

ALEC EXPOSED

"ALEC" has long been a secretive collaboration between Big Business and "conservative" politicians. Behind closed doors, they ghostwrite "model" bills to be introduced in state capitols across the country. This agenda-underwritten by global corporations—includes major tax loopholes for big industries and the super rich, proposals to offshore U.S. jobs and gut minimum wage, and efforts to weaken public health, safety, and environmental protections. Although many of these bills have become law, until now, their origin has been largely unknown. With **ALEC EXPOSED**, the Center for Media and Democracy hopes more Americans will study the bills to understand the depth and breadth of how big corporations are changing the legal rules and undermining democracy across the nation.

ALEC's Corporate Board --in recent past or present

- AT&T Services, Inc.
- centerpoint360
- UPS
- Bayer Corporation
- GlaxoSmithKline
- Energy Future Holdings
- Johnson & Johnson
- Coca-Cola Company
- PhRMA
- Kraft Foods, Inc.
- Coca-Cola Co.
- Pfizer Inc.
- Reed Elsevier, Inc.
- DIAGEO
- Peabody Energy
- Intuit, Inc.
- Koch Industries, Inc.
- ExxonMobil
- Verizon
- Reynolds American Inc.
- Wal-Mart Stores, Inc.
- Salt River Project
- Altria Client Services, Inc.
- American Bail Coalition
- State Farm Insurance

For more on these corporations, search at www.SourceWatch.org.

DID YOU KNOW? Corporations VOTED to adopt this. Through ALEC, global companies work as "equals" in "unison" with politicians to write laws to govern your life. Big Business has "a VOICE and a VOTE," according to newly exposed documents. **DO YOU?**

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Access to Medicaid Act

Did you know that global pharmaceutical company Bayer Healthcare was the corporate co-chair in 2011?

Summary

The purpose of this Act is to **privatize Medicaid** through the use of vouchers and thereby create a program that would decrease state expenditures, streamline state Medicaid programs, improve access to quality health care, and provide health care to a greater number of needy families. ALEC's Medicaid Plan would provide a publicly financed voucher program to provide access to privately delivered health insurance coverage for eligible Medicaid recipients. Vouchers would be limited to AFDC recipients, beginning at 100 percent of the federal poverty level. Each eligible recipient would receive a voucher for a specified, reimbursable amount to purchase a family health care policy. The state would work with insurance companies and organized health care systems to provide a policy containing certain core benefits at a reasonable rate. Each health insurance policy would be exempt from the existing mandated benefits but include the nine federal Medicaid mandates. Employers would be allowed to buy into the program in order to provide insurance during transitional stages of employment. Cost containment mechanisms would be included, such as cash refunds to Medicaid recipients for utilizing only a percentage of yearly benefits.

Model Legislation

{Title, enacting clause, etc.}

Section 1. This Act may be cited as the Access to Medicaid Act.

Section 2. {Definitions.} As used in this Act:

(A) "INSURER" means any insurance company authorized to do the business of sickness and accident insurance in this state or any health maintenance organization authorized to operate in this state.

Section 3. {Purpose.} The legislature hereby enacts the Access to Medicaid Act for the purpose of providing a publicly financed voucher program to provide access to privately delivered health insurance coverage for residents of this state who qualify for the benefits under Section 4.

Section 4. {Eligibility Requirements.}

(A) The following persons are eligible for coverage under the program:

(1) any person who is an AFDC recipient; and

(2) any person whose income is equal to or less than 100 percent (or insert other appropriate percentage) of the federal poverty level, and who is not covered under an employer-provided health care plan, as provided in paragraph 3 of this section;

(3) those persons described in paragraph (A)(2) of this Section whose incomes are equal to or greater than 100 percent of the federal poverty level, but not more than 150 percent of the federal poverty level (or insert other appropriate percentage), shall be required to pay 10 percent of the reimbursable premium amount determined by the Director of Human Services.

Section 5. {Issuance of Proof of Eligibility Forms.} If the Department of Human Services (or insert appropriate department) determines that a person meets the eligibility requirements set forth in Section 4 of this Act, the Department shall issue that person a proof of eligibility form, which entitles the person to coverage under any health insurance or health care policy or contract, offered in accordance with this Act, in the amount of the premium indicated on the form and for a policy or contract period of one year.

Section 6. {Offering of Policies and Contracts.} If coverage is issued to the individual, policyholder, or contract holder, the insurer shall submit the proof of eligibility forms and a request for reimbursement of premium to the Department of Human Services.

Section 7. {Standards Applicable to the Policies and Contracts.} The health insurance or health care policies and contracts for which insurers are eligible shall be provided in accordance with the following conditions:

(A) The cost of the policies and contracts shall not exceed the reimbursable premium

amount indicated on the proof of eligibility form.

(B) The policies and contracts are not subject to any previous state mandatory benefits.

(C) Each policy and contract must include the following:

- (1) all nine of the federal Medicaid mandates;
- (2) 30 days in-patient care coverage for mental health, mental retardation, and substance abuse;
- (3) prescription drugs;
- (4) prenatal care coverage; and
- (5) life-style incentives with preventive education

(D) The nine federal Medicaid mandates referred to in paragraph (C) consist of the following:

- (1) inpatient/outpatient hospital services;
- (2) rural health clinic services;
- (3) other laboratory and x-ray services;
- (4) nurse practitioners' services;
- (5) nursing facility services and home health services for individuals 21 and older;
- (6) early and periodic screening, diagnosis, and treatment for individuals under 21;
- (7) family planning services and supplies;
- (8) physicians' services; and
- (9) nurse-midwife services.

