HJR 35

<target><bill>HJR 35</bill><subject>HJR 35</subject><comm>HFIN26</comm></target>

HOUSE COMMITTEE REPORT

(11)
Date Referred to Committee: March 12, 2010 **FURTHER REFERRALS:**

Date of Committee Action: 4/10/10

The FINANCE Committee considered: **HOUSE JOINT RESOLUTION NO. 35**

Proposing amendments to the Constitution of the State of Alaska prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system.

HJR 35-CONST AM: HEALTH CARE

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____ (_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
DHS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
Assigned by Chief Clerk's Office

List by Dept(s):	FN#	Fiscal	Indet.	Zero

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN#	Fiscal	Indet.	Zero
GOV	1	✓		

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Thomas	✓			
	Gara				✓
Mikey Doogan	DOOGAN		✓		
	Joule			✓	
	Austerman			X	
Mikelly	KELLY	✓			
	Foster		✓		
Anna L. Fairclough	FAIRCLOUGH				✓
Chair:	Stoltze	✓			
Chair:	Hawker			*	

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HJR 35
(H) Publish Date: 2/17/10

Identifier (file name): HJR-035-OOG-DOE-2-9-10
Dept. Affected: OOG
Title: Constitutional amendment prohibiting passage of laws that interfere with direct payments for health care services....
RDU: Elections
Component: Elections
Sponsor: Reps. Kelly, Keller, P. Wilson, Gatto, Ramras, T. Wilson
Requester: House Health & Social Services
Component Number: 21

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual		1.5					
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**1.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF		1.5					
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**1.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The passage of this resolution would require the constitutional amendment to appear on the 2010 general election ballot. The cost of providing information about the constitutional amendment in the Official Election Pamphlet, as required by AS 15.58 is $1.5. Should the addition of this question require printing an 8-1/2 by 18 inch ballot, the cost will increase to $22.0.

Prepared by: Gail Fenumiai, Director — Phone 465-4611
Division: Division of Elections — Date/Time 2/9/10, 8:53am
Approved by: Linda Perez, Director — Date 2/9/2010
Division of Administrative Services

(Revised 10/13/2009 OMB)

2452

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Member
House Finance Committee

Representative Mike Kelly

House District 7

SPONSOR STATEMENT

HJR 35 – HEALTHCARE FREEDOM ACT

"Proposing amendments to the Constitution of the State of Alaska prohibiting passage of laws that interfere with direct payments for health care services and the right to purchase health care insurance from a privately owned company, and that compel a person to participate in a health care system."

HJR 35 would give Alaskans the opportunity to vote on a Constitutional Amendment prohibiting the passage of laws that would force any person or employer to participate in a particular health care system or plan. Similar measures are under consideration in 35 states.

The Health Care Freedom Act seeks to protect two essential rights. First, it would protect a person's right to participate or not in any health care system, and it would prohibit the government from imposing fines or penalties because of that person's decision. Second, it would protect the right of an individual to purchase – and the right of doctors to provide – lawful medical services without government fines or penalties. HJR 35 would place these essential rights in the state constitution.

Few Alaskans question the need for effective health care reform to improve access, quality and affordability while ensuring that personal health care is patient-driven. Advocates of a larger government role in regulating and providing health insurance and care support forcing individuals to join a government-approved health insurance plan, whether or not they want it, can afford it, or it best meets their personal needs. But the overwhelming majority of Alaskans oppose this mandate.

If the federal government adopts nationalized health care and a significant block of states change their constitutions to protect their citizens, a legal clash may well be winnable for the states. This United States Supreme Court may just be in the mood to protect individual liberty and state sovereignty in such a private matter as personal health care.

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Member
House Finance Committee

Representative Mike Kelly

House District 7

MEMORANDUM

DATE: **February 8, 2010**

TO: **Representative Kelly**

FROM: **Derek Miller**

RE: **Sectional Analysis for HJR 35 (26-LS1063\R)**

A sectional summary of a bill should not be considered an authoritative interpretation of the bill. The bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1.
Proposes to amend Article 1, Section 15 of the State of Alaska Constitution by inserting **(a)** before the clause.

Section 2.
Proposes to amend Article 1, Section 15 of the State of Alaska Constitution by inserting a new section that would prohibit the passage of laws that prohibit a person or penalize a person for making direct payments to a health care provider for tendering health care services or prohibit or penalize the purchase of health care insurance from a privately owned health care insurance company. The section also prohibits the passage of laws that compel a person, employer, or health care provider to participate in a health care system or that penalizes a person, employer, or health care provider for declining to participate in a health care system. The section exempts a health care system that provides indemnity and medical benefits to injured workers.

Section 3.
Places the amendments proposed by this resolution before the voters of the state at the next general election in conformity with Article 13, Section 1 of the Constitution of the State of Alaska and the election laws of the state.

April 9, 2010

Karen L. Vernon
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RE: HJR 35

To House Finance Committee: Co-Chairs, Rep. Hawker and Rep. Stoltze, Vice Chair, Thomas and Committee Members: Reps. Austerman, Fairclough, Joule, Kelly, Doogan, N. Foster, Gara, Salmon and Chenault,

I urge you to vote on passage of HJR 35, as this legislation is of utmost importance to the people of Alaska and to the state as a whole. These proposed changes to the Constitution For The State of Alaska are needed to protect the people and the state. It is your sworn duty to do so.

Thank you for your public service.

Please enter this letter as my testimony for the hearing on April 10, 2010 on HJR 35.

Karen L. Vernon

Karen L. Vernon

Health Care Policy and Constitutional Rights:

The Health Care Freedom Amendment

Testimony Presented Before the Alaska House Finance Committee

April 10, 2010

by Dave Roland

Co-Chairperson Hawker, Co-Chairperson Stoltze, Vice-Chairperson Thomas, and members of the committee, I thank you for the opportunity to offer this testimony. My name is Dave Roland, and I am a policy analyst for the Show-Me Institute, a non-profit, non-partisan, Missouri-based think tank that supports free-market solutions to the state's social challenges. Prior to joining the Show-Me Institute, I spent several years in Washington, D.C., gaining expertise in constitutional law as a litigator with the Institute for Justice, a public-interest law firm that specializes in the protection of Americans' liberties. The ideas I will offer today are my own, and should not be taken as necessarily representative of the organizations with which I am affiliated.

Among the elements of the new health care reform law that was passed by Congress is a requirement that almost every adult would either have to purchase a health insurance policy or face punitive fines to be collected by the Internal Revenue Service.[1] There has been widespread debate in legal circles about whether the courts would uphold such a requirement, but lawmakers in at least 40 states are trying to do what they can to insulate their citizens from such a requirement. In Alaska, members of this legislature are considering HJR 35, which very closely resembles the legislation known in other states as "Health Care Freedom" amendments. HJR 35, if passed by this legislature, would offer citizens the opportunity to modify the Alaska Constitution to formally recognize their right to decide for themselves whether they will participate in any private health care system. Under this amendment, the government would not be permitted to prevent citizens from offering or accepting direct payment for health care services, and neither could it substantially limit the purchase or sale of health insurance in private health care systems.[2]

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[1] The law makes exceptions for members of religious groups whose beliefs forbid the acceptance of modern medical treatments.

[2] It appears from the current text of the Health Care Freedom Amendment that the Legislature would retain the ability to pass a comprehensive, tax-based, single-payer public health insurance system, so long as in doing so it did

My testimony today is not intended as an endorsement of any legislation, but rather to explain the policies implicated by the state bill and the federal law just mentioned. I will particularly address the constitutional issues raised by one element of the federal health care reform law, the way that courts would likely resolve those constitutional issues, and the likely impact of the Health Care Freedom Amendment on the courts' resolution.

Should Everyone Have Health Insurance?

The linchpin of the new federal health care reform law is a requirement that by 2014 almost every adult in the nation must obtain a health insurance policy that would meet certain requirements imposed by Congress. In addition to the fact that many Americans currently carry health insurance policies that would *not* fit the requirements Congress is considering, there are also many who have reasons for choosing to remain uninsured. A brief look at the basic mechanics of the health insurance industry will help illustrate why some people make these choices.

Insurance is gambling, both for the insurers and the insured. The insurer looks at your profile and makes a careful statistical determination of how much your health care is likely to cost them over a given period of time. They then charge you a premium that - if their calculations are correct - would allow them not only to cover your expenses, but also to pay their employees and to make a profit on top of that. Their risk lies in the possibility that you might incur costs greater than they expect and/or sooner rather than later. But the odds are heavily stacked in their favor. These companies are very good at making their guesses, and the large pool of resources that results from their customer base means that, just like a casino, they almost always come out ahead.

For the insured, there is also a gamble involved. If, in fact, the insurance companies are correct (as they usually are), the insured will end up paying far more for their health care than they would have if they had remained uninsured. This is the risk they assume in order to gain peace of mind that, should a catastrophic injury or illness occur sooner rather than later, they will be taken care of. But, financially speaking, the great majority of people would be better off

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not either outlaw the sale or purchase of private insurance policies or restrict citizens' abilities to offer or accept direct payment for health care services.

putting 85% of what their insurance premium would have been into a savings account earmarked for health care expenses.[3] Then, whenever health care costs emerge, the money is ready to be used - and, importantly, it can be used for any procedure and any health care provider the insured prefers.[4]

So the health insurance trade off is, the insured sacrifices extra money and a significant range of choice as to providers and procedures for the assurance that they will have their expenses covered if they should need treatment sooner than they would otherwise be able to pay for it. It is not a necessity, and a large majority of people would ultimately be better off if they simply saved their money instead of giving it to insurance companies. That is why it very easily could make economic sense to forgo health insurance.

