

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.

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?**

[Home](#) → [Model Legislation](#) → [Health and Human Services](#) → [Market Based Medicaid Reform Act](#)

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

Summary

This Act provides a cost-effective program for Medicaid recipients by offering the option of a Medical Assistance Account (MAA) with a catastrophic health policy. Under the supervision of the Department of Human Services, the MAA would allow \$500 - \$1000 for an individual or \$1000 - \$2500 for a family to be deposited into an account which would cover all health related expenses for the recipient, after which the recipient is responsible for the payments of co-payments. Fifty percent of the remaining funds at year's end, can be used in the form of a voucher for educational, job training, and child care services. This Act also allows for a debit card to be used to automatically debit services rendered, as well as for the use of the Department of Human Services to monitor the status of the account at year's end. In addition to the MAA, the program offers traditional health insurance with co-payments or a prepaid health care delivery plan (HMO) to all recipients.

Model Legislation

Section 1. Title: This Act may be cited as Market Based Medicaid Reform Act.

Section 2. Definitions. As used in this Act.

- (A) "Insurer" means any entity which provides health insurance in this state.
- (B) "Health insurance policy" means any health insurance policy or contract issued by an insurer that is authorized to do business in this state.
- (C) "Health maintenance organization"(HMO) means any managed health care organization authorized to do business in this state.
- (D) "Participant" means an eligible Medicaid recipient as described in Section 4 (A) of this Act.
- (E) "Department" means the Department of Human Services (or insert appropriate department).
- (F) "Medical Assistance Account" means an account, electronic vouchers or otherwise established for the Medicaid recipient to be administered by the Department in his/her name to pay the eligible medical expenses of the account holder or his or her dependents.
- (G) "High deductible insurance" means an insurance policy with a deductible of not less than (amount e.g. \$500 - \$1000 for the individual) and not more than (amount e.g. \$1000 - \$2500 for the family) in any calendar year.

Section 3. Purpose Section:

- (A) The purpose of this Program is to 1) provide a more cost effective means of providing health care coverage for certain Medicaid eligible individuals, 2) create patient awareness of the high cost of medical care, 3) reduce inappropriate use of health care services, 4) enable clients to take responsibility for healthy outcomes and lifestyles, 5) provide incentives to patients to seek preventive and primary care services, 6) provide Medicaid recipients vouchers to purchase private insurance, Medical Assistance Account, or a prepaid health care delivery plan.
- (B) The Department shall request a waiver for the establishment of this Program if the state deems necessary.

Section 4. Eligibility Requirements.

- (A) The following persons are eligible for coverage under this program:
- (1) Persons who would be eligible to receive medical services under the Aid to Families with Dependent Children assistance category and who are not aged, blind, or disabled;
- (2) Persons who would be eligible to receive medical services under the medically needy category and who are not aged, blind, or disabled;

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

(3) A pregnant woman who is eligible because she is categorically needy or medically needy but is not aged, blind, or disabled; and

(4) A person under the age of twenty-one (21) who is eligible because the person is categorically needy or medically needy but is not aged, blind, or disabled.

(B) The Department shall establish procedures of due process.

Section 5. Administration of the Program

(A) The Department of Human Services (or insert appropriate department) shall provide health care coverage for participants in the program by entering into contracts or agreements with at least two insurers offering an individual or group policy of health insurance, at least two insurers offering individual or group policy of health insurance with a high deductible, and at least two health maintenance organizations offering prepaid health care delivery plans. Participants shall be given the option whether to be covered by a policy of 1) traditional health insurance with co-payments, 2) catastrophic health insurance with a Medical Assistance Account, 3) a prepaid health care delivery plan (HMO). The department on behalf of the participant shall pay the premium or enrollment fee of the policy or health insurance or prepaid health care delivery plan.

(B) The contracts or agreements entered into pursuant to subsection (1) of this section shall provide that:

(1) The department shall pay any deductibles charged pursuant to the policy or plan directly to the health care provider for participants in the Medical Assistance Account option; and

(2) The total of deductibles charged for a calendar year may not be less than nor exceed:

(a) (Insert appropriate amount e.g. \$500 - \$1000 to be established by rule by the Department) for a participant in an individual Medical Assistance Account as established in Section 7 of this Act; or

(b) (Insert appropriate amount e.g. \$1000 - \$2500 to be established by rule by the Department) for a participant in a family Medical Assistance Account as established in Section 7 of this Act.

