs;



G. Work with participants, employers, child care providers and the community to identify child care needs, improve access to care and expand availability of child care;

H. Seek sources of private funding to match employment skills advancement grants; and

I. Identify motivational training programs, including programs that enhance parenting skills.

**Section 5. Performance Standards.**

The Department shall establish performance standards for the administration of Work-Not-Welfare programs. If a Workfare Agency does not meet the standards the Department may withhold any or all payment from the Workfare Agency.

**Section 6. Performance Incentives for Workfare Agencies.**

A. The Department must award the Agency a bonus for each recipient placed in employment, the longer the recipient remains employed, and will decrease on a sliding-scale {insert time frame, e.g. 12 months} the longer the recipient remains unemployed. *Drafting Note: A maximum bonus amount and maximum time frame must be established.*

B. The Department must submit an annual report regarding quality performances, outcome measure attainment, and cost-effectiveness to the state legislature and Governor.

**Section 7. {Severability Clause.}**

**Section 8. {Repealer Clause.}**

**Section 9. {Effective Date.}**

*Approved by the Health and Human Services Task Force.*

## **Proof of Custody Act**

### *Summary*

Any child for whom welfare eligibility is sought may be in the custody of the mother, the father, or both jointly. The current welfare system fails to determine whether the parent receiving welfare coverage actually has custody of the child. If one parent presents a child for welfare eligibility while the other parent (or the parents jointly) actually have legal custody of the child, a fraud has been committed.

### *Model Legislation*

**Section 1. Title:** This act may be cited as the Proof of Custody Act.

**Section 2. Purpose Section.** To eliminate cases of welfare fraud based on a non-custodial parent seeking assistance for a child which is not legally their own.

**Section 3. Main Provision.** No funds shall be available under this Act for payment to a parent on behalf of a child unless the parent seeking eligibility has sole custody of the child or, in cases of joint custody, the parents apply jointly for benefits.

**Section 4. {Severability Clause.}**

**Section 5. {Repealer Clause.}**

**Section 6. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1996.*

## Public Welfare Accountability Act

### *Summary*

State public welfare departments are arguably one of the fastest-growing departments in state government. Not only is the cost of actual assistance growing exponentially, but the appropriation needed to fund the permanent welfare bureaucracy have grown substantially as well. And, despite real reductions in caseloads during the 1980s, 1990s and 2000s, many state welfare bureaus did not reduce accordingly. States should stop this unwarranted growth in bureaucracy.

This legislation provides real financial penalties for state and county public welfare departments, as well for cash assistance programs, if a state public welfare department fails to meet mandatory work participation rates (50% overall; or 90% for a two-parent family) set by the federal government under the federal welfare program known as Temporary Aid to Needy Families (TANF). These financial penalties will only be assessed once during each fiscal year.

### *Model Legislation*

**Section 1. Short Title.** This Act shall be known as the "Public Welfare Accountability Act."

### **Section 2. State Appropriations.**

A. For general government operations of **{insert state department of public welfare}**, each fiscal year the **{insert state treasurer}** shall publish in the **{insert state bulletin}** notice of whether the department is in compliance with the mandatory work participation rates for the Temporary Assistance to Needy Families program (TANF), as required under federal law. The **{insert state treasurer}** shall use the following documents to determine compliance:

1. TANF reports submitted by **{insert state department of public welfare}** to the United States Department of Health and Human Services regarding compliance; or
2. Written notice by **{insert state secretary of public welfare}** regarding compliance; or
3. Written notice by the United States Secretary of Health and Human Services regarding compliance.

B. If noncompliance is found by the **{insert state treasurer}** by **{insert date}**, the amount of appropriations for general government operations of **{insert state department of public welfare}** shall be reduced by **{insert amount}**.

### **Section 3. County Appropriations.**

A. For general government operations of **{insert county administrative office for welfare and Medicaid}**, each fiscal year the **{state treasurer}** shall publish in the **{insert state**

**bulletin** notice of whether the **{insert state department of public welfare}** is in compliance with the mandatory work participation rates for TANF, as required under federal law. The **{insert state treasurer}** shall use the following documents to determine compliance:

1. TANF reports submitted by **{insert state department of public welfare}** to the United States Department of Health and Human Services regarding compliance; or
2. Written notice by **{insert state secretary of public welfare}** regarding compliance; or
3. Written notice by the United States Secretary of Health and Human Services regarding compliance.