While some people may not carry health insurance because it is unaffordable, many Americans *choose* not to purchase health insurance. Some people's religions may not permit the use of modern medicine, while others may not believe it to be effective. Still others are simply confident enough in their propensity for health that they are willing to risk the costs of illness or injury in order to direct their money to concerns that they believe to be more pressing for themselves and their families. And there are some who, recognizing that most people pay far more to insurance companies than they are ever likely to need for their own treatment costs, would prefer to self-insure by creating their own health fund. For each of these people, a congressional directive to purchase a health insurance policy would mean giving up a huge amount of money — as well as a significant amount of autonomy and privacy — committing themselves to a contract for goods and services that they do not want, and in some cases may be prohibited from using.

The Federal Constitution

As we all remember from high school, congressional authority is limited to those powers explicitly granted by the Constitution.[5] In this case, the question would be whether the

[3] Even the best of health insurance companies usually only apply about 85% of the premiums they receive on their clients' health care costs.

[4] Most health insurance companies place limits on the doctors from whom a policy holder can receive treatment as well as on the types of treatment that are covered.

[5] These eighteen powers are enumerated in Article I, section 8, of the U.S. Constitution: 1) To tax and spend for "the common defense and general welfare of the United States"; 2) To borrow money; 3) To regulate commerce with

Constitution gives Congress the authority to punish citizens for refusing to purchase health insurance.

Those arguing in favor of the law's constitutionality suggest that this authority is part of part of Congress' power "to regulate commerce ... among the several states[.]"[6] It is true that since 1937 courts have generally interpreted this power very broadly,[7] resulting in a U.S. Supreme Court decision that a farmer named Filburn was bound by agricultural regulations regardless of whether he took his grain to market.[8] More recently, the Supreme Court also held that Angel Raich was subject to federal drug laws even though her medical marijuana was homegrown and neither bought nor sold.[9]

But courts have also recognized that congressional authority under the Commerce Clause *is* limited. In *U.S. v. Lopez*, the Supreme Court held that the Commerce Clause did not permit Congress to create a federal law banning possession of firearms in a school zone.[10] In *U.S. v. Morrison*, the court struck down a law that addressed the subject of gender-based violent crime.[11] The primary reason that the court struck down the laws in *Lopez* and *Morrison* was that the subjects Congress sought to regulate lacked a clear nexus with commerce among the states.

Even though much of the health insurance industry is handled within the bounds of individual states,[12] courts will likely find that health insurance as a whole is an issue with a sufficient connection to interstate commerce to permit congressional regulation. But now that

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foreign nations and among the several states; 4) To establish rules governing naturalization of citizens and bankruptcies; 5) To coin money and regulate its value; 6) To punish counterfeiting; 7) To establish a postal service and post roads; 8) To establish copyright laws; 9) To constitute a federal court system inferior to the Supreme Court; 10) To punish piracies on the high seas and offenses against the law of nations; 11) To declare war and make rules concerning captures on land and water; 12) to raise and support armies; 13) To provide a navy; 14) To make rules to govern the army and navy; 15) To provide for the use of militia to enforce laws, suppress insurrections, and repel invasions; 16) To provide for organizing, arming, and disciplining the militia; 17) To govern the District of Columbia; and 18) to make laws "necessary and proper for carrying into execution the foregoing powers".

[6] U.S. Const. Art. I, § 8.

[7] Prior to 1937, the power of the federal government was regularly held in check by the Supreme Court. A number of factors, including President Franklin Roosevelt's threat to pack the court with his own appointments in order to ram through New Deal legislation, led to what has been termed a "constitutional revolution". For the past 73 years, the general rule has been for courts to presume that the Commerce Clause grants Congress nearly unlimited authority to regulate the behavior of citizens—particularly as pertains to their ability to obtain, keep, and use property.

[8] *Wickard v. Filburn*, 317 U.S. 111 (1942).

[9] *Gonzalez v. Raich*, 545 U.S. 1 (2005).

[10] *U.S. v. Lopez*, 514 U.S. 549 (1995) (finding no clear connection between mere possession of a firearm in some proximity to a school and the stream of interstate commerce).

[11] *U.S. v. Morrison*, 529 U.S. 598 (2000).

[12] In part as a result of federal law, it is very unusual for individuals to be able to purchase insurance from companies outside the state in which they are currently domiciled.

Congress has passed a law mandating that individuals must either buy health insurance or face financial sanctions, courts will still have to answer a very specific question: Does the power to regulate interstate commerce give Congress the authority to penalize citizens *who do not wish to engage in commerce*?

As Prof. Randy Barnett pointed out at a Heritage Foundation debate,[13] the Supreme Court has never faced such a question, so we cannot be certain of its answer. I tend to agree with Barnett that the Court's response will likely hinge on the solicitor general's ability to explain which aspects of citizens' lives (if any) would remain beyond the reach of congressional regulation if the Court permitted these mandates to be enforced. If the Solicitor General offers a reasonable response that acknowledges clear limits to the powers available under the Commerce Clause, the Court may sustain the individual health insurance mandate. If not, I believe that the majority of justices will strike the mandate as unconstitutional.

Some professors have argued that even without relying on the Commerce Clause, authority for the health insurance mandate could be found in Congress' power "to lay and collect taxes ... [to] provide for the ... general welfare of the United States",[14] or even in the Sixteenth Amendment's authorization of an income tax.[15] I disagree. While the taxation power *might* permit Congress to create a tax-based, universal public health insurance system like Medicare,[16] this sort of comprehensive, tax-based program is not the object of the penalties that would be assessed upon those who choose not to comply with the insurance mandate. In fact, these penalties cannot properly be considered "taxes" at all unless their primary purpose is to raise revenue for the government rather than to regulate the behavior of citizens.[17] Thus, while

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[13] Video available at http://volokh.com/2009/12/09/video-of-heritage-session-on-constitutionality-of-health-care-mandate/.

[14] U.S. Const. Art. I, § 8.

[15] U.S. Const. Amendment XVI.

[16] This might be possible, though politically impractical. First, they could not apply such a tax against everyone. It would have to take the form of some kind of an income tax or else it would violate the constitutional prohibition on "capitation" or "direct" taxes. See Article I, section 9. So, in order to mirror the effect of the current proposal while relying on the taxing power, they'd have to jack up the income tax rates by 2% across the board, then offer a 2% tax credit for anyone who obtains a qualifying health insurance policy. That would likely pass muster, constitutionally, but it would almost guarantee an enormous political backlash because people hate having their taxes raised - even if many would have a relatively easy way to get out from under it. This approach, by the way, would also make it much harder to exempt people with religious reasons for not obtaining health insurance, which would be another major knock against such a plan.

[17] "The test to be applied is to view the objects and purposes of the statute as a whole and if from such examination it is concluded that revenue is the primary purpose and regulation merely incidental, the imposition is a tax and is controlled by the taxing provisions of the Constitution. Conversely, if regulation is the primary purpose of the statute, the mere fact that incidentally revenue is also obtained does not make the imposition a tax, but a sanction

Congress can properly impose fines for violation of a law that it is permitted to enforce pursuant to its authority to regulate commerce, it may not call a fine a "tax" in order to justify penalties for behavior *not* within its authority to regulate commerce. Furthermore, even if the fees for failing to purchase health insurance were classified as a tax authorized by Article I, section 8, Congress is specifically denied the authority to impose capitation taxes "unless in proportion to the census," a requirement that the current proposal does not seem to meet.[18] Therefore, Congress may not justify the mandate and its penalties unless they are enacted pursuant to one of the other powers enumerated in Article I, section 8.

The next question courts would have to answer is whether the issue should be reserved to the states under the Tenth Amendment.[19] This is shakier ground for a constitutional defense than one would really like to have. While the original intent of the Tenth Amendment was clearly to keep the federal government in its proper, limited sphere, the test of the amendment states that it applies only where courts have determined that a specific power has not been delegated to Congress. If a court has already located congressional authority in either the Commerce Clause or the taxing power, it is a near certainty that it will also determine that the Tenth is simply inapplicable as a barrier against the federal statute.

After considering the question of whether Congress generally has the authority to create an individual health insurance mandate, the question will then become whether such a mandate violates liberties preserved under the first nine amendments to the U.S. Constitution. The relevant provisions are contained in the First, Fifth, and Ninth Amendments.[20] The Supreme Court has previously recognized that the Constitution protects citizens' rights to associate with

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imposed for the purpose of making effective the congressional enactment. There is a marked distinction between taxation for revenue, as authorized and limited by Article 1, Sections 2 and 9 and Clauses 3 and 4 of the Constitution, and the imposition of sanctions by the Congress under the commerce clause. The power of Congress to 'regulate commerce' is the power to prescribe the rules by which commerce is to be governed and the Congress is at liberty to adopt any method which it deems effective to accomplish the permitted end. Congress has a discretion as to what sanctions shall be imposed for the enforcement of the law and this discretion is unlimited so long as the method of enforcement does not impinge upon some other constitutional prohibition." *Rogers v. United States*, 138 F.2d 992 (6th Cir. 1943)

[18] It might be argued that the penalties for failing to obtain health insurance could be considered an "income tax" of the sort that is exempted from the limitations of Article I, section 9. I think that such a penalty could not be considered an "income tax" because it would be selectively applied and collected separately from the general income tax authorized in the Sixteenth Amendment.

[19] U.S. Const. Amendment X.

[20] While the U.S. Supreme Court has rarely discussed the Ninth Amendment as a substantive source of individual liberties, its text—"The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people"—suggests that it should be seen as such. See Justice Arthur Goldberg's concurring opinion in *Griswold v. Connecticut*, 381 U.S. 479 (1965).

others of their choosing,[21] to enter into contracts, to make their own decisions regarding health care, and, of course, their right to privacy.[22] A violation of any one of these rights could be sufficient to invalidate the health insurance mandate.

