STATE INTERPOSITION OF FEDERAL AFFORDABLE CARE ACT

Senate Bill _____ and/or House Bill _____.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF_____,

An Act to codify interposition required against the Federal Affordable Care Act under authority of state law titled:

STATE INTERPOSITION ACT

Which codifies in perpetuity ***"Defend state prerogatives by adopting "the simple expedient of not yielding" to federal blandishments whenever we do not want to embrace the federal policies, as States are separate and independent sovereigns. Sometimes States have to act like it."*** –Chief Justice John Roberts, Supreme Court of the United States, 2012.

Section 1. SUMMARY

This Act codifies the sworn duty and process of our State to interpose to prevent usurpation or encroachment upon our sovereign state by the federal government's Affordable Care Act, declaring it void ab initio, in violation of state rights in intrastate commerce, culture, federalism, and our citizen constitutional rights.

Section 2. LEGAL FOUNDATION

a. State rights and powers are sovereign, a unique culture, heritage, and history with liberties requiring neither permission or approval by the Federal Government, while federal gov-

ernment powers are enumerated, limited and defined by the U.S. Constitution and subsequent federal law of the land.

b. James Madison, in his Virginia Resolution of 1798, asserted state governments not only have the right to resist unconstitutional federal acts, but that, in order to protect liberty, they are "duty bound to interpose" or stand between the federal government and the people of their state.

c. The Supreme Court of the United States confirmed state interposition rights in great detail, setting new precedent in *National Federation of Business et al v. Sebelius, 2011.*

Chief Justice John Roberts' majority opinion…
See state law titled…STATE INTERPOSITION ACT.

Section 3. VIOLATIONS, USURPATION, ENCROACHMENTS of the FEDERAL AFFORDABLE CARE ACT (ACA).

a. **ACA TORT INTERFERENCE IN EXISTING CONTRACTS**

1. Existing state health care is a collective product of decades of market driven, complex network of implied and written contracts, between consumers, physicians (and their employees, vendors), hospitals (and their employees, vendors), employers (and their employees, vendors), insurance companies (and their employees, vendors), medical industry suppliers (and their employees, vendors), pharmaceutical industry suppliers (and their employees, vendors, investors), and state departments supervising, monitoring, and licensing all concerns in order to protect the state health care system quality for legal state residents. Contracts provide stability, mutual trust, and State systems developed.

2. Contracts vary widely in longevity, but the expressed will, implied and documented in contracts, are the intent of consumers and their doctors, to build and share a long term mutual trust relationship which enhances quality of care in their mutual interests. Without such mutual trust covenant

relationships, which can only achieve the highest quality care with mutual maturity over time, neither can be content in care delivered or received in terms of quality, costs, prices.

3. State licensed and contracted health insurance agents have for decades performed administration of health insurance purchasing by employers, at a proven stable 2 percent cost. ACA usurpation destroys and replaces this entire industry with proposed "health exchanges" at a 3.5 percent cost, subject to unlimited increase. The 3.5 percent cost being known only after ACA approval by Congress, by administration rule, is in direct contradiction to facts presented that were voted upon by Congress. This is a material breach and fatal flaw exposing an ever changing law by Executive Branch fiat, illegally circumventing Congress.

4. ACA only allows state-ran exchanges to offer insurance subsidies and to tax employers for failing to provide health insurance. Federally-ran exchanges can do neither, by ACA, the law passed by Congress. The Executive Branch however, after ACA passage, circumvented Congress to unilaterally and dictatorially rewrite existing law by issuing an IRS rule granting federally-ran exchanges the same powers as State operated, a blatant usurpation overruling its own legislation. Destroying existing law or contracts by Executive order and/or rules is unconstitutional.

5. ACA passed by Congress proved to be a snapshot in time of an ever changing, moving target. It immediately became a constantly moving undefined concept that Congress did not approve, but is a blank check for an undefinable contract of unknown terms and conditions that morph daily by unlimited changes via unilateral Executive Branch order or administrative rule added or removed at will. This is illegal, unworkable, and an unlimited burden being forced upon States, our employers and residents.