B. If noncompliance is found by the **{insert state treasurer}** by **{insert date}**, the amount of appropriations for general government operations of **{insert county administrative office for welfare and Medicaid}** shall be reduced by **{insert amount}**.

#### **Section 4. Services Related to Welfare-to-Work Activities.**

A. For services related to welfare and work activities, including employment and training, child care, and work support services, each fiscal year the **{state treasurer}** shall publish in the **{insert state bulletin}** notice of whether the **{insert state department of public welfare}** is in compliance with the mandatory work participation rates for TANF, as required under federal law. The **{insert state treasurer}** shall use the following documents to determine compliance:

1. TANF reports submitted by **{insert state department of public welfare}** to the United States Department of Health and Human Services regarding compliance; or
2. Written notice by **{insert state secretary of public welfare}** regarding compliance; or
3. Written notice by the United States Secretary of Health and Human Services regarding compliance.

B. If noncompliance with mandatory work participation requirements is found by **{insert state treasurer's office}**, appropriations for welfare-to-work services, including employment and training, child care, and work support services shall be reduced by **{insert amount}**.

#### **Section 5. Review of Compliance.**

The **{insert state legislative audit bureau}** shall review the written notice submitted by **{insert state secretary of public welfare}** and the notice of compliance submitted by **{insert state treasurer}** as required in Sections 2, 3, and 4 to verify its accuracy and compliance with federal law.

#### **Section 6. {Severability Clause.}**

#### **Section 7. {Repealer Clause.}**

#### **Section 8. {Effective Date.}**

*Passed by the Health and Human Services Task Force on December 8, 2007.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy  
SUMMERVIEW

## **Residency Requirements for TANF Recipients Act**

### *Summary*

This Act requires persons receiving TANF benefits to be a resident of that state.

### *Model Legislation*

#### **Section 1. {Title.}**

#### **Section 2. {Definitions.}**

**Section 3. {Eligibility.}** Except as hereinafter otherwise provided, and subject to the rules, regulations, and standards established by (insert department), both as to eligibility for assistance and as to its nature and extent, needy persons defined by (insert state) shall be eligible for assistance as follows:

(A) Assistance may be granted only to or in behalf of a resident of (insert state.)

(B) Needy persons who do not meet the residency requirements stated in this Act and who are transients or without residence in any state, may be granted assistance up to seven days in the form of vendor payments, all in accordance with the rules, regulations, and standards established by the (insert department.)

(C) Notwithstanding the maximum aid payments as determined by the (insert department), recipients of general assistance and Aid to Families with Dependent Children who have resided in (insert state) for less than 12 months shall be paid an amount calculated in accordance with (insert department) standards, but not to exceed the maximum aid payment that would have been received from the recipient's state of prior residence, unless that amount exceeds the maximum payment level available to recipients in (insert state). When the maximum aid payment from a recipients's state of prior residence exceeds that amount which would otherwise be available in (insert state), the recipient shall receive an amount not to exceed the amount available in (insert state.)

#### **Section 4. {Severability Clause.}**

#### **Section 5. {Repealer Clause.}**

#### **Section 6. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1995.*



## TANF Applicant Job Search Program

### *Summary*

Employment is the single means to long-term self-sufficiency for all Americans. Substituting a pay-check for a welfare check restores dignity to the individual and opens many doors of opportunity to secure a better quality of life.

### *Model Legislation*

**Section 1. Title.** The short title of the Act shall be the "TANF Applicant Job Search Program."

**Section 2. Program.** The state of *{insert state}* shall implement an TANF Applicant Job Search Program in the following manner:

(A) {AFDC Applicants.} All new applicants to the Aid to Families with Dependent Children Program shall at the time at their application for TANF be interviewed to determine their eligibility for the Applicant Job Search Program.

(1) Individuals who are eligible to receive AFDC assistance but are not eligible to participate in the Applicant Job Search Program shall have their TANF application processed in the normal manner.

(2) Any individual eligible to receive TANF assistance who is eligible to participate in the Applicant Job Search Program, hereinafter referred to as an "eligible applicant," shall have the processing of his or her TANF application postponed for 30 days while he or she participates in the Applicant Job Search Program.

