CHARITY HEALTH CARE TAX CREDIT ACT (DRAFT, MAY 11, 2012)

SUMMARY

This Act provides state tax credits for individuals ($1,000/year), families ($2,500/year), and nonprofit charity organizations (up to 75% of income tax liability) who provide healthcare services to the uninsured.

MODEL LEGISLATION

Section 1. Title. This Act shall be known as the "Charity Health Care Tax Credit Act."

Section 2. Definitions. For the purposes of this Act:

A. "Charity health care organization" means a nonprofit corporation supporting 50 or more charity health care clinics providing health care services to the uninsured and qualified as exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code.

B. "Charity health care organization" means a nonprofit corporation supporting 50 or more charity health care clinics providing health care services to the uninsured and qualified as exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code and approved by the **{insert state department of health and human services}** pursuant to this Act.

C. "Qualified charity health care expense" means the expenditure of funds by the taxpayer during the tax year for which a credit under this Act is claimed and allowed.

Section 3. Eligible Charity Health Care Organizations. The **{insert state department of health and human services}** shall approve and maintain a list of charity health care organizations eligible for the purposes of the charity health care tax credit.

Section 4. Charity Health Care Tax Credit.

A. An individual taxpayer shall be allowed a credit against the tax imposed by **{insert reference to state tax code}** for qualified charity health care expenses as follows:

   1. In the case of a single individual or a head of household, the actual amount expended or $1,000.00 per tax year, whichever is less; or

   2. In the case of a married couple filing a joint return, the actual amount expended or $2,500.00 per tax year, whichever is less.

B. A corporation or other entity shall be allowed a credit against the tax imposed by **{insert reference to state tax code}** for qualified charity health care expenses in an amount not to exceed the actual amount expended or 75 percent of the corporation's income tax liability, whichever is less.

C. In order for the taxpayer to claim the charity health care organization tax credit under this Act, a letter of confirmation of donation issued by the charity health care organization to which the contribution was made shall be attached to the taxpayer's tax return. However, in the event the taxpayer files an electronic return, such confirmation shall only be required to be electronically attached to the return if the Internal Revenue Service allows such attachments when the data is transmitted to the department. In the event the taxpayer files an electronic return and such confirmation is not attached because the Internal Revenue Service does not, at the time of such electronic filing, allow electronic attachments to the **{insert state}** return, such confirmation shall be maintained by the taxpayer and made available upon request by the **{insert state revenue commissioner}**. The letter of confirmation of donation shall contain the taxpayer's name, address, tax identification number, the amount of the contribution, the date of the contribution, and the amount of the credit.

D. The **{insert state revenue commissioner}** shall be authorized to promulgate any rules and regulations necessary to implement and administer the tax provisions of this Act.

Section 5. Limitations and Reporting Requirements.

A. In no event shall the total amount of the tax credit under this Act for a taxable year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the taxpayer against the succeeding five years' tax liability. No such credit shall be allowed the taxpayer against prior years' tax liability.

B. In no event shall the aggregate amount of tax credits allowed under this Act exceed $2 million per tax year for the three years beginning January 1, 2013, except that any unused aggregate credits shall carry over until December 31, 2018, at which time any unused aggregate tax credits shall expire.

C. The **{insert revenue commissioner}** shall allow the tax credits on a first come, first served basis.

D. For the purposes of Paragraph B of this Section, a charity health care organization shall notify a potential donor of the requirements of this section. Before making a contribution to a charity health care organization, the taxpayer shall notify the **{insert state department of revenue}** of the total amount of contributions that the taxpayer intends to make to the charity health care organization. The **{insert state revenue commissioner}**shall preapprove or deny the requested amount within 30 days after receiving the request from the taxpayer and shall provide written notice to the taxpayer and the charity health care organization of such preapproval or denial which shall not require any signed release or notarized approval by the taxpayer. In order to receive a tax credit under this Act, the taxpayer shall make the contribution to the charity health care organization within 60 days after receiving notice from the **{insert state department of revenue}** that the requested amount was preapproved. If the taxpayer does not comply with this paragraph, the **{insert state revenue commissioner}** shall not include this preapproved contribution amount when

calculating the limit prescribed in Paragraph B of this Section. The **{insert state department of revenue}** shall establish a web-based donation approval process to implement this Section.