(3) The participant shall be responsible for the payment of co-payments after they have exceeded their Medical Assistance Account.

(4) Co-payments are required under all options and will be paid for by the Medicaid recipient at the point of service as follows: (a) One dollar (\$1) per prescription copayment for outpatient prescription drugs; (b) Three dollars (\$3) per office visit for physician services; (c) Ten dollars (\$10) for nonemergency services (as defined by the Department) delivered in a hospital emergency room or for nonemergency health transportation services.

(5) A contract or agreement entered into pursuant to this section shall provide coverage for all services outlined in Section 6 of this Act.

(6) The Department of Human Services may enter into a contract or agreement only after taking competitive bids. However, the department may elect to rebid the contract or contracts.

(C) Health care providers shall charge program participants the same fee for services regardless of whether the service is reimbursed by the participant's Medical Assistance Account or by the participant's health benefit plan under the program.

(D) To the extent permitted by federal law, if any program participant fails to pay required copayments, the amount of any copayments owed by the participant shall be deducted from future payments for any program of public assistance for which the participant may be eligible.

Section 6. Standard Benefits

The health insurance or health care policies and contracts of which recipients are eligible shall be provided in accordance with the following conditions:

(A) The policies or contracts shall not be subject to any previous state mandatory benefits.

(B) Each policy or contract may include the following: (1) basic provisions for some mental health coverage; (2) prescription drugs, (3) pre-natal care coverage, (4) inpatient/outpatient hospital services, (5) rural and urban health clinic services; (6) other laboratory and x-ray services; (7) nurse practitioners' services, (8) nursing facility services for individuals 21 and older, (9) home care services and equipment; (10) early and periodic screening, diagnosis, and treatment for individuals under 21; (11) family planning services and supplies; (12) physicians' services; (13) nurse-midwife services; and (14) inpatient psychiatric services for children under the age of 18.

(THESE ARE JUST SUGGESTED BENEFITS. EACH STATE SHOULD DETERMINE ITS OWN BENEFITS PACKAGE, BUT SHOULD NOT PROVIDE A BENEFITS PACKAGE RICHER THAN WHAT MOST SMALL BUSINESSES IN YOUR STATE ARE ABLE TO AFFORD.)

(C) The Department shall provide each new enrollee in the Medical Assistance

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Account Program with an educational brochure explaining the options provided, and the differences in these options.

Section 7. Establishment and Administration of Medical Assistance Accounts

(A) The Department of Human Services shall establish Medical Assistance Accounts as follows:

(1) An individual Medical Assistance Account shall be established for any individual participant who does not qualify for a family Medical Assistance Account under paragraph (2) of this subsection.

(2) A family Medical Assistance Account shall be established for any group of two or more participants who are related to each other by blood or marriage. One adult participant in a family Medical Assistance Account or a parent or guardian of a participant shall be designated as responsible for the account.

(B) On January 1 of each calendar year, or on the day the Medicaid recipient is enrolled, the department shall:

(1) Deposit in an individual Medical Assistance Account the sum of (Insert appropriate amount e.g. \$500- \$1000, not to exceed the deductible); and

(2) Deposit in a family individual Medical Assistance Account the sum of (Insert appropriate amount e.g. \$1000- \$2500, not to exceed the deductible).

(C) The department may expend money deposited in Medical Assistance Accounts pursuant to subsection (B) of this section to pay deductible payments required under the applicable policy or plan.

(D) The money deposited in the Medical Assistance Account will be pro-rated on a daily basis after January 1 of each calendar year.

(E) The department shall terminate an account whenever a person dies or no longer qualifies as a participant under Section 4 (A) of this Act. Any sums remaining in the account shall be paid as follows:

(1) If a person dies the remaining funds shall go to the into the General Fund to be credited to the Department of Human Services.