(B) {Eligible Applicant.} For purposes of this Act, the term "eligible applicant" shall mean:

(1) a parent or legal guardian who is eligible for TANF, and

(2) who has no dependent children who are less than 3 years of age, and

(3) who is neither:

(a) ill or incapacitated, nor,

(b) needed at home to care for an ill or incapacitated spouse or child, and

(4) who is not in immediate need of assistance.

(C) (Participation.) Eligible Applicants shall upon receipt of their application for TANF be informed of their eligibility to participate in the Applicant Job Search Program, the content of that Program, and the extent of their obligations and responsibilities under the Program.

(1) Eligible applicants will, upon application for TANF, immediately begin participation in a program of organized job search.

(2) The participation of eligible applicants in organized job search shall continue for 30 days or until the applicant has obtained employment.

(3) The *{insert dependent}* shall provide to eligible applicants any funds for transportation or child care expenses that are necessary for the applicant to participate in the Applicant Job Search Program. Funding for such expenses shall be provided from the AFDC program.

(4) At the end of 30 days for eligible applicants who are still eligible for TANF assistance, the *{insert department}* shall commence processing of the TANF application in the normal manner.

(5) Eligible applicants who fail to comply with the job search requirements of the Applicant Job Search Program during the 30 day period shall at the end of 30 days have their TANF grant amount computed without consideration of the needs of the adult members of the TANF unit.

(D) {Organized Job Search.} For purposes of this Act "organized job search" shall mean a program which:

(1) counsels eligible applicants concerning the requirements and intent of the job search program;

(2) motivates eligible applicants to obtain self-sufficient employment and informs the applicant of the negative effects of dependency on the individual and the community;

(3) provides training in job search and interview skills;

(4) conducts an organized job search team and job search phone bank for eligible applicants;

(5) provides other job search counseling deemed to be necessary for individual applicants; and

(6) provides closely supervised individual job searches for applicants.

All eligible applicants must participate in the activities specified in Subparagraphs (1), (2), (3), and (4) above. The *{insert department}* shall ensure that eligible applicants participate in organized job search activities for a minimum of 30 hours per week throughout the 30 day duration of participation in the program or until the applicant obtains employment. The 30-hour requirement may be prorated in the event an individual's participation in the program commences or ends in the middle of the work week.

(E) {Immediate Need of Assistance.} For purposes of this Act the term "immediate need of assistance" shall mean individuals who:

- (1) have insufficient money to pay for basic necessities, or
- (2) have received a notice of eviction for failure to pay rent, or
- (3) have no place to reside.

**Section 3. Pilot Program.** The *{insert department}* shall rate the TANF applicant job search program in *{insert amount}* counties on a pilot basis.

(A) {Evaluation.} The *{insert department}* will operate the TANF Applicant Job Search Program on a pilot basis in *{insert amount}* counties for a minimum of 10 months. At the end of 10 months the *{insert department}* shall evaluate the pilot program by comparing the pilot counties to counties within the state in which pilot programs were not conducted. The evaluation will include:

- (1) comparison of changes in the rate of application to TANF;
- (2) comparison of eligible applicants who participated in the program (including those who withdrew application for TANF upon notification of the program requirements or who were sanctioned for noncompliance with program requirements) with another randomly selected group of eligible applicants from jurisdictions where on pilot program was conducted. The evaluation shall compare:
  - (a) average rate of participation in TANF;
  - (b) overall welfare benefits received including TANF, food stamps, and the cost of Medicaid services.

(B) {Cost Savings.} The *{insert department}* shall determine the overall cost savings in TANF, food stamps, and Medicaid expenditures, including those savings, if any, that result from a reduction in the TANF application rate.

(C) {Implementation.} If the evaluation shows that the applicant job search program is cost effective in that the reduction in welfare expenditure exceeds the normal operating costs of the program (excluding any administrative costs associated with the start up of a

new program), the applicant job search program shall be implemented on a statewide basis.

**Section 4. Waivers.** The Governor shall request any waivers needed to operate the program from the U.S. Department of Health and Human Services. The program shall not commence until the necessary waivers have been granted.

**Section 5. {Severability Clause.}**

**Section 6. {Repealer Clause.}**

**Section 7. {Effective Date.}**

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

SUNSHINE

## **TANF Continued Eligibility of Benefits Act**

### ***Summary***

This act would allow TANF recipients to establish trust accounts and the funds for education, purchasing a home, or an initial investment in a business. Individuals would be allowed to accumulate up to \$15,000 before losing eligibility for TANF payments. Trust accounts would encourage individuals to plan for their future and allow them to establish a means to move off of welfare and become contributing members of society.