E. Preapproval of contributions by the **{insert state revenue commissioner}** shall be based solely on the availability of tax credits subject to the aggregate total limit established under Paragraph B of this Section. The **{insert state department of revenue}** shall maintain an ongoing, current list on its website of the amount of tax credits available under this Act.

F. Notwithstanding any laws to the contrary, the **{insert state department of revenue}** shall not take any adverse action against donors to charity health care organizations if the **{insert state revenue commissioner}** preapproved a donation for a tax credit prior to the date the charity health care organization is removed from the list maintained by **{insert state department of health and human services}** pursuant this Act, and all such donations shall remain as preapproved tax credits subject only to the donor's compliance with Paragraph D of this Section.

G. No credit shall be allowed under this Act with respect to any amount deducted from taxable net income by the taxpayer as a charitable contribution to a bona fide charitable health care organization qualified under Section 501(c)(3) of the Internal Revenue Code.

Section 6. {Severability Clause}
Section 7. {Repealer Clause}
Section 8. {Effective Date}

REGIONAL HEALTH CARE COALITION ACT (DRAFT, MAY 11, 2012)

SUMMARY

This Act authorizes the insurance commissioner to establish a coalition of like-minded states with reciprocity agreements for the approval, offer, sale, and rating of comprehensive major medical health insurance plans. The coalition would also adopt an alternative approval process for such plans.

MODEL LEGISLATION

Section 1. Title. This Act shall be known as the "Regional Health Care Coalition Act."

Section 2. Statement of Purpose.

A. The **{insert legislature}** seeks to initiate cooperation of like-minded states to create a multistate coalition with reciprocity agreements for the approval, offer, sale, rating, medical underwriting, renewal, and issuance of comprehensive major medical individual and group health insurance policies.

B. The **{insert legislature}** recognizes that insured health policies must be filed in each state for approval and compliance with each separate state's administrative and coverage requirements. The **{insert legislature}** believes that a coalition of states with consistent health insurance laws will lower development and distribution costs, making the coalition states a larger attractive market for more rapid introduction of new products and services. In addition, a multistate market with common standards will encourage new insurers to locate and initiate business in the coalition states' market. The increased market size and common state requirements will increase competition among insurers and lower premiums.

Section 3. Definitions. For the purposes of this Act, the following definition applies:

A. "Comprehensive major medical" means a plan with at least a $1 million coverage lifetime maximum; a cost sharing out-of-pocket maximum no greater than that applicable in any given year to a high deductible health plan as defined under Section 223 of the Internal Revenue Code with applicable annual indexing; and coverage for at least:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services;
6. Prescription drugs;
7. Rehabilitative and wellness services;
8. Chronic disease management; and
9. Pediatric services.

Section 4. Duties of the Insurance Commissioner.

A. It shall be the duty of the Insurance Commissioner to identify at least four states with insurance laws sufficiently consistent with the laws of this state in order to create an efficient regional or multistate market.

B. The Insurance Commissioner shall be authorized to take a lead role in establishing a coalition of other states to adopt an alternative policy approval process for comprehensive major medical policies that utilize a common set of policy approval requirements among the coalition states.

C. The Insurance Commissioner shall approve for sale in **{insert state}** comprehensive major medical individual and group policies that have been approved for issuance under the alternative policy approval process in the coalition states where the insurer is authorized to engage in the business of insurance, so long as the insurer is also authorized to engage in the business of insurance in **{insert state}** and provided that any such policy meets the requirements established by the Insurance Commissioner.

D. The Insurance Commissioner shall adopt rules and regulations necessary to implement this Act.

Section 5. Dispute Resolution. Any dispute resolution mechanism or provision for notice and hearing currently provided under **{insert state}** law shall apply to insurers issuing and delivering plans pursuant to this Act.

Section 6. {Severability Clause}
Section 7. {Repealer Clause}
Section 8. {Effective Date}

ZAREPHATH CHARITY HEALTH CARE ACT (DRAFT, MAY 11, 2012)

SUMMARY

This Act provides full malpractice immunity for medical professionals who volunteer at least for hours per week, for four consecutive weeks, at a non-governmental free clinic that provides charity care to the poor. *(Note: See background document for more information.)*

MODEL LEGISLATION

Section 1. Title. This Act shall be known as the "Zarephath Charity Health Care Act."