6. ACA illegal interferences with, and irreparable harms inflicted on many long term existing contracts, grants, investment and numerous other implied and written contracts involving medical research by removing the incentive of a truly

open market place where years of private or state investment for excellence in research produces new innovation in every area of medical and mental health care. ACA mission is a single payer provider system that removes competition, incentive, private investment motive for research and development. New Medical equipment is taxed by ACA instead of being rewarded with research investment, which destroys incentive to exist, a life and death, unacceptable, penalty on all state residents.

7. The Employer Mandate in PPACA requires all employers with fifty or more full time employees provide adequate health care coverage to their employees. (§ 1513, §1514, and §10106). If they do not, these employers could face a tax of $2,000 or $3,000. This interferes directly with fundamental compensation contracts between employer and employees, written and implied, that tear the fabric of their relationship to their mutual detriment. No other employment compensation interference would be tolerated, such as federal government law unilaterally setting wages paid above minimum wage. ACA is unacceptable as well, destroying by usurping private employment contracts, written and implied.

8. PPACA Section 1555 provides waiver from participation our State codifies herein as law.

H.R. 3590–142 SECTION 1555

FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS

"No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage ***shall be required to participate in any federal health insurance program created under this Act*** *(or any amendments made by this Act), or in any federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs."*

b. **USURPATION OF INTRASTATE COMMERCE**

State commerce is unique with wide variations in the numerous geographic areas, such that state-wide companies like Blue Cross Blue Shield have a different set of rules, forms, criteria, processes, procedures, style and even costs or pricing based on local market conditions, available local resources and providers, and many other local driven factors. Each local area market is widely different, as a rural location has completely different issues than an inner city area or an affluent suburb area with plush resources. Commerce inside state borders is a state right specifically, as only interstate commerce channels are an enumerated federal government authority. Forcing the ACA "one size fits all" system on all state areas, their local employers and legal residents, is an illegal usurpation of intrastate commerce. Local areas have civil liberties and established intrastate commerce to meet their needs that the State must protect by interposition, by whatever legal remedies are required.

c. **USURPATION OF STATE CULTURE, HERITAGE**

State employers and legal residents enjoy a shared, yet unique to their locality, culture, heritage, over centuries and many generations that bind them with purpose in pursuit of happiness only pride and contentment in our past and present make possible. Local doctors in many areas know patients not just by a 15-minute office visit each year, but even more by implied contracts made in mutual trust via local social interaction, in church activities, ball games, civic events, recreation activities, where everyone knows everyone and their parents, children, friends and relatives. Smaller localities lacking sophisticated technologies and facilities requiring a drastically higher level of available resources, often deliver superior quality of life care by offsetting resources of increased observation time via personal relationships and experiences in mutual trust, where patients actually follow "doctor's orders" and change detrimental ways. Cultures where doctors, pharmacists, clinics, even hospitals, would rather close their doors than dispense in cases of addiction and help patients person-

ally until restored. Forcing the ACA "one size fits all" system on all state areas, their local employers and legal residents, is an illegal usurpation and/or destruction of state culture, heritage, and abandonment of history. Local areas have civil liberties and established culture and heritage to meet their needs that the State must protect by interposition, by whatever legal remedies are required.

d. **UNLIMITED UNFUNDED MANDATE FORCED ON STATE WITHOUT CHOICE**

ACA is a blank check for an unlimited, unknown amount, based on federal assumption they can continue borrowing 46 cents or more of every dollar or implement an inflation tax by creating money out of blank paper, and that either way state residents will pay this bill or pass it on to their children and grandchildren's children to pay off, in perpetuity, inflicting an illegal, immoral state of economic slavery that denies their civil rights even before birth. Further, ACA forces States to pay 10 percent of the total cost after the first two years. This unfunded mandate is illegal and a certain financial catastrophe that will bankrupt a State, as proven by the State of Tennessee's failed TennCare experiment attempting to provide unlimited health care for all residents. Further, state-managed exchanges have a minimum of $50 million initial investment to set up, no sure cap or maximum required, to implement rules not even determined, all of which are material changes to ACA law approved by Congress, therefore an illegal circumvention of Congress.

e. **USURPATION OF MEDICAL and HEALTH INSURANCE INDUSTRY, PROVIDER SUPERVISION, QUALITY, and TRUST FUNDS**

ACA imposes new layers of political bureaucracy that dictates by fiat all aspects of health care and health insurance, which are distinctly unique operations under distinct state authority and responsibility, led by a state health commissioner for health care, and a state insurance commissioner for health insurance, who also supervises insurance of all types, such as commercial lines and personal lines with life, automobile,

home owners, and rental insurance.