(E) The insurer shall not impose any waiting period for benefits, or otherwise reduce or restrict benefits, for any claim that is the result of a high risk condition.

(F) The insurer shall refund to the insured, in accordance with the program established by the Director of Human Services (or appropriate department director), a portion of the premium for coverage of an eligible person if the total amount of claims submitted by the person is less than the amount of the premium paid. (refund is 50 percent of premium.)

(G) The insurer shall refund to the insured, in accordance with the program established by the Director of Human Services, a portion of the premium for coverage of an eligible person if the person locates any item or service listed on a billing statement was not received by, or rendered to, the person. (Refund for overbilling, errors, or services not rendered could be 50 percent, 33 percent, OR 25 percent).

Section 8. {Reimbursement of Insurers.} Within thirty days after receipt of a valid proof of eligibility form and request for reimbursement from an insurer, the Department of Human Services shall issue payment to the insurer in the amount of the premium indicated on the form.

Section 9. {Duties of Director; Rulemaking Authority.}

(A) The Director of Human Services (or appropriate department director) shall within 90 days after the effective date of this Act, adopt rules in accordance with this Act that provide for the fair, reasonable, and equitable administration of this program, including provisions relative to procedures for determining eligibility under the program, issuance of proof of eligibility forms by the Department of Human Services, determinations of the reimbursable premium amount, and procedures for the reimbursement of insurers that issue policies and contracts to eligible persons. Rules adopted under this Section shall also include a schedule for the implementation of the program on an incremental basis. The duties of the Director shall be to:

- (1) administer and implement the program;
- (2) monitor the operation of the program;
- (3) disseminate, to insurers and to the public, information concerning the program and the persons eligible to receive benefits under the program;
- (4) implement a system to provide information and guidance to all persons eligible under the program relative to the program's procedures and the selection of the most appropriate benefits under a health insurance or health care policy or contract;
- (5) in accordance with Section 7 (F) implement a program whereby a portion of the premium for coverage, other than coverage for preventive care, of an eligible person shall be refunded by the insurer to the person if the total amount of claims submitted by the person for that coverage is less than the amount of the premium paid for that coverage.
- (6) implement a program whereby a portion of the premium for coverage of an eligible person shall be refunded by the insurer to the person if the person locates any item or service listed on a billing statement that was not received by, or rendered to, the person;
- (7) study and evaluate the operation of the program, and annually submit its findings to the legislature.

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Section 10. {Annual Amount of Reimbursable Voucher.} An independent board shall be responsible for annually determining the premium amount that is reimbursable by the department for both individual and family coverage. This board shall be comprised of the Director of Health and Human Services, the Insurance Commissioner, and three other members appointed by the Governor.

Section 11. {Creation of Fund; Funding; Uses.}

(A) There is hereby created in the state treasury a Medicaid Access Fund, which shall consist of all of the following:

(1) federal payments received as a result of any waiver of requirements granted by the United States Secretary of Health and Human Services under the Health Care Programs, other than the nursing facility care programs and the intermediate care facility programs for the mentally retarded, established under Title XIX of the "Social Security Act."

(2) state funding in an annual amount equal to the funding appropriated for expenditure in the fiscal year in which this act is enacted for purposes of the (current state Medicaid program), other than the nursing facility care programs and the intermediate care facility programs for the mentally retarded. Such money shall increase in proportion to any increase in the federal payments received by the plan pursuant to Subsection (A)(1) of this Section.

(3) all other money appropriated to the fund, interest earned on investments or deposits, grants and gifts made to the fund from public or private sources, or moneys acquired otherwise by the fund.

(B) The fund shall be administered by the Director of Human Services (or appropriate director) and shall be used solely for purposes of reimbursing insurers for the provision of health insurance or health care policies and contracts to resident of this state who are eligible for benefits under this Act.

Section 12. {Prohibition Against "Dumping."} An employer shall not fail to extend coverage to, or continue coverage of, an employee or his dependents under any health care coverage provided by the employer solely to render the employee or dependent eligible to receive benefits provided under this Act.

Section 13. {Employer Buy-in.} Employers who hire current Medicaid voucher recipients shall be permitted to provide health care coverage for the employee by buying into the remaining term of the Medicaid recipient's health plan. The amount of the plan would be prorated for the number of months remaining in the current year of coverage. The money from the employer buy-in would go directly to the State's Medicaid Access Fund.

Section 14. {High-Risk Individuals.} Medicaid recipients who have been previously rejected by two or more insurers due to high-risk conditions shall be placed into the state high-risk pool. The difference between the value of the voucher and the high-risk pool premium shall be paid by the state Medicaid program. (See ALEC'S Insurance Pool Act.)

Section 15. {Severability clause.}

Section 16. {Repealer clause.}

Section 17. {Effective date.}

Were your laws repealed?

1995 Sourcebook of American State Legislation

About Us and ALEC EXPOSED. The Center for Media and Democracy reports on corporate spin and government propaganda. We are located in Madison, Wisconsin, and publish www.PRWatch.org, www.SourceWatch.org, and now www.ALECexposed.org. For more information contact: editor@prwatch.org or 608-260-9713.

Center for Media and Democracy's quick summary

This bill would replace the Medicaid system with a voucher system, where eligible participants receive a voucher to purchase insurance policies in the private insurance market (greatly benefitting private insurance companies). State-mandated benefits would not have to be included, and participants who did not use the full value of their benefits would receive a partial refund (thereby encouraging low-income Medicaid recipients to go without medical care in order to supplement their income).

Wisconsin Congressman Paul Ryan proposed a similar voucher program for Medicare (rather than Medicaid) in his 2011 budget proposal.