### ***Model Legislation***

**Section 1. Short Title** "This Act may be cited as the TANF Continued Eligibility of Benefits Act"

### **Section 2. Legislative Declarations**

An Act allowing the Department of Health and Human Services, upon receiving the appropriate waiver from the federal government, to disregard certain income and resources when determining the continued eligibility of a person receiving aid to families with dependent children; repealing an obsolete provision that allows higher grants of assistance for job training purposes; and providing for an effective date.

### **Section 3. Main Provisions**

Under regulations adopted by the department, the department shall, when determining the continued eligibility of a person receiving assistance, disregard from the assistance unit's income and resources, in addition to other income and resources that may be disregarded under other laws.

(A) earned income otherwise available to the assistance unit, up to a \$200 monthly maximum for the assistance unit, that is deposited into a trust account approved by the department under this section;

(B) the amount in a trust account approved by the department under this section, up to a maximum of \$15,000;

(C) money deposited into a trust account approved by the department under this section by a nonprofit organization to match, on a dollar-for-dollar basis, contributions to the account by the assistance unit; however, the amount disregarded under this paragraph, when added to the amount disregarded under A) of this subsection, may not exceed \$200 monthly; and

(D) interest earned on money in a trust account approved under this section, subject to the requirement that the interest remain in the account until expended under this section and that only \$15,000 of the account may be disregarded as a resource, regardless of interest income to the account.

**Section 4.** The department shall adopt regulations under which a recipient of assistance may establish a trust account administered by a financial institution regulated under *{insert state bill number}* under which money in the account may be used only for;

(A) books, tuition, and required fees for attendance by a member of the assistance unit at a career education program, college, or university in the state that has been approved under *{insert state bill number}* and for room and board while attending the program, college, or university if the person does not live at home during attendance;

(B) books, tuition, and required fees for an adult member of the assistance unit who is attending a public secondary school or an equivalent level of vocational or technical training in the state;

(C) the down payment and closing costs for the purchase by an adult in the assistance unit of real property that includes a residence that will, upon purchase, be the primary residence of the adult and a minor who is or was a dependant child,;

(D) initial capitalization and the first three months of operating expenses for a business owned and managed by an adult in the assistance unit.

(E) expenses of the trustee in administering the trust; or

(F) other purposes, but only when circumstances arises after establishment of the trust that make disbursements under (A-D) of this subsection impossible or highly impractical, considering the changed circumstances; the trust documents must provide that, if circumstances change while the assistance unit is still receiving assistance, the department shall determine whether the requirements of this paragraph have been met; the trust documents must provide that the trustee shall make this determination, in the trustee's complete discretion, if the beneficiaries of the trust are not receiving assistance when circumstances change.

**Section 5.** A person who intends to establish a trust account under this section shall submit the proposed trust agreement to the department for approval. The trust agreement must provide that the trustee may make payments from the trust only;

(A) for the purpose described in section 4,

(B) after 15 days prior to the notification to the department if payments under section 4 A-D are proposed to be made while the person who established the trust is a recipient of assistance.



**Section 6.** The department shall adopt regulations specifying the requirements that must be met by a nonprofit organization that intends to make matching contributions to an account established under this section. The regulations may relate to only the manner in which the contributions are made.

**Section 7.** The department may not approve more than one trust account under this section for an assistance unit, regardless of how many persons are in the unit or how many contribute earned income to the trust account.

**Section 8. {Severability Clause.}**

**Section 9. {Repealer Clause.}**

**Section 10. {Effective Date.}**

*Approved by the Health and Human Services Task Force.*

## **TANF Limits on Benefits for Additional Children Act**

### ***Summary***

This act would eliminate the increment in benefits under the TANF program for which the family would otherwise be eligible as a result of the birth of a child during the period in which the family is eligible for TANF benefits.