Insurance is protection against unaffordable loss or catastrophic loss, which varies dramatically by individual consumer need and choice, therefore market options are a wide variety, with options for consumer deductible amounts from zero to $100, $250, $500, $1,000, even $5,000. These deductibles are incentives for consumers to share risk in direct proportion to reward.

Licensed insurance companies are monitored constantly by the State to ensure adequate reserves are set aside for potential claims based on actuarial data from a known, finite data pool, with an established maximum claim, i.e. the contracted market value of a house, car, boat, or a life.

No such process is possible with health insurance as unknown potential medical claims deposits could bankrupt any company, yet still be catastrophically insufficient, as future medical needs of an infinite, unknown quantity or quality data pool cannot possibly be projected. It is a blank check with no maximum amount on any person, or pool of persons. It is financial suicide.

Health insurance is based on a finite data pool carefully reviewed to determine terms, conditions, inclusions, exclusions, and the costs for a group, pursuing the highest quality and value that group of consumers deems best. At that point a very small percentage of premiums paid, usually 4 percent, are paid to insurance companies for administration service costs of provider contracting, filing claims, billing and collection. Insurance companies create surpluses or profits by wisely investing money collected and placed in a trust fund until drawn out to pay a claim.

State supervision of these trust funds have proven trustworthy and transparent over many decades in marketplace investing that safely yields superior cash flows that pay all claims submitted, and more, plus asset appreciation value provides secondary security.

Federal Government, serving as fiduciary, knowingly committed consistent theft of trust funds for Social Security, Medi-

care and Medicaid, a total of $77 trillion in known current obligations due as of year end 2012, with no hope of honoring current obligations by replacing what has been stolen. Federal experience mismanaging this sacred trust is shameful and unacceptable.

ACA now demands that States turn over state health insurance company trust funds, an illegal demand made with unclean hands, disqualifying their demands out of common sense, fairness and justice, a life and death survival self defense via State Interposition fully warranted.

State residents have been irreparably harmed by theft of their funds placed in trust with the Federal Government over decades, with no end in sight to this exposed, ongoing theft. State interposition cannot resolve this ongoing theft, but our duty to protect our state citizens demands being a bulwark for our state health insurance trust funds, a bulwark against ACA or other means. No Legal authority can force financial homicide by known breach of fiduciary duties.

Duties of a fiduciary and federal government are completely incompatible, as $77 trillion placed in trust proves, none were valued as all were shamelessly and incompetently violated.

[A] Duty of Loyalty.

[B] Duty to Disclose Relevant Facts and Render Accounts.

[C] Duty of Due Care.

[D] Duty to Maintain Client Confidences.

Contract law generally assumes that parties bargain at arms length and that the resulting bargain governs their relationship.

Fiduciary relationships usually begin with a contract, but in the eyes of the law fiduciary relationships are never arms length.

ACA new regulations issued post November 2012 elections creates yet another fee on every employee, whether or not covered by an employer group plan. It set the per capita rate at $5.25 per month, which works out to $63 per year per employee, on top of whatever amount employers are contributing for employee health insurance.

This burden is "estimated" to be another $25 billion trust fund that could easily be $250 billion at any time when an executive branch department is allowed to circumvent Congress to make material changes in existing law. This cannot stand.

The fee will be assessed on all "major medical" insurance plans, including those provided by employers and those purchased individually by consumers. Large employers will owe the fee directly. That's because major companies usually pay up front for most of the health care costs of their employees. It may not be apparent to workers, but the insurance company they deal with is morphing, basically into an agent administering the plan for their employer.

The fee will total (estimated) $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016. That means the per-head assessment would be smaller each year, around $40 in 2015 instead of $63.