Unfortunately, merely establishing an infringement of constitutional rights does not usually end the analysis. In fact, the Supreme Court has long permitted infringement of these kinds of liberty, as long as the government could advance an interest in doing so that a majority of the justices considered sufficiently important. In the case of the individual health insurance mandate, the government's interest is to make insurance premiums more affordable and, thus, to increase the number of people with access to health care. The courts will have to balance this interest against the liberty and privacy interests violated when citizens are forced to purchase coverage that they do not want and may have no intention of using. My opinion is that, particularly given the extremely high value that several current justices place on protecting the privacy rights of individuals, it will be difficult for the Solicitor General to convince a majority that the *potential* for lower health insurance premiums (because, in fact, there is no guarantee that the plan will work in the way Congress intends) can justify forcing someone to disclose private information about themselves and their health care.

The Health Care Freedom Amendment

If everything I've discussed above fails to persuade the courts to strike down the individual health insurance mandate, then the arguments will come down to state constitutional protections. This is one reason (but only *one* reason) why Alaskans should take the Health Care Freedom Amendment seriously.

The Bill of Rights in the U.S. Constitution does not demarcate the outer limits of individual freedoms to which citizens are entitled. Rather, it merely establishes a baseline of liberty that cannot be violated by any level of government. The states, however, each have their own constitutions, and those documents can—and frequently do—provide an even higher level of protection for liberty than is afforded by the U.S. Constitution. Generally speaking, these additional protections are only applied against the actions of state and local governments, but if

[21] U.S. Const. Amendment I.
[22] U.S. Const. Amendments V and XIV (Due Process Clause).

Congress tried to enforce a law that directly violated the terms of the Health Care Freedom Amendment (or some other freedom guaranteed under a state constitution), the courts would have to decide whether a state's guarantee of liberty to its citizens can protect them from actions of the federal government that would violate that liberty.

This is currently an open question. There are cases in which federal courts have noted that the application of a federal statute could result in a violation of certain freedoms secured under state constitutions. In several of these cases, the courts required the government to come up with a sort of alternative structure that would respect the state constitutions – but in each of those cases there were also usually indications from Congress that they wanted to avoid violating state constitutional freedoms. In the case of the individual health insurance mandate, it would seem clear that Congress is not concerned with respecting state constitutional protections. This would set up a battle under the U.S. Constitution's Supremacy Clause.

The Supremacy Clause, found in Article VI, reads as follows:

> "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any state to the Contrary notwithstanding."

Of course, the central question here will be just how the courts will apply this language. The answer may not be as simple as it seems. Despite the text's indication that state laws and constitutions are subject to federal laws and treaties, a look into history shows that several important Founders rejected the idea that Congress could always enforce laws deemed unconstitutional by the states. When in 1798 Congress passed the Alien and Sedition Laws, which made it a criminal offense to publicly criticize certain government officials, James Madison—widely known as the Father of the Constitution—and Thomas Jefferson—author of the Declaration of Independence and the sitting Vice-President—drafted the Kentucky and Virginia Resolutions, in which those states rejected the constitutionality of the acts.[23] The U.S. Supreme Court was not called upon to resolve the question of whether states could legitimately

[23] Madison later said that, in his opinion, these resolutions were primarily useful as tools through which the power of Congress could be called into question—though not necessarily nullified. He believed that similar resolutions would signal to other states the potential necessity of modifying the current system of government to eliminate further abuses.

deny congressional authority in this way, but up until the Civil War different states repeatedly adopted similar measures.[24]

Without any directly applicable judicial precedent, some legal scholars have attempted to guess at how the justices might be inclined to resolve such a conflict between state constitutional liberties and federal laws. One of my colleagues, Clint Bolick, a co-founder of the Institute for Justice and the current leader of a constitutional litigation center at the Goldwater Institute in Arizona, has noted a recent judicial trend in which the Supreme Court has shied away from allowing federal laws to trump state constitutional requirements.[25] This might well signal that the justices are inclined to protect freedoms enshrined in state constitutions, but the only way we will be sure is if the U.S. Supreme Court is presented with a direct conflict. The Health Care Freedom Amendment, if adopted by the people of this state, could provide just such a conflict.

Summing Up

Now that Congress has passed the health care reform law, it will likely be several years before a case evaluating the constitutionality of the individual health insurance mandate reaches the U.S. Supreme Court. In fact, we have already seen a number of lawsuits filed in federal courts. Once the federal district courts have decided that this issue is ripe for adjudication, they are likely to deal with the issues quickly, render a decision, and kick the cases up to the circuit courts. Once the circuit courts have weighed in on the constitutional issues, the Supreme Court will choose the set of facts on which it will base its consideration of the law. Keep in mind that it doesn't have to take the *first* case to get resolved by a circuit court, although it only takes four justices agreeing in order to get a case in front of the Supreme Court.

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[24] Many northern states refused to enforce the provisions of the Fugitive Slave Acts passed by Congress. Indeed, South Carolina's attempted nullification of a tariff passed by Congress in 1832 nearly sparked secession and armed conflict.

[25] Instead, the Supreme Court has generally tried to avoid finding a direct conflict between federal laws and state constitutional provisions. For example, in *Wheeler v. Barrera*, 417 U.S. 402 (1974), Congress had passed Title I, which required public educational funds to be distributed to disadvantaged children regardless of the schools they attended. This conflicted with Missouri's constitutional prohibitions against public dollars being sent to religious schools. Rather than address this apparent conflict, the Supreme Court noted that the legislative history of Title I suggested that Congress was sensitive to the presence of such state constitutional provisions and that they did not intend to require violation of those provisions. To get around the problem, the Court decided that a separate public fund – which would not be part of the state treasury – would be established as the conduit for Title I funds to the assistance of needy children in religious schools.

When the issue gets in front of the Court, I believe that proponents of the mandate (in other words, the Solicitor General) will have to satisfactorily answer at least two vitally important questions if they are to win a majority: 1) If the Commerce Clause permits Congress to force individuals to purchase goods and services that they do not want, where is the limit of that power - if, indeed, a limit can be articulated?, and 2) Is Congress's interest in (potentially) lowering the cost of health insurance premiums sufficiently compelling as to justify forcing individual citizens against their will to associate with others and to divulge to them all sorts of private information about one's health?

I believe, based on the current composition of the Supreme Court,[26] that the individual health insurance mandate would probably be found unconstitutional, either as a violation of the Commerce Clause or the individual right to privacy. I cannot see any of the four conservative-leaning justices (Roberts, Alito, Scalia, or Thomas) approving such a mandate as an exercise of the Commerce Clause, nor can I see any of the three liberal-leaning justices (Ginsburg, Breyer, and Sotomayor) disapproving the mandate. The deciding factor, then, will be whether Justice Kennedy will go for or against it, and I believe that will largely depend on how the Solicitor General articulates what limits might remain on congressional authority if the mandate is approved.

A more interesting question is how the justices might vote on the question of whether the right to privacy precludes the imposition of an individual health insurance mandate. Justices Thomas and Scalia have both rejected the notion that there *is* any such right to be found in the constitution, making it unlikely that they would rely on this right to strike down legislation as unconstitutional. On the other hand, several of the more liberal justices have previously written passionately about the importance of the right to privacy. It is possible that the privacy question might result in a majority of justices voting to strike down the mandate, but with Scalia and Thomas dissenting on this point.

Either way, it is my opinion that the Supreme Court is likely to find that an individual health insurance mandate violates the provisions of the U.S. Constitution. While the Supreme Court is thus unlikely to reach the question of whether the Health Care Freedom Amendment

[26] The April 9, 2010, announcement that Justice John Paul Stevens would be retiring from the Supreme Court is unlikely to alter this analysis. Justice Stevens was a reliable vote in favor of governmental authority to regulate individual citizens' lives, and he was widely expected to favor the constitutionality of the new health care reform law. Thus, no justice appointed by President Obama will improve the likelihood of the mandate's constitutionality being upheld – and they might actually become a vote *against* the mandate's constitutionality.

would be seen as an additional bulwark for liberty, the adoption of this amendment (and others like it in other states) would at a minimum offer the potential for a case that would test the boundaries of state sovereignty under our current constitutional system.

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Member
House Finance Committee

Representative Mike Kelly

House District 7

MEMORANDUM

DATE: **February 15, 2010**

TO: **Representative Mike Kelly**

FROM: **Derek Miller**

RE: **Answers to Questions @ 2/9/10 HESS Hearing**

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1) **Does HJR 35 prevent the State of Alaska from initiating a new tier to the state retirement system? How would this constitutional amendment impact future changes to the current State of Alaska retirement system?**
This resolution does NOT prevent the State from initiating a new tier to the state retirement system. Changes can be made to the retirement system as long as those changes aren't a mandate on individuals or employers to purchase insurance. The state would also be prohibited from passing laws that penalize or fine individuals or employers from choosing not to purchase coverage.

2) **Does this resolution prevent the federal government from making changes to Medicare, Tricare, Indian Health Services, etc...?**
This resolution does NOT preclude the federal government from doing anything. Individuals would still have the option to participate in the federal health insurance program. This act simply protects a person's right not to participate.

3) **How does this legislation address the problems the HESS committee has looked at? Example: Access, quality, affordability? Are there any fixes in the bill?**
HJR 35 prevents a one-size-fits-all universal coverage system. Alaska legislators must work on a targeted set of policy solutions to cover the uninsured and there are reforms that will advance this goal, along with HJR 35.