Section 2. Scope and Definitions. This Act shall apply to physicians and dentists, referred to in this Act as "volunteer medical professionals," who are licensed to practice medicine by **{insert state board of medical examiners}** or licensed to practice dentistry by **{insert state board of dentistry}** and have applied for and obtained "deemed status" under the Federal Tort Claims Act.

Section 3. Malpractice Immunity.

A. When a volunteer medical professional provides documentation of "deemed status" under the Federal Tort Claims Act to **{insert state health and human services commissioner}**, and provides documentation that the volunteer medical professional has performed four hours per week for four consecutive weeks of volunteer service at or as a result of a referral from a non-government free clinic, the **{insert state}** will then provide the volunteer medical professional with full immunity from malpractice lawsuits relating to his private medical or dental practice. The non-government free clinic must have its own 501(c)(3) charity status but may be located within a hospital.

B. Physicians with specialties that cannot be practiced in an outpatient clinic location (e.g., surgeons, anesthesiologists, obstetricians) will provide the equivalent of four hours per week of free care in their usual venue for patients referred through a non-government free clinic.

C. The medical director of the non-government free clinic and the volunteer medical professional shall certify every three months thereafter that the four hours per week of volunteer professional services have been performed.

D. The volunteer medical professional shall be considered an employee of **{insert state}** only for the purposes of medical malpractice coverage.

E. The **{insert state health and human services commissioner}** shall adopt rules and regulations to effectuate the purposes of this Act.

Section 4. {Severability Clause}
Section 5. {Repealer Clause}
Section 6. {Effective Date}

Replacing the Medicaid System with Real Charity

ALEC's 2012 Spring Task Force Summit

May 10, 11, 2012

Charlotte, North Carolina

By Alieta Eck, MD, President, AAPS

SUMMARY

Medicaid began in 1965 as a combined federal and state program to provide medical care for the poor and uninsured. Today, it severely underpays physicians, frustrates patients who are looking for physicians and is overwhelming the budgets of states. The federal *Patient Protection and Affordable Care Act* (PPACA) will put the states on the path to financial ruin, expanding the ineffective Medicaid program by at least 50%.

It is time to go back to real charity, where physicians do not charge, indigent patients do not pay and the taxpayer is removed from the transaction.

THE PROBLEM

Medicaid comprises one-quarter to one-third of the average state budget; $10.7 billion in my home state of New Jersey alone. Half comes from the federal government and half from the state—but all from the same taxpayers. It pays physicians so poorly that most do not enroll, and those who do enroll lose money on every transaction. Medicaid patients have difficulty finding physicians who "take their insurance," so they often go to the emergency room armed with their Medicaid card at no personal cost. The most common reason a Medicaid patient goes to the ER is for an upper respiratory infection—bronchitis, a sore throat or earache. The taxpayers pay dearly.

In determining where the Medicaid dollars go in New Jersey, for example, the numbers are startling. $5.3 billion pays for elder care including nursing homes. $5.4 billion pays for acute care. Of the acute care dollars, $2 billion goes to Medicaid managed care and $800 pays for federally qualified health centers. If one assumes 20% administrative costs, then $500 million is paying for administrators, while a mere $90 million goes for doctors, labs and x-rays. Doctors are underpaid, patients cannot find a physician, and yet the taxpayers are on the hook for $10.7 billion.

The Medicaid bureaucracy is huge—for they must enroll and dis-enroll patients, process claims, weed out fraud and abuse. Of the 491 New Jersey Medicaid employees, 50 are paid full-time to find fraudulent Medicaid recipients and false claims.

Medicaid has all the wrong incentives, as many beneficiaries take great pains to get enrolled and then become dependent on their "benefits." They are fearful of taking entry level jobs lest they lose their "coverage." They often have incentives to lie about or magnify their symptoms to remain on Medicaid.

PPACA will dramatically increase the Medicaid rolls. Currently one in seven residents in New Jersey is on Medicaid, and this will grow dramatically once PPACA is fully implemented. States are already overburdened.