Given these fee totals are impossible to know, here is a blank check for a new trust fund generated by state residents, vital to their personal survival, the state interposition requires.

With respect to such agreements, the law jettisons the general presumptions and standards of the law of contract and applies instead the stricter fiduciary standard. ACA violates both.

f. **CIVIL RIGHTS VIOLATIONS OF LEGAL STATE RESIDENTS**

ACA is tyranny that literally denies the fundamental rights to life, liberty, and the pursuit of happiness guaranteed by the U.S. Constitution. ACA is the ultimate example of abuse of power.

ACA dictates to state health commissioners charged with oversight are illegal and endangering to state residents, as States closely monitor health care providers to assure proper credentials are maintained, the licensing and renewal process maintains provider integrity, all toward maintaining the highest quality care possible. Circumvention of state oversight endangers.

ACA's public mission of single payer provider is inevitable

destruction of the existing state systems enjoyed as state-of-the-art for many decades. Removal of options is not liberty.

Forced single payer care at best destroys patient/doctor relationships forged in trust over years with mutual trust. In reality it removes all options for a majority of state citizens for the expressed purpose of forcing health care for all Americans.

Provisions that the Supreme Court did not rule on that are still being challenged include:

g. **FEDERALLY-FACILITATED EXCHANGE SUBSIDY**

In the PPACA approved by Congress and made existing law, only state-based health exchanges are authorized to provide premium assistance subsidies to individuals from 100 percent to 400 percent of the federal poverty level.

The PPACA does not authorize federally-facilitated exchanges to do the same.

New regulations from the Internal Revenue Service illegally circumvent Congress and existing law allowing all exchanges to provide premium assistance. The illegality of these regulations is incontrovertible and currently being challenged. This cannot stand.

h. **PREVENTATIVE CARE MANDATE V. RELIGIOUS CIVIL RIGHTS OF 83 PERCENT OF STATE RESIDENTS**

Section 2713 of the PPACA allows for the secretary to define preventive care services to be provided cost-free by all non-grandfathered insurance plans.

State rejects ab initio any mandate upon a state resident that assumes the role of private physician for the resident, without also assuming the responsibility, accountability, and liability for the success or failure of services forced upon the resident.

In August 2011, the secretary released a regulation that included contraceptive and some abortifacient services as preventative care.

The regulation has been challenged by numerous groups and individuals (in over 35 lawsuits) who have religious objec-

tions to paying for health insurance that includes coverage for contraception and some abortifacient services.

Eighty-three percent of Americans have Judeo-Christian religious beliefs opposing such "services."

Obvious conclusion is our State rejects ACA as a violation of religious rights.

i. **MAINTENANCE OF EFFORT (MOE)**

The Supreme Court's decision invalidated the provision of the PPACA which coerced States to expand their Medicaid program by threatening existing Medicaid funding. State maintenance of effort (MOE) requirement under ACA, requiring States to maintain their existing Medicaid eligibility until 2014, requires further adjudication to resolve.

j. **ORIGINATION CLAUSE**

The Supreme Court decision made it clear that the individual mandate is a tax, not a penalty as claimed by the administration. The PPACA originated in the Senate. The Constitution (Article I, Section 7, Clause 1) is clear that all taxes are to originate in the House, and thus the individual mandate has been contested as an unconstitutional tax.

Absent need or requirement for States to seek or have approval to exercise its sovereign rights, as they are not granted by the U.S. Constitution, nor limited except those powers enumerated in the U.S. Constitution specifically granted to the Federal Government, the incontrovertible evidence being ACA is an unconstitutional tax levied by Congress in error.

Further the ACA unconstitutional tax approved in error by Congress has since been circumvented by material changes in existing ACA law, i.e. a new tax of $5.25 per month on every employee in an employer provided group plan, and allowing subsidies for exchanges other than state-operated exchanges.