4) **Does this bind future legislatures from adopting the program the federal government comes up with?**
Yes, if that program includes mandating individuals and employers to purchase insurance or penalizes individuals for choosing not to purchase insurance. Individuals however, would still have the option to participate in the program.

5) **Does this amendment prevent the state from implementing a plan if it penalized employees and employers for not purchasing health insurance?**
Yes.

Source:

Christie Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
1101 Vermont Avenue, N.W., 11th Floor
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Direct: 202-742-8505

Governor Sean Parnell
STATE OF ALASKA

January 13, 2010

The Honorable Lisa Murkowski
United States Senate
709 Hart Senate Office Building
Washington, DC 20510

The Honorable Mark Begich
United States Senate
144 Russell Senate Office Building
Washington, DC 20510

The Honorable Don Young
United States Congress
2111 Rayburn House Office Building
Washington, DC 20515

Dear Senators Murkowski and Begich and Congressman Young,

As Congress contemplates final passage of the proposed health care reform legislation, I ask that you consider the concerns raised by my administration on behalf of Alaska's residents. As I have previously communicated to you, both publicly, and through my staff, the current federal proposal does little to address the main health care issues facing Alaskans – cost and access.

The current health care reform legislation before Congress is troubling on several levels. For the many Alaskans currently unable to afford insurance, the proposal, as outlined by Congress, will do nothing but mandate they purchase it, while increasing the insurance premiums. I am particularly concerned with the increase in costs by the pending legislation for Alaska's seniors, families, small businesses, and physicians. Beyond this burden, which is placed squarely on the shoulders of Alaskans, the legislation will put a significant strain on the State of Alaska's General Fund budget.

In addition to the enormous cost Alaskans would face, the proposal does little to address Alaska's health care workforce shortage; requiring individuals to purchase health insurance does not guarantee that people will have access to health care.

Beyond the practical concerns about the benefits of this legislation that I have raised, I am concerned about the constitutionality of forcing Americans to purchase health insurance. As you know, I have directed Alaska's Attorney General to conduct a review of the reform legislation, including this requirement.

So that you are fully aware of the State of Alaska's concerns, I am including two supplementary documents provided to you over the course of the health care reform debate. The first document updates a previously submitted policy review of the healthcare legislation passed by the Senate. The second document provides Alaska's perspective on the so-called "Nebraska Compromise" whereby the cost of

Medicaid expansion in Nebraska will be indefinitely supported by the federal government. As you will note, this expansion will cost Alaskans $700 million over the first 20-year window of implementation while Nebraskans will not be responsible for paying anything.

Finally, I ask that you consider securing a 100-percent federal Medical Assistance Percentage for services rendered to Native Americans and Alaska Natives outside of Tribal facilities. Such a provision would be advantageous to Alaska and other states with large Native populations. Supporting documents outlining this request have previously been submitted to you.

Thank you for your serious consideration of my concerns regarding the proposed legislation. I look forward to continue to work with you to ensure that Alaskans are treated fairly, and that the health care needs of the citizens of this great state are adequately met.

Sincerely,

Sean Parnell
Governor

Enclosures

State of Alaska
Patient Protection and Affordable Care Act Comments
January 11, 2010

Policy Considerations

Insurance Market Reforms
Guaranteed issue and guaranteed renewal rules would be imposed on all individual and small group plans, and exclusions for preexisting conditions and annual or life time caps would be prohibited. Rating rules would limit variations in premiums to geographic area, tobacco use, age, and family composition.

Guaranteed issue and renewal, modified community rating rules, and preexisting exclusions could be very problematic and potentially drive the cost of insurance premiums up significantly unless there is sufficient participation in the individual and small group markets to spread the risk. It could be anticipated that some employers and low risk individuals may chose to face tax penalties rather than enroll in insurance plans, leading to adverse selection.

Any insurance market rating reforms must provide adequate time to transition to new federal minimum standards and preserve state regulatory authority to ensure consumer protections.

Health Insurance Exchange Sec 1311
By 2014 states would be required to establish, using federal grant funds, an insurance exchange for individual and small group markets. Large employers may participate beginning in 2017. Insurers operating in the state, or multistate plans operating under this proposal, would be required to participate in the exchange. The exchange would develop standardized enrollment forms and formats for comparing plans. Individuals could only receive tax credits if they purchase coverage through the exchange. Exchanges must be fiscally self sustaining beginning Jan. 2015.

A health insurance exchange could assist individuals and groups to comparison shop for insurance and potentially enhance competition in the insurance market. This proposal envisions exchanges as tools for aggregating the risk of individual and small group coverage resulting in premium reductions. Should an exchange be required by law, an Alaska-based and administered exchange, or a state option to join with other states in a multi-state exchange, would be preferred over a national model.

The administrative and regulatory challenges will be very complex particularly considering that the legislation is overly prescriptive of operational requirements. There also appears to be potential for confusion between the role and authority of the Secretary of HHS and state insurance regulatory responsibilities. Becoming fiscally self sustaining can be a significant issue in a state such as Alaska where there is a very limited pool of insurers and the Exchange fees, whether on the plans or individuals, adds additional cost to already high insurance premiums.

The language should be modified to ensure maximum state flexibility to design and operate exchange mechanisms that facilitate the purchase of insurance.

Individual and Employer Mandates

The bill would require individuals to purchase at minimum a basic plan (that would cover 65% of health care expenses) beginning 2013, and would impose a tax penalty (graduated based on income) on those who do not enroll. Employers with more than 50 employees would be required to pay a tax for each employee who receives a tax credit through a state exchange.

Individual Alaskans and Alaska's business community are likely to oppose such mandates, which essentially translate into a new tax on families and individuals who currently do not have health insurance. Also, because the state's workforce includes a high level of seasonal and part-time employees, mandates would be difficult to track and enforce.

Medicaid Expansion Sec 2001

Beginning Jan. 2014 the bill expands Medicaid coverage for all legal residents up to 133% FPL, including childless adults. Income disregards would be prohibited and eligibility would be determined based on adjusted gross income through the annual IRS income tax reporting. The bills impose maintenance of effort requirements on eligibility, which means that eligibility standards and categories of eligibility cannot be reduced or made more stringent. The proposals also mandate new eligibility groups and additional benefits, again creating an additional cost to the state.

While the bill proposes significant increases in FMAP rates (91% in the House bill and about 82% in the Senate bill) to cover increased program costs to states for the expansion, the full cost of expansion is not assumed by the federal government, and there is no guarantee the higher FMAP levels would be maintained. The State of Alaska opposes new unfunded federal mandates. Requiring additional matching state funds is not viable in the current economic recession, the expected states' budget shortfalls anticipated over the next several years, and the competing state General Funds needs for education, corrections, public safety, etc.

New programmatic mandates, as outlined in the bill, will further exasperate this concern.

It is important to note that state participation in Medicaid is voluntary, but if a state chooses to participate then all of the federal requirements must be met. It may be that a state or some states are facing such severe economic difficulty in 2016 when significant state costs begin that opting out of Medicaid participation may become the only viable option in order to maintain other state programs.

Additionally, a huge increase in administrative burden and costs would be assumed by states to manage the expansion without an enhanced FMAP. This burden will be compounded by the proposed new eligibility processes which are very different from the current process, resulting in significantly increased costs to states to implement the change, while maintaining the current eligibility process for other programs, such as food stamps and TANF. In particular, an enhanced FMAP is needed to accommodate costs of enrollment for the currently eligible but not enrolled population.

Any Medicaid expansion should not increase costs to the state or include new unfunded mandates. Congress should include a 100% federal share for expansion.

Medicaid Quality Subtitle I
Establishes Medicaid Quality Measurement Program. Prohibits payments for health care acquired conditions. Establishes a bundled payment demonstration project.

Non-payment for services related to health care acquired conditions should serve as an effective incentive for health care providers and facilities to reduce infection and medical error rates. A demonstration project that comprehensively tests payment bundling to determine viability and effectiveness of this methodology may be a first step toward payment reform. Development of a quality measurement program will support Alaska's vision of moving toward performance-based purchasing for Medicaid.

CHIP(DKC) Sec 2101
The House version ends CHIP in 2014 and children then obtain coverage through the Exchange or Medicaid. The Senate continues CHIP to 2019 and provides a 23% FMAP boost the last three years.

CHIP programs have been well supported throughout the states and considered quite successful in insuring children. It is likely Congress will have significant difficulty ending CHIP as a distinct program and merging it with Medicaid or Exchange coverage. Continuation as proposed by the Senate will save some GF the last three years, however it is unlikely Congress will end the program.

Should these provisions remain intact, the state requires maximum flexibility to transition children into Exchange plans.

Definition of Medical Assistance
Redefines "medical assistance" in the Medicaid program to include both the means of payment of part or all of the cost of medical care and the services and care themselves.

Based on past Ninth Circuit Court of Appeals decisions, this proposed change would increase lawsuits against states. As a result, states will lose much of their ability to control programs and expenditures.

This new definition should be deleted.

Maternal and Child Health Sec 2951
Establishes new federal grant program or optional Medicaid service expansion for early childhood home visitation programs

Alaska (DHSS) would seriously consider developing this program if federal resources become available and operational control is minimized at the federal level. Research-based home visitation models have demonstrated good return on investment and positive outcomes for families, including improved maternal and newborn health, child development and early identification of problems, school readiness, juvenile delinquency and family self sufficiency.

Promoting Disease Prevention and Wellness Title II

Authorizes incentives for Medicare and Medicaid enrollees who complete healthy lifestyles programs. Creates new Medicaid state plan option for "health homes" providing care coordination/management and health promotion (among many other services) through integrated care teams for enrollees with multiple chronic conditions. Incentivizes states to cover preventive services and immunizations under Medicaid. Appropriates funding for Childhood Obesity Demonstration Project.