Federally Qualified Health Centers (FQHCs) are heavily endowed by the federal and state governments. They were started in an attempt to have a place where Medicaid patients could go. They cost 10x more than a real charity clinic—$150 per patient visit, versus $15 in a non-government free clinic (NGFC).

ADVANTAGES OF NON-GOVERNMENT CHARITY

Charity implies personal sacrifice to aid a fellow human being. When the charitable person is compensated, it is no longer true charity. The Zarephath Health Center (ZHC), a NGFC in central New Jersey, sees 300-400 patients per month while open only 12 hours per week. It is an efficient organization, run completely by volunteers. Its total budget in 2010 was $58,000, none from the taxpayers.

At the ZHC, the community comes together to help the poor in ways other than just health care—support groups, literacy training, job training, mentoring, and health classes can be provided. Food and clothing is available next door. Poverty ought to be a temporary condition, not a way of life. Volunteers help people improve their circumstances in individualized ways. Both the giver and recipient of true charity are uplifted.

Having many NGFCs dotted around the state would provide ready access to people who find themselves sick with no insurance or means to pay. As it was before 1965, the poor would go where they knew volunteers would help them instead of running to a government agency where they would have to fill out papers. Baby Boomers are retiring at a rate of 10,000 per day in this country, so they could form an army of experienced volunteers, able to use their time and expertise to volunteer in free clinics.

The difficulty lies in finding enough physicians to volunteer. They are small businessmen, being crushed by third party underpayment, government over-regulation and the overzealous medical malpractice industry.

The *Federal Tort Claims Act of 1996* (FTCA) provides medical malpractice coverage to physicians who volunteer at NGFCs. These professionals are considered part of the Federal Public Health Service for the purpose of malpractice coverage. In the eight years since this has been implemented, there have been no successful lawsuits nationwide against a physician in a volunteer clinic. The scope of FTCA coverage is limited—only covering the work actually performed at the approved NGFC. Work done at the hospitals such as surgery or deliveries are not covered by the federal government.

PROPOSAL FOR THE STATES

We would like to propose that the states encourage the opening of many NGFCs, each with its own 501(c)3 charity status—run by volunteers from churches, synagogues, philanthropic groups, the Salvation Army, Kiwanis, etc.

We would propose that physicians could donate four hours a week at such a facility, ensuring the availability of every specialty. Each clinic would set criteria to determine the eligibility of the patients seen. There would be no entitlement ID cards handed out to patients.

We would simply ask the states to extend the FTCA medical malpractice coverage to entire practices of physicians who volunteer at NGFCs, considering them part of the State Public Health Service for purposes of medical malpractice coverage. We are not asking the state to buy commercial insurance for each physician, but just cover them like they do any other public official. If a patient wants to sue, he would be suing the state, not the individual physician.

This would require a single state office where the program would be monitored, clinic start-ups would be encouraged, and data would be collected to verify the hours the physicians participated. Surgical specialties could provide their volunteer services in the hospitals on patients referred through the NGFC.

The cost to the state would only be incurred in the event of a lawsuit. In that regard, the numbers speak volumes. Currently, physicians in New Jersey pay a total of $300 million in medical malpractice premiums. If nothing changed and they continued to be sued at the current rate, taking on this liability would still be a huge savings for the state. $300 million is a good deal less than $5.4 billion in acute care Medicaid expenditures.

But, judging from the experience of the FTCA where no volunteering physician has been sued in the past 8 years, we believe the lawsuit volume would decrease dramatically. Patients and lawyers are less likely to sue the state than a physician with coverage from a private medical malpractice insurer. All defensible lawsuits, now considered to be 70%, would disappear. Yet if a patient were harmed, the state would provide the compensation.

As for hospitals, there are two ways that they deal with the poor—through pre-enrollment in the Medicaid system or through what is called "charity care." The hospitals could continue the current charity care system where eligibility is determined at the point of need. Hospitals are reimbursed by the state at the end of the year or absorb the cost of charity care patients. Also, hospitals typically hold benefits and fundraisers to help defray the costs of the charity care. In New Jersey, the state currently budgets $900 million per year for charity care.

The overall results of returning charity to the communities would be better access for the poor in low-cost venues, lower physician overhead in the way of relief from having to pay medical malpractice premiums, and a huge burden lifted off the backs of the taxpayers. Prosperity and economic growth for the State of New Jersey would ultimately result.