In the new monthly tax of $5.25, it was not originated in the House, and is illegal, as are all material changes to existing ACA law approved by Congress, even were ACA taxes originated in the House as required by U.S. Constitution (Article I, Section 7, Clause 1).

k. **INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)**

Sections 3403 and 10320 of the PPACA created this 15-member federal board that is granted the authority to make payment changes for the Medicare program without approval from Congress. There are also no administrative or judicial reviews of these decisions. Material changes to existing law without congressional review and approval are illegal ab initio, and therefore has no standing in our State.

l. **LEGALITY OF RULEMAKING/GUIDANCE AS MATERIAL CHANGES CIRCUMVENTING EXISTING LAW**

With many of the provisions of the PPACA, formal rules and regulations have been delayed or even non-existent. These are fatal flaws in light of the Administrative Procedures Act, Congressional Review Act, and other balance of power law governing these known issues, as well as the obvious fatal flaw of infinite future material changes.

m. **FATALLY FLAWED AGENDA AND POLICY**

While HHS has repeatedly said that the States serve as incubators of innovation, the PPACA robs States of sovereign rights to exercise this ability enjoyed over decades, by limiting their opportunities to enact meaningful state-led health care reform.

For example, the concept for an exchange originated as a free market idea meant to lower the cost of health insurance for those who decide to purchase such insurance.

In academic theory, an increased pool for those deciding to purchase health insurance is a good idea. It provides individuals the ability to select the insurance coverage that they want at a lower cost. If this were truly the framework for the exchange model outlined in PPACA, the State would be glad to evaluate it as an option, adopting it to our State's needs as another arrow in our state quiver as a consumer option.

However, the PPACA exchange is only masquerading as free market idea, and instead creates a vehicle for the Federal Government to tightly control ALL coverage options available to consumers, raising costs and limiting choice.

Many employers will drop the health insurance coverage they currently provide to employees, leaving individual health care needs to the Federal Government. Specifically, the consequences of the PPACA exchange and associated insurance changes are harmful to State residents in numerous, infinite, unlimited ways, including those defined herein.

n. **FATAL ENDING OF CONSUMER CHOICE**

When the PPACA was proposed, the President issued an implied contract with state residents and health care providers and health insurance companies, by his personal public promise that if individuals liked their current health care insurance, they could keep it, with no changes.

However, the PPACA model will actually force individuals into the bankrupt, dysfunctional, broken beyond repair, federal government-operated Medicaid system and into heavily regulated, government-ran health care plans (deemed "minimal essential coverage" by the Federal Government) which are detrimental and harmful to state residents, so interposition is required.

State residents have now, and must continue in perpetuity to have the personal civil right to select what health care plan is best for them, and not be limited to a one-size-fits-all product that a political process deems is "essential." By mandating that certain benefits be provided in all insurance plans, the price of premiums will increase, leaving individuals unable to continue the coverage they like, want or need, with a price they can afford or prioritize in a family budget.

o. **INCREASED TAXES**

The PPACA requires that all exchanges be financially self-sufficient by 2015. This will require the exchange to generate revenue, either by instituting user fees in the exchange market or in the entire insurance market essentially a tax on all insurance plans purchased. This will only further drive up the costs of premiums in the exchange market for consumers and for individuals who will have to pay the premium assistance through their taxes.

The PPACA also includes a tax on insurance premiums

which are proposed to be paid for by "the industry." It is troubling that these same taxes will affect managed care organizations, proven mechanisms for more effectively controlling cost for Medicaid and Medicare, especially needed for States with limited financial resources.

These provisions require new taxes of unknown amounts, yet another circumvention of Congress, as all taxes must originate in the House, and be approved by Congress.

p. **DEVASTATING IMPACT ON EMPLOYERS AND EMPLOYEES**

The employer mandate, a tax on employers with 50 or more employees who decide not to provide "adequate" health insurance coverage to their employees, is a disincentive to provide coverage, an experimental, illegal agenda which cannot possibly "count the costs" to impose.

It will destroy historical success of state systems which provided fertile fields that produced our existing state-of-the-art medical, mental health and pharmaceutical innovations which are the envy of the world.