Improving health and wellness behaviors of Medicaid recipients is important for their long term health, though educating recipients and providers about the proposed incentives and also tracking recipient compliance might prove to be a challenge. Also, financial incentives alone for completing a healthy lifestyle program cannot be expected to automatically translate into improved behaviors, but should be accompanied by programs (such as the proposed Childhood Obesity Demonstration Project) that address the barriers individuals face to engaging in healthy behaviors.

Alaska could benefit from a Medicaid option that would provide a mechanism to reimburse for the services of integrated health care teams serving as the medical "health" home for Medicaid recipients with multiple chronic conditions.

Payment Reform Sec 2705
Establishes CMS Innovation Center to test new provider payment models, and pilot program to encourage improved coordination of care between hospitals, physicians, and post-acute providers through payment bundling.

Alaska's private medical sector is behind most states in development of integrated care systems, and there are no health maintenance organizations in our state. Encouraging service integration through new payment mechanisms could help improve the efficiency of Alaska's health care delivery system.

Workforce Title V
Provides 10% Medicare bonus for primary care providers and general surgeons practicing in HPSAs; redistributes unused graduate medical education training slots and encourages residencies in outpatient settings, and proposes a number of committees, studies and pilot projects related to health workforce development. The senate version appropriates significant funds for the National Health Service Corp and various other sections of this expansive provision, including loan repayment and retention funding.

The proposal does not go far enough in supporting the development of the health care workforce. Ensuring an adequate supply and distribution of health care workers is as essential (if not more so) to increasing access to health care as expanding access to health insurance. To support health workforce development, additional resources above and beyond the provisions in these bills need to be provided for training and for recruitment.

It does not appear that the significant reimbursement changes needed to encourage and support primary care practitioners are present in the legislation..

Title V – Fraud, Waste, and Abuse

Proposed strategies for reducing fraud, waste and abuse in Medicare and Medicaid include a new provider enrollment process, data sharing across federal programs, increased penalties, and requirement for providers to implement a compliance program.

Though fraud and abuse are significant concerns, these proposals, in addition to current requirements, will increase costs and increase procedural requirements imposed on providers. These proposals may serve as a deterrent to provider participation in Medicare and Medicaid, further decreasing access to care and services for Alaskan enrollees.

Congress has created fraud and abuse detection and compliance programs in addition to other such programs. It appears that there is minimal coordination or collaborative effort to determine what works and is cost effective. Federal auditors and contractors overlap and overlay with state and other federal fraud and abuse efforts. While this is all well intended, it appears to be duplicative and ineffective. Congress and the administration should examine all of the current programs and proposed programs to find cost effective methods to better combat fraud and abuse across all private and public programs.

Revenue Items

Proposal increases revenue to partially cover cost of service expansion through taxes on insurers, drug companies, medical device makers, laboratories, and high cost insurance plans.

The proposed new taxes on the health care sector is likely to increase costs to the consumers and government health care programs, potentially off-setting the income generated by these new fees.

"Cadillac Plan" taxation in the Senate version would affect AlaskaCare plan members, and raises questions about who or what entity would be liable for the tax, and if the State plans are considered "insurance companies." If the tax is levied on insurance companies, can the Federal Government tax the State? Are retiree health trusts similarly "insurance companies" subject to tax?

Community Living Assistance Services and Supports Sec 8001

Both bills propose a national voluntary long term care insurance financed by wage based premiums. The senate bill requires a long term actuarially sound benefit of at least $50/day.

This may be of some benefit to individuals permit them to remain in their own homes longer. However, a benefit of at least $50/day will not cover the significant cost of assisted living. It will only supplement other payers or perhaps briefly delay eligibility for public programs. To the degree that it delays eligibility for Medicaid or offsets Medicaid payments this will benefit states, but likely not to a significant extent.

Indian Health Care Reauthorization Act Sec 10221

Both bills have differing versions of reauthorization. This is important to Alaska as this act has not been reauthorized for many years and new provisions should strengthen the tribal health care organizations, which benefits the state.

For the first time federal law will recognize that tribal services are no longer linked to provision in a facility, but can be provided in the community. This clearly allows tribal organizations to

expand into providing long term care services for their beneficiaries, which several in Alaska wish to do. This is important in securing 100% FMAP for these Medicaid services. (*See discussion paper on tribal 100% FMAP).* In addition there are programs to increase Indian health care workforce, new models of behavioral health delivery and disease prevention and youth suicide prevention, all items that could benefit Alaska.

Medicaid Pharmacy Changes Sec 2503

Beginning January 2010, both the House and Senate bills increase the federal Medicaid drug rebate minimum level for brand and generic products.

While these proposals will increase the federal rebate dollars, the net effect will be to decrease the state drug rebate collection. Currently Alaska and many other states collect supplemental drug rebates above the federally mandated amount. Increasing the federally mandated base rebate lessens or eliminates the supplemental rebate states have been collecting. In addition, the savings attributable to the new rebate bands accrue only to the federal government. These savings should be shared between the state and federal government as under current law.

Increase Funding for Federally Qualified Health Clinic Sec 5601

The House bill increases funding by $12 billion over 5 years and the Senate bill provides $33 billion over 6 years.

New funding can be used to expand current public capacity as well as build new capacity. This will be critical in creating access for Medicare, Medicaid and tribal beneficiaries as the other provisions in these bills do not significantly address workforce and private reimbursement issues.

Considering Alaskans' reliance on FQHCs, it is imperative that the state receive a large allocation.

Medicare Subtitle B

The bills phase in payment reductions to Medicare Advantage plans, develop quality measures and payment models, begins to reduce the 'doughnut hole' for Medicare pharmacy and other extensive changes.

The changes to Medicare Advantage plan reimbursement will likely have minimal impact upon Alaskans. It appears that the few plans operating in Alaska were recently pulled. Closing the "doughnut hole", while apparently phased in slowly, will eventually provide significant out of pocket cost savings for Medicare eligible Alaskans that have significant drug usage. Individual savings will be determined by the rate at which the "doughnut" hole is closed. This has yet to be resolved by the legislation.

These bills do not address the physician payment reductions that result from the Sustainable Growth Formula. Until resolved, it is likely to dampen provider willingness to serve Medicare eligible patients.

State as Employer Considerations

1. *Excise tax on insurers for employer-sponsored health plans: a 40% tax on value above $8,000/individual and $21,000/family for 2013 and indexed on CPI beginning 2014. The threshold amounts will be increased for retirees and employees engaged in high risk professions by $750/individual and $2000/family.*
    - Value is defined broadly as the aggregate value of all employer-sponsored health insurance coverage, including coverage in the form of reimbursement under a Health flexible spending/reimbursement arrangement, dental and vision coverage and other supplementary coverage. First, it is not clear that state governmental plans are included; clarification is necessary. Second, if the state is subject to this bill and provision, it would be taxed to some degree.

2. *New fees on segments of health care sector including annual fee on health insurance sector.*
    - Unclear whether state's self-insured healthcare programs would be included as insurance sector.

3. *Plans report proportion of premium dollars spent on administrative expenses.*
    - Self-insured plans use a per capita fund accumulation and are not-for-profit, unclear if this will affect the state.

4. *Large employers prohibited from annual and lifetime limits.*
    - State plans have annual limits for some coverage, lifetime unlimited for Actives, $2mm for Retirees.

5. *Preventive care must be covered 100% or value based design.*
    - Will require changes to state's plans. "Preventive Care" is ill-defined; costs unknown. "Value-based" also poorly defined, but may result in lower payments on behalf of members who do not follow protocols. Impact unknown.

6. *Maximum out-of-pocket limit.*
    - Will require changes to state's plans. Impact unknown.

7. *Plan applicability uncertain – Retiree Plans.*
    - Uncertain if applicable to retiree plans. Alaska is a rare pre-funder of retiree health obligations. Uncertain if SB125 contributions and/or investment returns will be considered in measuring excise tax triggers. Plan design changes may violate Alaska Constitution if perceived as "diminishment."

Health Care Reform Medicaid Cost Gap Analysis
Applying the "Nebraska Compromise" to Alaska

Health care reform, as passed in the Senate, contained the so-called "Nebraska Compromise." This provision states that new Medicaid spending in Nebraska would be funded at 100% by the federal government. The Alaska Medicaid Budget Group performed an analysis to determine the amount of funding that the state would receive for the newly eligible Medicaid population should Alaska benefit from a similar provision. Over the 20-year period from 2017 to 2036, the cost of covering this newly eligible Medicaid population will amount to over $700 million in state general funds. In this scenario, additional annual state general fund spending will increase from $17 million in 2017 to approximately $60 million in 2036.

These figures were determined by using the most recent 3-year average of uninsured adults; estimated population growth among adults; estimated health care inflation (3.4%); and an estimated increase in utilization of Medicaid services (2.1%/year).

Children at or below 133% of the Federal Poverty Level are currently eligible for Medicaid and are not included in the newly eligible group. In determining these figures, the Alaska Medicaid Budget Group assumed that only 75% of newly eligible non-Natives adults and 50% of newly eligible Native adults would enroll.

Care provided at Indian Health Service (IHS) facilities for current and newly eligible Alaska Native adults would be covered at a 100% Federal Medical Assistance Percentage (FMAP). The above calculation assumes that two-thirds of all care for newly enrolled Alaska Natives would be provided at IHS facilities and one-third of care would be provided at non-IHS facilities. Care provided at non-IHS facilities would be reimbursed at the FMAP set for the newly eligible non-Native population.

Finally, it is difficult to assume the final cost to the state per new Medicaid enrollee. In response, the Alaska Medicaid Budget Group assumed that new enrollee cost would amount to $3540 per person in 2009. This amount equates to the average costs for the Family Medicaid and Transitional Medicaid groups. Given the data currently available, this is the most reasonable cost estimate available; actual costs may be much higher.