The plan would be completely reproducible in all other states.

HEALTH CARE PRICE DISCLOSURE ACT (DRAFT, MAY 11, 2012)

SUMMARY AND BACKGROUND

This Act requires health care professionals to make available the "direct pay" price for at least the 25 most common services or procedures; the Act also requires health care facilities to make available the "direct pay" price for (if applicable) at least the 50 most used diagnosis-related group codes and at least the 50 most used outpatient service codes for the facility.

Over the past 45 years, health care has evolved to a point where consumers have little impact on pricing. The most recent data on health care spending in the United States, released in January 2012, revealed that the bottom 50% of health care utilizers in the country spend only about 3% of health care dollars. The bottom 70% of health care utilizers spend only about 10% of health care dollars.

Only 12 cents of every health care dollar is paid directly out-of-pocket by patients. The rest is paid by government and insurance—and billings seen by patients rarely reflect actual prices paid, frightening patients about the idea of directly paying for services. Our health care system has put us in a Catch 22: We do not want to pay for health care ourselves because it's so expensive, but it's so expensive because we do not pay for it ourselves.

There is little incentive for providers to post prices due to competitive motives. Price transparency for direct cash payers is essential if we are ever to transition to a more market-oriented, competitive health care system.

Transparent pricing will help give episodic health care users—the group the makes up a significant majority of the population—better access to understandable price information, and the marketplace would likely make good use of the open information to disseminate that data in the ways used by every other aspect of our economy.

MODEL LEGISLATION

Section 1. Title. This Act shall be known as the "Health Care Price Disclosure Act."

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

A. "Direct pay price" means the price that will be charged for a lawful health care service if the service is paid without a public or private third party, not including an employer, paying for any portion of the service.

B. "Health care facility" means a hospital, outpatient surgical center, treatment or diagnostic imaging center or urgent care center.

C. "Health care professional" means a person licensed by **{insert state licensing boards}**.

D. "Health care provider" does not include a hospital licensed pursuant to **{insert state statute covering license provisions for construction or modification of a health care institution}**.

Section 3. Health Care Insurer; Providers; Negotiated Rates. A health care insurer may not use the direct pay price of a health care provider for a health care service as the basis to decrease any negotiated rate between that health care provider and the health care insurer.

Section 4. Public Availability; Health Care Professional Charges. A health care professional must make available to the public on request in a single document the direct pay price for at least the 25 most common services for the health care professional. The services may be identified by a common procedural terminology code or by a plain English description. The document must be updated at least annually. The direct pay price is for the standard diagnosis for the service and does not include any complications or exceptional treatment.

Section 5. Public Availability; Health Care Facility Charges.

A. A health care facility must make available to the public on request in a single document the direct pay price for at least the 50 most used diagnosis-related group codes, if applicable, for the facility and at least the 50 most used outpatient service codes, if applicable, for the facility. The document must be updated at least annually. The direct pay price is for the standard diagnosis for the service and does not include any complications or exceptional treatment.

B. A health care facility is not required to report the direct pay prices to the **{insert state department of health and human services}** for review or filing as a prerequisite to operation. This Section does not authorize the department or **{insert state health and human services secretary}** to approve, disapprove, or limit a health care facility's direct pay price for services.

Section 6. {Severability Clause}
Section 7. {Repealer Clause}
Section 8. {Effective Date}

PHYSICIAN AND PATIENT FREEDOM OF VACCINE CHOICE ACT (DRAFT, MAY 11, 2012)

SUMMARY AND BACKGROUND

This Act requires the state Department of Health and Human Services to implement a system that allows providers to choose among all vaccine products that are deemed safe and effective by the FDA and are best for each provider's patients.

Choice allows each provider to decide which vaccine to use, based on their medical experience/expertise and the specific needs of his or her patients. Choice allows patients and parents of young children the ability to take part in the decision regarding which vaccines are best for their own circumstances.

Clear, free market-based provider access to all FDA-approved and CDC-recommended (not mandated) vaccines will help ensure strong competition and continued innovation among biopharmaceutical companies to research, develop, and manufacture the next generation of immunization products. Such innovation helps lead to product and price competition, lower healthcare system costs, and better public health outcomes in the United States.