### ***Model Legislation***

#### **Section 1. {Title.}**

#### **Section 2. {Definitions.}**

**Section 3. {Determination of need.}** (A) In determining the amount of assistance payments to a recipient family for Aid to Families with Dependent Children, the *{insert department}* shall revise the schedule of benefits to be paid to the recipient family by eliminating the increment in benefits under the program for which that family would otherwise be eligible as a result of the birth of a child during the period in which the family is eligible for TANF benefits, or during a temporary period in which the family or adult recipient is ineligible for TANF benefits pursuant to a penalty imposed by the department for failure to comply with benefit eligibility requirements, subsequent to which the family or adult recipient is again eligible for benefits. The department shall provide instead that a recipient family in which the adult recipient parents an additional child during a temporary penalty period of ineligibility for benefits, may receive additional benefits only pursuant to Subsection (B), except in the case of a general increase in the amount of TANF benefits which is provided to all program recipients.

(B) In the case of a family that receives TANF in which the adult recipient parents an additional child during the period in which the family is eligible for TANF benefits subsequent to which the family of adult recipient again becomes eligible for benefits, the department, subject to federal approval, shall, in addition to eliminating the increase in the benefit as provided in Subsection (A), provide that in computing the amount of financial assistance that is available to the family that receives TANF, the monthly earned income disregard for each employed person in the family shall increase by an amount equal to that which the family would have otherwise received by parenting an additional child, adjusted for family size.

#### **Section 4. {Severability Clause}.**

#### **Section 5. {Repealer Clause}.**

**Section 6. {Effective Date}.**

*Approved by the Health and Human Services Task Force.*

Obtained and released by:  
Common Cause and  
The Center for Media and Democracy

**SUNSHINE VIEW**

## Time Limits on TANF Benefits Act

### *Summary*

This TANF benefits act delineates several time constraints in regards to eligibility for TANF financial assistance, several eligibility renewal requirements, and several social services exception regulations and procedures regarding time limits. Each participating recipient of TANF financial assistance may receive this assistance for no more than twenty four months, unless otherwise exempted by the specified hardship exceptions. A local social services department shall give notice of TANF benefits termination sixty days prior to that termination, along with the appropriate extension of benefits regulations and procedures.

### *Model Legislation*

**Section 1. Title:** This act may be cited as the "Time Limits on TANF Benefits Act."

**Section 2. Purpose Section.** Time limits help facilitate a person to move away from receiving TANF financial assistance. However, this act does allow for an extension of the TANF benefits beyond the twenty four month reception limit in cases where there is danger to the welfare of the dependent children.

**Section 3. Definitions.** For the purpose of this act, "assistance unit" means recipient of TANF financial assistance.

### **Section 4. Legislative Modifications.**

(A) A participating assistance unit may receive TANF financial assistance for a maximum of twenty four months only, unless otherwise exempt subject to Section 5. An assistance unit may renew his/her eligibility to receive TANF assistance, if otherwise eligible, after a subsequent period of twenty four months during which he/she did not satisfy at least one of the following conditions:

- (1) Participate in a work program (insert appropriate title for your state);
- (2) Receive TANF financial assistance;
- (3) Receive transitional assistance (if available in your state).

(B) The local department of social services shall notify a participating assistance unit that their TANF financial assistance is scheduled to be terminated as provided in this section. Notice shall be given sixty days prior to such termination and shall inform the

participating assistance unit of the exception regulations promulgated by the (appropriate state agency) and the procedure to be followed by the participating assistance unit if it believes that it is entitled to an extension of benefits.

**Section 5. Hardship Extensions.** The (appropriate state agency) shall promulgate regulations providing exceptions to the time limitations of this chapter in cases of hardship. Exceptions can only be provided where the program participant loses his or her job as a result of factors not related to his or her job performance.

**Section 6. Assistance Unit Restriction.** Any child ineligible because of the time limit in one assistance unit cannot be eligible for assistance in another assistance unit.

**Section 7. {Severability Clause.}**

**Section 8. {Repealer Clause.}**

**Section 9. {Effective Date.}**

*Approved by the Health and Human Services Task Force.*

## Welfare System Integrity Act

### *Summary*

Many states are facing harsh economic realities—meanwhile, citizens are demanding greater accountability on how their tax dollars are spent. In many states, citizens are voicing concerns over the escalating cost of the welfare portion of the state budget, which is quickly outpacing other state funding priorities.

The easiest way to break the cycle of welfare dependency, as well to stop the perceived and real abuses within the welfare system, is to prevent it in the first place by reducing the number of new enrollments. Front-end fraud prevention is the logical method to avoid the cost of investigation and prosecution later.