January 13, 2010

The Honorable Harry M. Reid
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable John Boehner
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Senator Reid, Senator McConnell, Speaker Pelosi, and Representative Boehner:

As governors, we believe the reform of the health care system can be very beneficial to our nation's economic future and the well-being of our citizens; however, the current health care bills are a lost opportunity to improve the lives of Americans, create a sustainable system of health care and help stabilize both our state and national economies.

Health care reform should be about fixing our broken Medicaid and Medicare systems; instead, the current health care bills entitle 15-20 million more people to Medicaid. While providing health care to low income individuals is important, the net result of this entitlement expansion will be a significant cost shift to those privately insured around the country. According to the Congressional Budget Office (CBO), the unfunded mandate to states and territories is $25 billion; although many states disagree with that figure. For example, Texas costs are estimated to be $21 billion over ten years.

The National Association of State Budget Directors (NASBO) has demonstrated states/territories are in no position to comply with the maintenance of effort provisions found in the bills or to accept any increased costs or additional administrative burdens to expand Medicaid. State general fund expenditures have dropped for the second year in a row. The December 2009 survey shows that the budget situation faced by states truly is unprecedented. Many states cannot afford their current share of the Medicaid program, and they will also have to face a funding cliff whenever the stimulus-enhanced FMAP dollars are exhausted. States have already been forced to cut vital services with 30 states cutting education, 29 states cutting Corrections, and 28 states already cutting Medicaid.

Current federal proposals would strip the states of our ability to negotiate Medicaid provider rates, and we believe that states and territories should be allowed to negotiate Medicaid provider rates as found in current law. The pending bills cause states and territories to lose money through the bills' treatment of the prescription drug rebate provisions. States and territories also should not be asked to forego a share of the savings from any new Medicaid rebates collected for the dual eligible population receiving prescription drugs through the Medicare Part D program.

These bills also impose a one-size-fits all federally-designed health insurance exchange and the insurance rating rules tie states' and territories' hands. Health insurance exchanges desired by any state should be state-based and state-designed to ensure maximum state flexibility to design and operate exchange mechanisms that facilitate the purchase of insurance. Utah should not be forced to replicate Massachusetts' exchange, and vice versa. In the same vein, the health insurance rating rules should account for the existing variation in state and territory statutes and the state and territory should retain the authority to provide oversight and adopt tighter rating bands if necessary.

In order to pay for the bills, the legislation cuts Medicare $571 billion in the House bill and $466.7 billion in the Senate bill. Also included are far-reaching massive tax increases which will impact American individuals and families at all income levels. From employer mandates and taxes on high-value insurance plans to taxes on both branded and generic drugs and medical devices, these bills are funded, and thereby the bills' costs are lowered, by taking more from taxpayers and reforming the health care system less. In particular, the Senate's $6.7 billion insurance premium tax will be passed directly to consumers and will impose new costs on Americans who already have coverage. The unfunded mandates to states likely will require many states to necessarily raise taxes, too.

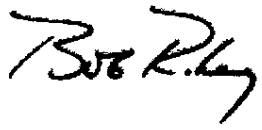
Although CBO has scored the Senate bill at $842 billion and the House bill at $1.3 trillion both bills are full of budget gimmicks. The bills delay spending until the fourth year and exclude the costly "Doc Fix" which ignores the over $200 billion price tag associated with stopping the unavoidable cuts to physicians under the Medicare program.

Governors agree we should work to enhance the quality of health care while making it more affordable and efficient. Unfortunately, the opportunity to truly lower the cost of care has been lost in the rush to try to finish health reform. Both CBO and the Chief Actuary of the Centers for Medicare and Medicaid Services have warned the current legislation will increase the overall costs of health care. The federal government and the states should refocus efforts to lowering the cost of care which will in turn increase coverage, but simply increasing the number of individuals on the public plans without a plan to improve the public programs for participants is irresponsible.

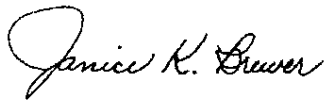
At this juncture, small businesses, seniors, states and territories, and taxpayers have anxiety about Congress' pending health care legislation and rightfully so-- one-sixth of our GDP is at stake. As Republican Governors, we believe in a system which eliminates red tape, empowers consumers to engage in making good health care decisions in the private market, and guarantees affordable coverage for patients with preexisting conditions. Missing from this important legislation is real medical liability reform and provisions which protect seniors' Medicare benefits and access to care. Several states have already implemented medical liability reform with good results; no real medical reform can be accomplished without tort reform. Instead, premiums are increased and small businesses are faced with onerous mandates rather than given the power to pool together and offer health care at lower prices, just as corporations and labor unions do.

Along with the majority of Americans and as leaders of 20 states and territories, we are disappointed with the lack of transparency. We urge you not to circumvent the normal committee process and to conduct an open, fully-bipartisan negotiation. It is time to slow down and pass meaningful health care reform, not hastily prepared partisan legislation which omits reform and saddles American taxpayers for generations to come.

Sincerely,



Governor Bob Riley, Alabama

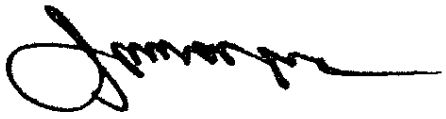


Governor Jan Brewer, Arizona

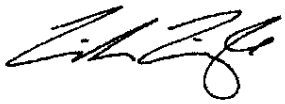
Governor Sean Parnell, Alaska

Governor Charlie Crist, Florida

Governor Sonny Perdue, Georgia

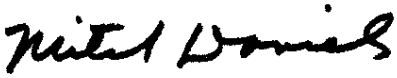


Governor Felix Camacho, Guam



Governor Linda Lingle, Hawaii

Governor C.L. "Butch" Otter, Idaho

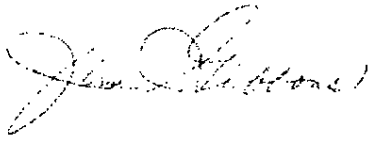


Governor Mitch Daniels, Indiana

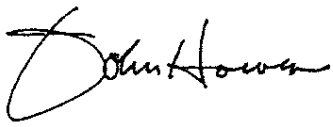
Governor Bobby Jindal, Louisiana

Governor Tim Pawlenty, Minnesota

Governor Haley Barbour, Mississippi



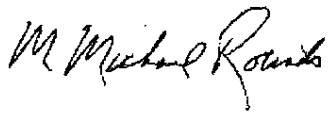
Governor Jim Gibbons, Nevada



Governor John Hoeven, North Dakota

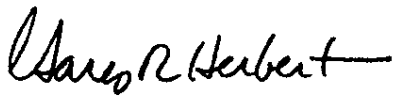
Governor Don Carcieri, Rhode Island

Governor Mark Sanford, South Carolina

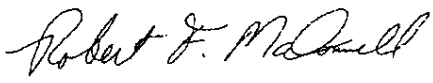


Governor Mike Rounds, South Dakota

Governor Rick Perry, Texas



Governor Gary Herbert, Utah



Governor-elect Bob McDonnell, Virginia

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

Questions and Answers: ALEC's *Freedom of Choice in Health Care Act*

For more information, contact Christie Herrera, director of ALEC's Health and Human Services Task Force, at (202) 742-8505 or christie@alec.org.

Why does my state need the *Freedom of Choice in Health Care Act*?
Efforts in our state capitol, and in Washington, are gaining steam to put complete control over your health care in the hands of government bureaucrats and appointed "experts." Government control means you will have less freedom to make the health care choices that are best for you and your family. The *Freedom of Choice in Health Care Act* will protect your health care freedom from these threats.

What does the *Freedom of Choice in Health Care Act do*?
The *Freedom of Choice in Health Care Act* will preserve and protect your right to make your own health care and health insurance choices. Specifically, it would protect your right to pay directly for medical care, and it would prohibit any individual or employer from being penalized for not purchasing government-defined health insurance.

Why should my state's constitution protect the right of patients to pay directly for medical care?
Single-payer systems, like in Canada, make it illegal for citizens to go outside of the government's health care plan and contract for their own medical services. The *Freedom of Choice in Health Care Act* would make this fundamental provision of Canadian-style, single-payer health care unconstitutional.

Patients should have the right to pay directly for medical services with their own money. When consumers control the dollars, they make the treatment decisions. When the government controls the dollars, they make treatment decisions based on what's best for the government, not what's best for the patient.

The consequences of government making medical decisions are often dire, and sometimes deadly. In New Zealand, breast cancer patients were blocked from accessing the lifesaving drug Herceptin because it cost too much. In Sweden the wait for heart surgery can be as long as 25 weeks. In Canada more than 800,000 patients are currently on waiting lists for medical procedures.

The *Freedom of Choice in Health Care Act* will ensure that patients, not government bureaucrats, decide which doctor to see or what medical treatments to get.

More information about the consequences of single-payer health care can be found in:

* Michael Tanner, "The Grass Is Not Always Greener: A Look at National Health Systems Around the World," Cato Institute Policy Analysis No. 613, March 18, 2008: http://www.cato.org/pubs/pas/pa-613.pdf.

* John C. Goodman, Linda Gorman, Devon Herrick, and Robert M. Sade, *Health Care Reform: Do Other Countries Have the Answers?*, National Center for Policy Analysis, March 10, 2009: http://www.ncpa.org/pdfs/sp_Do_Other_Countries_Have_the_Answers.pdf.

* http://BigGovHealth.org: A website with "single-payer horror stories" and fact sheets on the U.S. and worldwide infant mortality/life expectancy statistics; whether the U.S. Veterans Administration is a model for health reform; and much more.