Already, businesses are attempting to modify their business structure to avoid the law's mandates (either by laying off employees or reducing the number of hours these employees work). Even those employers who provide coverage can be taxed an additional $3,000 if that employee is eligible and enrolls in coverage on the health insurance exchange. So instead of building upon the existing insurance market, the PPACA is undermining it, with an agenda to replace it.

q. **UNREALISTIC AND NAIVE DEMANDS ARE INSURMOUNTABLE HURDLES**

The deadline for all exchanges (both state- and federally-facilitated) to be ready for open enrollment is October 1, 2013. Many exchanges will not be ready by that point, even in those States that are supportive of the PPACA. The guidance received from the Federal Government is delayed, conflicting, illegal, naïve, harmful or non-existent, as it is a codified concept targeting forced control immediately and once power is achieved, then determine the terms and conditions at some

future time. Even when ACA was approved by Congress, we still could not read what was in "the bill," because the bill is being rewritten daily, circumventing Congress.

For a project as large and complicated as health care reform, this is an insurmountable hurdle for the States to overcome. ACA is not "health care reform," but rather "health care replacement," an agenda to replace existing state systems developed over many decades by harnessing private industry intellectual property from the best medical and health insurance minds on our planet.

There are infinite fatal flaws, questions and major unresolvable problems remaining about exchanges and the provisions of the PPACA entangled with them.

Continuing issues include:

r. **EXCHANGES IN GENERAL**

In order for an exchange to be ready for open enrollment on October 1, 2013, it must be approved or conditionally approved by January 1, 2013. However, there are no formal regulations regarding what guidelines HHS will use to determine if an exchange is conditionally approved or not. States cannot and will not attempt building new structures with no blueprints.

It has been continuously promised by officials at HHS that there will be cost comparisons between the federally-facilitated exchange, the state-based exchange and the partnership exchanges. These cost estimates have not yet been made public, so all estimates are useless.

s. **FEDERALLY-FACILITATED EXCHANGES**

To date, in addition to the incomplete final rule for health insurance exchanges, there has been no rulemaking regarding the federally-facilitated exchanges and their interactions with the respective states' eligibility systems. Promised in the March 2012 final exchange regulation was further guidance regarding the federally-facilitated exchange. Since that point, only a questions and answers document has been released. ACA passed by Congress cannot now be materially changed by federal fiat, in whatever form attempted, i.e. new IRS Rule or Executive order. Material changes must pass Congress, by

U.S. Constitution and the Congressional Review Act.

Numerous contracts have been signed for the development of the federally-facilitated exchange, but these documents have not been made public. The State of Louisiana filed a Freedom of Information Act request for these contracts and received no documents. Senator Orrin Hatch of Utah requested similar documents in his role as ranking member on the U.S. Senate Committee on Finance and received no response. It is necessary for these documents to be made public so that States can make informed decisions concerning exchanges. It is foretelling a catastrophic disaster in waiting for States and state citizens whose very lives depend on open and transparent communication process by ACA to survive.

t. **PARTNERSHIP EXCHANGE**

A partnership exchange will be a federally-facilitated exchange with certain functions run by the State. It is an option first introduced by a PowerPoint® presentation and further expanded by a document entitled "General Guidance on Federally-facilitated Exchanges," but has yet to be defined in federal regulations. The final exchange rule proposed no regulations regarding this option. It remains an unfunded mandated codified concept without terms and conditions.

There has been no answer from the Federal Government concerning whether the Federal Government or the States will be responsible to pay for the state-run functions of a partnership exchange.

u. **THE WORKINGS OF AN EXCHANGE**

The exchange is required to provide premium tax credits to an unknown actual number of those between 100 percent and 400 percent of the federal poverty line. Originally "projected" to cost the Federal Government $462 billion between 2012 and 2019, these subsidies are now "projected" to be $574 billion during the same period by the Congressional Budget Office, based solely on unknown number of persons, unknown number of services required for those unknown numbers of persons, at unknown actual costs, resulting in a blank check, post dated.