One key challenge is to separate those who are truly needy and eligible for TANF, food stamps, and Medicaid from those who are not. This critical first step in the process will allow the system to focus its efforts on those who have the most difficulty becoming self-sufficient, and it will free up the resources and energy needed to deal with the underlying problems that promote this perpetual cycle of dependency.

This legislation will establish the Income Eligibility Verification System (IEVS), a computerized system designed to find and root out welfare fraud. Currently, the federal government requires all states to have a computerized system of databases in order to eliminate fraudulent applications for assistance. However, the federal government requires that only four database matches be used. This updated legislation requires the state to institute a system of 17 different database matches, 13 more than currently mandated by federal law.

The IEVS proposed for use here is similar to the one that was successfully enacted as part of Mayor Rudy Giuliani's welfare reform initiative in New York City. Using a parallel system, 10,000 fleeing felons alone were found to be abusing the welfare system in NYC.

### *Model Legislation*

**Section 1. Short Title.** This Act shall be known as the “Welfare System Integrity Act.”

### **Section 2. Definitions.**

A. As used in this Act, the following definitions apply:

1. “Significant discrepancy” means information regarding assets, income, resources, or status of an applicant or recipient of assistance, derived from one or more of the databases in this Act, which gives the department grounds to suspect that either:

a. An applicant or recipient is ineligible to receive assistance, under federal or state law, due to the applicant's or recipient's status; or



b. The assets, income, or resources of an applicant or recipient are at least, in terms of a dollar amount, twenty-five percent greater than the dollar amount reflected in the information the department possesses about the applicant or recipient with respect to the applicant's or recipient's assets, income, or resources.

2. "Status" means that the applicant or recipient is in the United States illegally, is no longer living, is an inmate in a prison or jail, or is a fleeing felon.

### **Section 3. Income Eligibility Verification System.**

A. The {insert state department of public welfare} shall establish a computerized income eligibility verification system in order to eliminate duplication of assistance and to deter fraud.

B. The department shall require that as a condition of assistance, an applicant or a recipient supply the social security number of the applicant or recipient. The department shall match the social security number of all applicants and recipients with the following databases, or with databases that are substantially similar to, or successors of, the following databases:

1. Unearned income information maintained by the United States Internal Revenue Service;
2. Employers' quarterly reports of income and unemployment insurance benefit payment information maintained by the {insert state wage collection agency};
3. Earned income information maintained by the United States Social Security Administration;
4. Immigration status information maintained by United States Citizenship and Immigration Services;
5. Death register information maintained by the United States Social Security Administration;
6. Prisoner information maintained by the United States Social Security Administration;
7. Public housing and Section 8 payment information maintained by the United States Department of Housing and Urban Development;
8. National fleeing felon information maintained by the United States Federal Bureau of Investigation;
9. Wage reporting and similar information maintained by contiguous states;
10. The Beneficiary Data Exchange (BENDEX) Title H database maintained by the United States Social Security Administration;

11. The Beneficiary Earnings Exchange Report (BEER) database maintained by the United States Social Security Administration;
12. The **{insert state new hire database}** maintained by the state;
13. The **{insert national new hire database}** maintained by the federal government;
14. The State Data Exchange (SDX) database maintained by the United States Social Security Administration;
15. The Veterans Benefits and Veterans Medical (PARIS) database maintained by the United States Department of Veterans Affairs and the United States Department of Health and Human Services;
16. The **{insert state day care subsidy payments database}** maintained by the state; and
17. The Low Income Energy Assistance Program (LEAP) Reporting Utility Expenses database maintained by the state.

C. Notwithstanding any provision of law to the contrary, the income eligibility verification system shall be utilized for an applicant at the time of application for assistance, and for a recipient on a quarterly basis.

D. The department shall notify applicants and recipients of the requirement of providing a social security number at the time of application for assistance and as needed thereafter and pursuant to the provisions of this Act.

#### **Section 4. Discrepancies.**

A. If a significant discrepancy results from a match between the applicant's or a recipient's social security number and one or more of the databases set forth in this Act, the department shall review the applicant's or recipient's case, as appropriate, and shall investigate the circumstances of the discrepancy in order to determine eligibility of the applicant or recipient.

B. The department shall institute the following procedure to investigate the circumstances of a significant discrepancy.

1. If the information is known to the department, is accurate, and does not result in ineligibility or modification of the amount or type of assistance, the department shall take no further action.