Why should my state's constitution block penalties for individuals or employers who don't purchase health insurance?

It is important for people to have health insurance coverage, but a government requirement to purchase health insurance is ineffective, bureaucratic, and costly. The *Freedom of Choice in Health Care Act* would strike at heart of individual and employer mandates—implemented in Massachusetts, Hawaii, and elsewhere—that just don't work.

In Massachusetts—a state that imposed an individual mandate and an employer mandate in 2006—more than 1/3 of their uninsured still don't have coverage; health insurance is 40% more expensive than in the rest of the country; it's getting harder to see a doctor since before "reform" was enacted; and legislators expect a $2-$4 billion shortfall over the next decade.

The Massachusetts mandate didn't just affect the uninsured. The Massachusetts government actually told 20% of its already-insured citizens to buy more health insurance, because their existing coverage wasn't "good enough." When the government enforces a requirement for people to buy health insurance, they need to define what "insurance" is. The Cato Institute estimates that a federal individual mandate will force 100 million Americans to drop their existing plans and buy more expensive health insurance that is "good enough" for bureaucrats.

Employer mandates don't yield universal coverage and are harmful for consumers and workers. Hawaii has had a "pay or play" employer mandate for 35 years, and yet the number of uninsured has remained the same because employers shifted jobs to (exempt) part-time employees. And when the government forces businesses to buy health insurance for their

workers, it really means higher taxes and fewer jobs. When businesses face cost increases, they'll pass on those costs in the form of increased prices, job cuts, or wage freezes.

An individual mandate would harm patients, and an employer mandate would threaten our fragile economy. The *Freedom of Choice in Health Care Act* would protect our citizens from these threats.

More information about the consequences of individual and employer mandates can be found in:

* Michael Tanner, "Massachusetts Miracle or Massachusetts Miserable: What the Failure of the 'Massachusetts Model' Tells Us About Health Reform," Cato Institute Briefing Paper No. 112, June 9, 2009: http://www.cato.org/pubs/bp/bp112.pdf.

* Michael F. Cannon, "All the President's Mandates: Compulsory Health Insurance *Is* A Government Takeover," Cato Institute Briefing Paper No. 114, September 23, 2009: http://www.cato.org/pubs/bp/bp114.pdf.

* James Sherk and Robert A. Book, "Employer Health Care Mandates: Taxing Low-Income Workers to Pay for Health Care," Heritage Foundation WebMemo No. 2552, July 21, 2009: http://www.heritage.org/Research/HealthCare/upload/wm_2552.pdf.

Does supporting the *Freedom of Choice in Health Care Act* mean that I favor "free riders" who choose to not purchase health insurance and then show up in the emergency room?
Free riders do present a cost-shifting problem as uncompensated care costs are borne by the already-insured—although researchers estimate uncompensated care to be just 2-3% of overall health costs. The Massachusetts data reveal that at best, an individual mandate didn't affect ER visits at all—and at worst, an individual mandate actually increased ER usage by 17%.

The Massachusetts example shows that an individual mandate alone will not decrease ER usage. One Massachusetts survey reported that although the newly-insured had "insurance coverage" on paper, 90% of them did not have access to care from a non-ER provider. Other reports indicate that average wait times to get appointments with doctors in Boston ranged from 21 days for cardiologists to 70 days for obstetrician-gynecologists. And the Massachusetts Medical Society reports that the average wait to see a primary care doctor is 36 days.

Lawmakers cannot artificially create a growing demand for care without other policies (encouraging "minute clinics," enacting medical liability reform to encourage more doctors to practice, loosening scope of practice laws, etc.) to encourage healthcare supply. And those reforms can be achieved without a bureaucratic, ineffective, and costly requirement to

purchase health coverage.

More information about the why an individual mandate won't solve the "free rider" problem can be found in:

* Minna Jung, "What Massachusetts Teaches Us About Emergency Departments and Reform," Robert Wood Johnson Foundation's User's Guide to the Health Reform Galaxy Blog, October 5, 2009: http://rwjfblogs.typepad.com/healthreform/2009/10/what-massachusetts-teaches-us-about-emergency-departments-and-reform.html.

* Liz Kowalczyk, "ER Visits, Costs in Massachusetts Climb," *Boston Globe*, April 24, 2009: http://www.boston.com/news/local/massachusetts/articles/2009/04/24/er_visits_costs_in_mass_climb/.

Does the *Freedom of Choice in Health Care Act* only benefit insurance companies?
The *Freedom of Choice in Health Care Act* prohibits the forced purchase of private health insurance plans. This benefits patients, not insurance companies.

How will the *Freedom of Choice in Health Care Act* affect Medicaid, SCHIP, or Medicare?
The *Freedom of Choice in Health Care Act* will not in any way impact the funding of, or functioning of Medicaid, SCHIP, or Medicare. The language "This section does not affect laws or rules in effect as of January 1, 2009" clarifies this matter. Citizens will be free to participate in any safety net program (Medicaid, Medicare, SCHIP) to which they are entitled, as well as participate in any proposed programs (the public option or the national health insurance exchange) as they do today. The *Freedom of Choice in Health Care Act* simply ensures that citizens are not forced into these programs.

Does the *Freedom of Choice in Health Care Act* enable my state to block any kind of federal health reform?
No. The *Freedom of Choice in Health Care Act* would not attempt to block implementation of any federal law as long as the federal law does not require an individual/employer mandate, or forbid patients from paying directly for medical services.

Congress is still debating health reform. Doesn't this solve a problem that doesn't yet exist?
Two hundred and twenty years ago, some founders questioned the need for the Bill of Rights to be included in the U.S. Constitution. Eventually, they realized that the Bill of Rights was essential in protecting the people from a powerful central government. Today, the First through Tenth Amendments preserve our freedoms—and the *Freedom of Choice in Health Care Act* will protect our right to health care freedom in the same way.

But this is more than an issue of federal encroachment. Threats of single-payer health care, or of an individual/employer mandate, also exist at the state level. In 2009, 14 states introduced legislation to enact state-based, single-payer health care. Countless other states have proposed requirements for individuals or employers to purchase health coverage or else pay a fine to the state. The *Freedom of Choice in Health Care Act* would make these state-based assaults on patients' rights unconstitutional.

Does supporting the *Freedom of Choice in Health Care Act* mean that I am against health reform? Doesn't this tie our hands with future reforms?
No. The *Freedom of Choice in Health Care Act* simply states that the cornerstone of any future health care reform must be the preservation and protection of patients' rights.

# # #

GOLDWATER
INSTITUTE

The Health Care Freedom Act:
Questions & Answers

by Clint Bolick, Litigation Director, Goldwater Institute

The Health Care Freedom Act will appear as a proposed constitutional amendment on Arizona's 2010 election ballot, and similar measures are under consideration in more than 30 other states. With the possibility that Congress will enact some sort of national health insurance legislation, questions are being raised about the scope of the Health Care Freedom Act and its effect should a federal bill become law. In the following pages, Clint Bolick, who helped to author the Health Care Freedom Act, answers frequently asked questions.

Q: What is the Health Care Freedom Act?

A: The Health Care Freedom Act is a proposed amendment to the Arizona Constitution that would preserve certain existing rights that individuals have regarding health care. It was initially proposed by two Arizona physicians, Dr. Eric Novack and Dr. Jeffrey Singer, with drafting assistance from the Goldwater Institute. The measure qualified as a voter initiative on the 2008 ballot, and despite a well-financed opposition campaign, it was defeated by less than one-half of 1 percent of the vote. Changes were made to address concerns raised by the opponents, and the Arizona Legislature voted to refer the revised version to the 2010 ballot.

The American Legislative Exchange Council adopted model legislation based on the Arizona measure, and activists and legislators in at least 35 additional states are pursuing constitutional amendments or statutes based on the Arizona model.

Q: What are the key provisions?

A: Although the precise language varies from state to state, the Health Care Freedom Act seeks to protect two essential rights. First, it protects a person's right to participate or not in any health care system, and prohibits the government from imposing fines or penalties on that person's decision. Second, it protects the right of individuals to purchase—and the right of doctors to provide—lawful medical services without government fine or penalty. The Health Care Freedom Act would place these essential rights in the state constitution (or, in some states, it would protect them by statute).

Q: What motivated the Health Care Freedom Act?

A: No one questions the need for serious health care reform. However, the proponents of the Health Care Freedom Act believe that regardless of how such reform is fashioned, either at the state or federal level, the essential rights protected by the Health Care Freedom Act should be preserved. Many advocates of a larger government role in regulating or providing health insurance support a mandate that would compel individuals to join a government-approved health insurance plan, whether or not they can afford it and whether or not the system best fits their needs. In some countries in which government plays a large role in providing health insurance, medical services are rationed and individuals are prevented or discouraged from obtaining otherwise lawful medical services. Supporters of the Health Care Freedom Act have a variety of perspectives on the form that health care reform should take. But they agree that no matter what legislation is passed, it should not take from Americans their precious right to control their own medical affairs.

Q: By what authority can states pass the Health Care Freedom Act?

A: It is well-established that the U.S. Constitution provides a baseline for the protection of individual rights, and that state constitutions may provide additional protections—and all of them do. For instance, some states provide greater protections of freedom of speech or due process rights. Because the Health Care Freedom Act offers greater protection than the federal constitution, states are allowed to enact it.

Q: Does it matter whether the Health Care Freedom Act is passed as a statute or as a constitutional amendment?

A: A state constitution is the organic law of the state, reflecting the most fundamental values shared by the citizens of the state. Moreover, a state constitutional amendment will ensure the state legislature can never infringe upon the protected rights. So a constitutional amendment is preferable, especially to protect against legislative tinkering. However, for purposes of a federalism defense against excessive federal legislation, it should not matter whether the people of the state have acted through their constitution or by statute.