(2) If a person no longer qualifies as a participant under Section 4 (A) of this Act, the remaining amount, prorated on a daily basis shall be divided between the account holder and the Department of Human Services for the Medical Assistance Account. Not less than ten percent (10%) nor more than twenty percent (20%) of the remaining balance will go to the account holder as cash (or a voucher for health care coverage, education, job training, etc.) and the balance of any sums remaining in the account will go to the General Fund to be credited to the Department of Human Services.

(3) Already existing funds within a person's Medical Assistance Account, can not be a factor in determining income, assets, or resources for purposes of eligibility for public benefits program in (insert state).

(4) Those who drop out of the Medical Assistance Account Program and receive a refund are not eligible for the Medical Assistance Account option for one full calendar year.

(F) The department may consolidate all sums in all Medical Assistance Accounts established under this section into one account for investment purposes. Interest from investments of sums in the accounts shall be paid into the General Fund to be credited to the Department of Human Services for the Medical Assistance Account.

(G) Account holders shall be given debit cards when available which would automatically debit from their Medical Assistance Accounts, as a credit card would, when services are rendered; or physicians could submit for reimbursement to the Department of Human Services and the Department would debit the sum from the account holder's account and send reimbursement to the health care provider.

(H) On December 31 of the year in which sums are deposited into a Medical Assistance Account, if any sums remain in the account, and if the person has met their preventive health care requirements as stipulated in Section 7 (J), the Department of Human Services shall provide a voucher of fifty percent of the balance remaining in the account to each participant or person designated as responsible for a family Medical Assistance Account in accordance with Section 7 (J). The remaining fifty percent would be paid into the General Fund to be credited to the Department of Human Services. A voucher provided pursuant to this subsection may be used only for the following purposes:

(1) Education for one or more participants in an account;

(2) Job training services for one or more participants included in an account;

(3) Child care services for one or more participants included in an account; or

(4) Other expenses as the Department of Human Services may allow.

(I) If a voucher is not used within six months of being provided to a participant, the

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voucher shall expire and shall revert to the Department of Human Services to be credited to the Medical Assistance Account program. Any attempted misuse of a voucher by a participant shall result in immediate loss of health benefits under the program for a period of not less than one year nor more than three years.

(J) To qualify for reimbursement in the form of a voucher, cash bonus, or roll over at the end of the year, the account holder must demonstrate with a physicians note, a physicians bill, or if a debit card is used the Department can verify such matters through the accountholders computer record, that they received their annual primary care check-up during the previous twelve (12) months in which the participant was eligible for the program, and they obtained prenatal care, immunizations, or preventive care for eligible children in accordance with schedules developed by the Department. The account holder shall not be eligible for a voucher, cash bonus, or roll over at the end of the year if they fail to obtain this care.

(K) At each year's end, a participant or person designated as responsible for an individual or family Medical Assistance Account may chose one of the following options:

(1) Elect to receive any excess sums in the Medical Assistance Account in the form of a voucher, not to exceed more than fifty percent of the remaining balance, depending on the amount the Department deposits in the Medical Assistance Accounts, with the balance of any sums remaining in the account paid into the general fund and credited to the Department. If the voucher is not used within six months, it will expire, as stated under Section 7 (I) of this Act.

(2) Elect to leave any excess sums in the Medical Assistance Account to carry over for the next year, not to exceed more than 50 percent of the remaining balance, depending on the amount the Department deposits in the Medical Assistance Accounts, with the balance of any sums remaining in the account paid into the general fund and credited to the Department for the Medical Assistance Account.

(3) Elect to receive any excess sums in the Medical Assistance Account as a cash bonus in an amount equal to not less than 10 percent nor more than 20 percent of the excess funds, depending on the amount the Department deposits in the Medical Assistance Accounts, with the balance of any sums remaining in the account paid into the general fund and credited to the Department for the Medical Assistance Account.

Section 8. The Department shall implement the Medical Assistance Program within 90 days of the enactment of this Act.

Section 9. The Department of Human Services shall adopt all rules consistent with Sections 2 to 9 of this Act.

Section 10. {Severability Clause}

Section 11. {Repealer Clause}

Section 12. {Effective Date}

1996 Sourcebook of American State Legislation

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