2. If Subparagraph 1 does not apply and a significant discrepancy results from the match between the applicant's or the recipient's social security number and one or more of the databases as listed in this Act, the applicant or the recipient, as appropriate, must be given an opportunity to explain the significant discrepancy. The department shall provide written notice to the applicant or recipient. Notice shall provide sufficient detail regarding the circumstances of the significant discrepancy, the opportunity to resolve the significant discrepancy, including the manner in which the significant discrepancy may be resolved, and the consequences of not responding to the notice or of resolving the significant discrepancy. The explanation of the

recipient or applicant may be given over the telephone as set forth in this Act, in person, or in writing. After receiving the explanation, the department may request additional documentation in person or in writing if it determines there is a substantial risk of fraud.

3. If the applicant or recipient, as appropriate, does not respond to the notice, the department may close the applicant's or recipient's case for failure to cooperate. In such a case, the department shall provide notice of intent to discontinue assistance. Eligibility for assistance shall not be reestablished until the significant discrepancy is resolved.

4. If the applicant or recipient disagrees with the findings of the match between the applicant's or recipient's social security number and one or more of the databases set forth in this Act, the department shall investigate the circumstances and make a determination regarding whether the position of the applicant or recipient is valid. If, after investigation, the department finds that there has been an error, the department shall take immediate action to correct the error, and no further action shall be taken. If, after investigation, the department determines that the position of the applicant or recipient is invalid, the department shall determine the effect of the match on the applicant's or recipient's case and take appropriate action. Written notice of the department's action shall be given to the applicant or the recipient.

5. If the applicant or recipient, as appropriate, agrees with the findings of the match between the applicant's or recipient's social security number and one or more of the databases set forth in this Act, the department shall determine the effect on the applicant's or recipient's case and take appropriate action. Written notice of the department's action shall be given to the applicant or recipient.

6. If the findings of the match between the applicant's or recipient's social security number and one or more of the databases set forth in this Act result in no change in eligibility or overpayment, the department shall take no further action.

C. The department may, in its discretion, review and investigate an applicant's or recipient's case when there is a match between the social security number of the applicant or recipient and one or more of the databases set forth in this Act and the match does not result in a significant discrepancy. In such a case, the department shall utilize the procedure for reviewing and investigating a significant discrepancy set forth in this Act.

D. The department shall establish a single statewide toll-free telephone number and call center that must be used by applicants and recipients in order to resolve discrepancies. The call center shall have sufficient capacity and staff to promptly handle incoming telephone calls. In addition, the department must assign sufficient numbers of government eligibility workers in order to make determinations regarding eligibility pursuant to this Act. The call center shall use available technology to route and track the calls. The department may develop a competitive request for proposal for operating the call center.

#### **Section 5. Further Anti-Fraud Provisions.**

A. No later than one year after the effective date of this Act and every year thereafter, the department shall provide a written report to the governor, the legislature, and the inspector

general detailing the results of the system, the amount of case closures that result from the system and the savings that result from the system.

B. Within one year of the effective date of this Act, **{insert county board}** shall establish procedures to identify, investigate, and resolve potential cases of fraud, misrepresentation, or inadequate documentation prior to determining an applicant's eligibility for assistance. Each **{insert county board}** shall submit to the department a plan describing its antifraud procedures. The plan must be systematic and ensure that every case is reviewed. Further, the review must include utilization of the income eligibility verification system established in this Act.

**Section 6. Determination of Eligibility.**

A. Caseworkers shall maintain close contact with an applicant, recipient, or assistance group. Home visits shall be scheduled as frequently as required by the circumstances of the applicant or recipient in order that any treatment or service tending to restore the applicant or recipient or assistance group to a condition of self-support and to relieve distress is rendered and in order that assistance is given only in such amount and as long as is necessary. The department may develop a competitive request for proposal for conducting home visits and may contract with a firm the department certifies as able to design and implement such a system.

B. Where inconsistencies or gaps in information presented by an applicant or recipient exist or where circumstances in the case indicate to a prudent individual that further information is needed, the caseworker shall seek additional information.