Q: Does the Health Care Freedom Act attempt to "nullify" federal health insurance legislation?

A: Absolutely not. If federal legislation is enacted, individuals would still have the option to participate in federal health insurance programs. This act simply protects a person's right not to participate.

Q: To the extent that the Health Care Freedom Act conflicts with provisions of federal legislation, isn't the state law automatically preempted by the Supremacy Clause of the U.S. Constitution?

A: No. In any clash between state and federal provisions, at least four federal constitutional provisions are relevant. The Supremacy Clause establishes the Constitution as the supreme law of the land and provides that federal laws prevail over conflicting state laws where Congress has the legitimate authority to enact the legislation and where it does not impermissibly tread upon state sovereignty. The federal government will have to demonstrate that its legislation legitimately is derived from congressional authority to regulate interstate commerce. It will also have to show the legislation does not violate the 10th Amendment, which reserves to the states all government power not expressly delegated to the national government; and the 11th Amendment, which protects states from being used as mere instrumentalities of the national government. This constitutional construct is known as federalism.

Q: Are certain provisions of proposed federal health care legislation vulnerable to constitutional challenge even without the Health Care Freedom Act?

A: Yes, in at least three ways. First, to the extent that the legislation purports to regulate transactions that do not directly affect interstate commerce, such as mandating insurance for individuals, Congress may lack authority to do so under the Commerce Clause. Several relatively recent decisions by the U.S. Supreme Court have invalidated federal legislation on this basis. In *U.S. v. Lopez* (1995), the Court struck down federal laws that restricted guns in school zones; and in *U.S. v. Morrison*, it struck down a federal statute involving violence against women. In both cases, the Court found the subject matter of the federal laws did not "substantially affect" interstate commerce, so Congress had no power to regulate it under the circumstances presented.

Second, to the extent the legislation interferes with the individual's right to choose health insurance providers, doctors, or lawful medical services, it may violate the right to medical self-determination recognized under the U.S. Constitution. As the Court declared in *Griswold v. Connecticut* (1965), "We have recognized that the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause." Several of the early abortion cases involved what Justice William O. Douglas, concurring in *Doe v. Bolton* (1973), described as the "right to seek advice on one's health and the right to place reliance on the physician of one's choice." Whether or not one agrees with those abortion rulings, they establish a strong basis for challenging certain federal and state intrusions.

Third, several recent decisions have invalidated federal laws that "commandeer" state governments to do their bidding. In *New York v. United States* (1992), for instance, the Court struck down federal rules requiring states to take ownership of certain radioactive waste and to expose themselves to liability. Speaking for the Court, Justice Sandra Day O'Connor ruled that

"no matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate." Tellingly, she added "the Constitution protects us from our own best intentions: It divides power among sovereigns . . . precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day." To the extent that federal health insurance legislation forces states to implement its provisions, it could be subject to robust constitutional challenge.

Q: Could the Health Care Freedom Act provide additional protection against federal health insurance legislation that violates protected rights?

A: Yes. Although the federal government usually prevails in federalism clashes, the current U.S. Supreme Court is the most pro-federalism Court in decades. There are no cases precisely on point, but the Court under Chief Justice John Roberts has sided with the states in at least three major recent federalism clashes. In the case most closely on point, *Gonzales v. Oregon* (2006), the Court upheld the state's "right-to-die" law, which was enacted by Oregon voters, over the objections of the U.S. Attorney General, who argued that federal law pre-empted the state law. Applying "the structure and limitations of federalism," the Court observed that states have great latitude in regulating health and safety, including medical standards, which are primarily and historically a matter of local concern. Holding that the attorney general's reading of the federal statute would mark "a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality," the Court interpreted the statute to allow Oregon to protect the rights of its citizens.

Horne v. Flores (2009) considered a measure adopted by Arizona voters to require English immersion as the state's educational policy for students for whom English is a second language. Lower federal courts had imposed an injunction based on a finding that Arizona was failing to comply with federal bilingual education requirements. The Supreme Court held that injunctions affecting "areas of core state responsibility, such as public education," should be lifted as quickly as circumstances warrant. It observed that "federalism concerns are heightened when . . . a federal court decree has the effect of dictating state or local budget priorities." The Court remanded the case to lower courts to reconsider the injunction.

In *Northwest Austin Municipal Utility District No. 1 v. Holder* (2009), the Court examined a challenge to section 5 of the Voting Rights Act, which places certain states and localities in a penalty box, requiring them to obtain "pre-clearance" by the U.S. Department of Justice for any changes that impact voting. The Court was sharply critical of the "federalism costs" imposed upon the covered jurisdictions. It avoided the constitutional question by applying the federal law in a way that allowed the utility district to "bail out" from pre-clearance requirements under section 5.

In each of these cases, the Court sided with states in federalism disputes with the federal government.

Q: Will the Health Care Freedom Act affect future state legislation regarding health insurance?

A: Yes. If it is passed as a constitutional amendment, it would prevent any future legislation that infringes upon the rights protected by the amendment.

Q: Won't this be really expensive for the states to defend in court?

A: The Goldwater Institute has offered to defend the constitutionality of the Health Care Freedom Act at no cost to any state. Because legal challenges would involve purely constitutional issues and would not require expensive trials, to the extent that states become involved in litigation, they should be able to do so within existing Attorney General litigation budgets. Moreover, depending on the details of national health insurance legislation, the cost of federal mandates is likely to far exceed the cost of litigation.

Q: Even if the states and individuals did not prevail in a challenge to intrusive federal health insurance legislation, would there be reasons to support the Health Care Freedom Act?

A: Yes. First, if these rights are given additional protection under state constitutions, they will create an absolute barrier to future state legislation that violates those rights. Moreover, efforts to enact the Health Care Freedom Act send a powerful message to our nation's capitol that people at the grassroots take these rights very seriously and intend to protect them.

Q: Does the Health Care Freedom Act impair drug laws?

A: Absolutely not. It protects the right to purchase or provide "lawful" medical services. It does not limit the power of any government to determine what constitutes lawful medical services.

Q: Does the Health Care Freedom Act affect the issue of abortion?

A: No. Again, to the extent that states may regulate abortion under applicable constitutional doctrine and state or federal law, this measure would not alter that power in any way. The Health Care Freedom Act does, however, prevent the government from forcing individuals into health care systems against their will, and matters of conscience may influence such individual decisions.

Q: Does the Health Care Freedom Act affect Veterans' Administration programs, workers' compensation, Medicare, Medicaid, or state health-care systems?

A: Generally, no. The Health Care Freedom Act leaves intact any rules and regulations that were in place as of January 1, 2009. The only way such programs could be affected is if they are changed in the future in ways that violate the freedom of choice protected by the Health Care Freedom Act.

Q: Will this restrict the government from limiting the choice of providers or imposing other limits for the people who do opt-in to a government health care system?

A: No and yes, respectively. If a person voluntarily joins a government health care system, the government may set the terms and conditions, including choice of providers. However, the government cannot prevent a person from purchasing, or a health care professional from providing, lawful medical services outside that system.

Q: Is the Health Care Freedom Act supported financially by insurance companies?

A: No. Many insurance companies support an individual mandate (requiring individuals to buy health insurance or face government fines), which the Health Care Freedom Act would prohibit. An individual mandate guarantees a customer base to the insurance industry. It is present in some legislative proposals as a means to subsidize health insurance for others. If insurance companies play a role in the battle over the Health Care Freedom Act, we expect they will oppose it, possibly with significant resources.

Q: Are there other ways in which freedom advocates can use state constitutions to protect their liberties?

A: Absolutely. State constitutions are full of provisions unknown to the U.S. Constitution that are designed to protect individual liberty and limit the power of government, such as the line-item veto, anti-monopoly provisions, prohibitions against corporate subsidies ("gift clauses"), constraints against earmarks ("special law clauses"), and the like. Citizens and legislatures can amend their state constitutions to add additional protections; and taxpayers can enforce their state constitutional rights in state courts. State constitutions were intended to be the first line of defense in protecting the freedoms of the people. As the power of government grows at every level, we need to use whatever tools are available to us to safeguard our rights. For more on how state constitutions can protect liberty, see the recent Goldwater Institute report, **"50 Bright Stars: An Assessment of Each State's Constitutional Commitment to Limited Government."**

NFIB

The Voice of Small Business®

ALASKA

January 19, 2010

The Honorable Mike Kelly
Room 513
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Kelly

RE: HJR 35

On behalf of the National Federation of Independent Business/Alaska, I wish to express our support for House Joint Resolution 35. The National Federation of Independent Business/Alaska is the largest small-business advocacy group in our state.

HJR 35 provides for placing an amendment to Alaska's Constitution before voters during the next general election making explicit the individual right to health care free choice. The constitutional amendment would prohibit passage of laws that compel any person or employer to participate in a particular health care system. The proposed constitutional change will also permit the purchase of private insurance and allow Alaskans to pay their own health care provider directly.

NFIB/AK is critically concerned about the cost and access to health care for Alaskans. The current versions of health care reform that have passed the U.S. House and U.S. will not address those issues. The mandates they include clearly impose unreasonable burdens on Alaskans and Alaskan businesses. These mandates cannot address the needs of Alaskans.

This proposal will protect Alaskans from the unconstitutional federal mandates to purchase health insurance that may not meet their needs. It will protect small businesses from being taxed for not providing health insurance designed by the federal government that may not meet the needs of their employees.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

Cc: NFIB/AK Leadership Council

National Federation of Independent Business – ALASKA
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