MODEL LEGISLATION

Section 1. Title. This Act shall be known as the "Physician and Patient Freedom of Vaccine Choice Act."

Section 2. Provider Choice System for Vaccines.

A. The **{insert state department of health and human services}** shall establish and implement a provider choice system for the vaccines for children program operated by the **{insert state department of health and human services}** under the authority of 42 USCS Section 1396s, and for any other program that supplements the vaccines for children program using state or federal funds.

B. The **{insert state department of health and human services}** shall ensure that eligible health care providers participating in the vaccines for children program, including providers participating in state and local health departments, federally qualified health centers, or rural health clinics, or any other program that supplements the vaccines for children program using state or federal funds, may select any vaccine licensed by the U.S. Food and Drug Administration, including combination vaccines and any dosage forms, that is:

   1. Recommended by the federal Advisory Committee on Immunization Practices; and

   2. Made available to the **{insert state department of health and human services}** by the Centers for Disease Control and Prevention of the United States Public Health Service.

C. The **{insert state department of health and human services}** shall allow providers to make such vaccine product selection at all regular ordering and reordering intervals throughout the calendar or fiscal year.

D. This section does not apply in the event of a disaster or public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

Section 3. Implementation. The **{insert state department of health and human services}** shall implement all or part of the provider choice system as soon as it is determined to be feasible; however, the **{insert state department of health and human services}** shall complete full implementation of the system not later than **{insert date for full implementation}.**

Section 4. {Severability Clause}
Section 5. {Repealer Clause}
Section 6. {Effective Date}

RESOLUTION SUPPORTING THE REPEAL OF THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) (DRAFT, MAY 11, 2012)

SUMMARY AND BACKGROUND

On March 22, 2012, the U.S. House of Representatives passed H.R. 5, the *Protecting Access to Healthcare (PATH) Act*, by a 223-181 vote. This bill repeals the Independent Payment Advisory Board (IPAB) established in the *Patient Protection and Affordable Care Act* (PPACA). The U.S. Senate has yet to take up the issue.

This resolution calls for the repeal of IPAB, and for the repeal of any funding for IPAB's establishment or operation.

MODEL RESOLUTION

WHEREAS, Section 3403 of the Patient Protection and Affordable Care Act (PPACA) established the Independent Payment Advisory Board (IPAB) consisting of 15 members appointed to six-year terms, and charged it with the reduction of spending in Medicare by reducing payments to medical professionals; and

WHEREAS, Twelve IPAB members will be appointed by the President, and practicing medical professionals, including physicians, are prevented from membership, almost certainly guaranteeing that only academics will serve on IPAB; and

WHEREAS, The decisions of IPAB cannot be challenged in the courts and are freed from the normal administrative rules process, such as requirements for public notice, public comment or public review; and

WHEREAS, IPAB recommendations carry the full force of the law, and will be very difficult for Congress to override unless 2/3 of the House and Senate vote to do so; and

WHEREAS, The IPAB board is specifically forbidden from "any recommendations to ration health care," but PPACA fails to define the word "ration." Instead, it allows IPAB to pay doctors reimbursement rates below costs, which in essence would constrict a physician's ability to treat patients; and

WHEREAS, Other provisions of PPACA already cut payments to medical professionals so deeply that by the end of this decade, Medicare payments will be lower than Medicaid payments, likely resulting in additional enrollment in Medicaid programs and pressure on state budgets; and

WHEREAS, Medicare-eligible seniors and others already have difficulty finding medical professionals to treat them without enactment of PPACA provisions.

NOW THEREFORE BE IT RESOLVED THAT, {Insert state legislature} believes it is not in the best interest of the state, or Medicare-eligible residents of the state, for the Independent Payment

Advisory Board to be implemented because its decisions will most certainly limit patient access to quality medical care; and

BE IT FURTHER RESOLVED THAT, {Insert state legislature} urges Congress to repeal provisions of Section 3403 of the Patient Protection and Affordable Care Act that establish the Independent Payment Advisory Board, as well as any funding for the establishment or operation of IPAB.

BE IT FURTHER RESOLVED THAT, Copies of this resolution be sent to the President of the United States, the appropriate leadership of the United States Congress and the United States Department of Health and Human Services, and the entire **{insert state}** delegation in the United States Congress.