**Section 7. Effective Date.** This Act shall take effect immediately.

*Approved by the Health and Human Services Task Force on July 27, 2007.*

## Workfare Act

### *Summary*

Public assistance should be formulated in terms of a contract between government and the individual. Responsibility must flow in two directions. The individual must be committed to undertaking a number of specific actions to prepare for and seek a job, with the objective of achieving self-sufficiency.

The major obligation of the individual in the public assistance contract is to prepare for, seek, accept, and retain a job. All employable welfare recipients should be required to seek employment or perform public service in exchange for their benefits. Employable recipients who refuse to comply should be denied their benefits.

Experiments in Arkansas, California, and Washington have shown that required job search programs or job search combined with "work experience" where the welfare recipient performs service in a government agency or non-profit agency in exchange for benefits) can significantly reduce welfare rolls and costs.

According to the evidence available, job search and work experience programs produce greater increases in employment and are more cost effective than training programs for welfare recipients.

### *Model Legislation*

(Title, enacting clause, etc.)

#### **Section 1. Participation.**

The following individuals shall be required to participate in the workfare and employment program subject to the guidance specified in Section 1.

(A) Adult AFDC recipients who: are not disabled; do not have a child under age six; have no record of employment during the past two years; and have been enrolled in the AFDC program for at least one year.

(B) Male parents in families on the AFDC-UP program who: are not disabled; and have been enrolled in the AFDC-UP for at least three months.

#### **Section 2. Program requirements.**

Recipients entering the workfare program will participate in the following sequence of activities. Recipients will first participate in an organized job search workshop for a period of eight weeks. Those who have not obtained employment at the end of this eight

week period will participate in the Community Work Experience Program (CWEP). Participants who do not obtain paid employment while participating in the work experience activities will continue in the CWEP for at least six months.

(A) The organization job search workshop will provide for one week of job search orientation instruction followed by seven weeks of closely supervised group job search including participation in a job search phone bank.

(B) Individuals in the work experience program will serve in an unpaid position in the public or private sector non-profit organization. The number of hours of work experience per week in the CWEP program will be determined by dividing the value of the family AFDC grant and food stamps received by the family by the federal minimum wage or the state minimum wage wherever applicable, at least four hours of required participation per week will be set aside to provide the participant with the opportunity to engage in supervised job search activities if desired.

**Section 3. Program Phase-In.**

AFDC and AFDC-UP recipients identified in Section 1A and 1B shall be termed "program eligible recipients." Participation in the work program by eligible recipients shall be phased-in in the following manner.

**Section 4. {Severability Clause.}**

**Section 5. {Repealer Clause.}**

**Section 6. {Effective Date.}**

*Approved by the Health and Human Services Task Force in 1989.*



## **8. Resolution Opposing Employer-Paid Health Care Mandates**

### **Summary**

A resolution in opposition to recent efforts by some state legislatures to mandate that private employers purchase health insurance for their employees. Research has shown that a recent example of such legislation would cost employers, in one state, an additional \$11.4 billion per year, and would not fulfill its goal of providing insurance to the uninsured.

### **Model Resolution**

**WHEREAS**, the American Legislative Exchange Council (ALEC) opposes interference in the labor market by burdensome regulations and mandates; and

**WHEREAS**, some states have mandated or proposed that employers pay for the majority of the health care costs for their employees, or else pay a fee to a state-operated insurance fund that provides insurance to the working uninsured; and

**WHEREAS**, mandates and proposals affect businesses of all sizes, including most small businesses; and

**WHEREAS**, ALEC has previously resolved that small businesses are disproportionately burdened by state mandates and has worked to remedy this situation through its Regulatory Flexibility Act and other initiatives; and

**WHEREAS**, these mandates represent an unfair burden on all businesses operating within a state; and

**WHEREAS**, such mandates amount to a significant new tax on entry-level employment and restrict the ability of businesses to hire new staff, leading to increased job loss for a state's least skilled workers; and

**WHEREAS**, research has shown that only 35 percent of the uninsured will receive insurance under such legislative mandates, while 60 percent of the insurance spending will be for individuals who are already insured;

**THEREFORE BE IT RESOLVED** that because these legislative mandates fail to meaningfully address the problem of the uninsured while at the same time significantly increasing the cost of doing business, and increasing job loss, ALEC opposes employer-paid health insurance mandates.

*Adopted by the CIED Task Force at the Annual Meeting July 29, 2004. Approved by the ALEC Legislative Board August 2004.*

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The Center for Common Cause and Democracy  
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