Already, Medicare funding will be cut by $700 billion to pay for these premium tax credits. These levels of subsidies are unsustainable, so the number of Americans eligible for premium assistance subsidies will be reduced in number, adding to the "projected" 30 million who will not have health insurance even if ACA is fully implemented and could survive, which it cannot.

v. **ESSENTIAL HEALTH BENEFITS AND ACTUARIAL VALUES**

All plans in the individual and small group markets (including plans sold on the respective state exchanges) must meet "essential health benefits," benefits not yet defined by the Secretary of HHS in formal rulemaking. Initial informal guidance suggests that these benefits will be based off of the "most popular" existing small group plans in each State in addition to benefits specified by the PPPACA. The States, insurance companies, and other stakeholders are awaiting formal regulations about essential health benefits as yet undefined. This State opts to leave the "most popular" existing small group plans alone to continue serving our residents.

The States await a promised new unproven invention, an "actuarial value calculator" to accurately determine actuarial values for plans sold on the exchange. This still has not been delivered and infinite questions remain about how actuarial value of health insurance plans will be determined.

w. **INFINITE REFORMS REQUIRED FOR VIABILITY**

It is most disappointing that the PPACA failed to offer sustainable reform of the nation's health care system. Instead of strengthening the market to lower costs and increase consumer choice, the PPACA created a big government "solution" – the type of solution history tells us will only create infinite increased debt and worry for future generations of Americans.

Health care reform must focus on improving the value of health care in America by bringing down costs and improving quality.

There are several ways to do this. Transparency in health care is essential for individuals to be better consumers of care. The cost and success rates of different procedures can be made

publicly available to help individuals make decisions about their care. Increased competition through individuals being allowed to purchase insurance across state lines can create greater competition and lower costs, but at a cost of State oversight protecting state residents from insurance companies that become insolvent and cannot pay claims submitted, which can bankrupt residents quickly at no fault of their own. State supervision has proven successful.

Similarly, just as individuals should have more investment in their health care choices, States should have greater ability to design programs that meet the needs of their people. States know how to take care of their residents more than the bureaucrats in Washington, distant both in geography and in experience. Louisiana, for example, has been able to make remarkable progress in its care of the Medicaid population through an innovative model of managed care, saving money and improving the quality of care. However, constrained by the federal requirements for Medicaid, Louisiana can only do so much. It is time to give the States the option to administer this program through block grants to save both the federal and state taxpayers money and eliminate the perverse incentives created by federal rules and funding streams.

Tennessee's experiment with TennCare proved how quickly a State can face bankruptcy by funding a health care program with unknown numbers of residents having unknown numbers of medical needs. Former Governor Bredesen reformed TennCare by stopping blank checks and installing reasonable limits in terms and conditions so it could remain viable, as it is today.

Governor Bredesen advised publicly that ACA would bankrupt States and why, but was ignored. This State finds Governor Bredesen highly credible, and reject ACA ab initio.

The PPACA must be repealed and replaced with a system giving States sole oversight, with the ability to truly innovate, such as block grants to serve clear and achievable objectives.

x. **MEDICAID EXPANSION**

The Supreme Court effectively made the ACA's Medicaid

expansion optional. Governors are refusing to extend their programs even though the Federal Government will initially pay 100 percent and eventually 90 percent of the costs for newly eligible enrollees.

Most low-income, uninsured residents in states that do not expand Medicaid will be ineligible for subsidies in the exchanges and will therefore remain without coverage. The hospital industry could become a powerful advocate for states to accept additional federal Medicaid funds.

Without the expansion, hospitals still face the prospect of reduced Medicare reimbursement and cuts in payments for seeing a disproportionate share of low-income patients but won't have enhanced Medicaid coverage to help offset their losses. EMTALA reform or state interposition appears the ultimate means of protecting the financial integrity of state hospitals.

y. **ACA CODIFIED CONCEPT FAILURE ASSURED**

Even after the ACA as approved law is fully implemented, the Congressional Budget Office estimates that 30 million U.S. residents will remain uninsured. This "estimate" is drawn from data most favorable to ACA advocates presented and accepted without review or scrutiny.

Destroying state health care delivery proven successful over many decades in mutual trust only achievable over generations, to replace it with a codified concept already proven a failure, is irreparable harm demanding state interposition ab initio, and this State so declares as law.

z. **HISTORICAL PRECEDENT, UNCREDIBLE AND DISCREDITED SOURCE**

The ACA initiates from the most uncredible and discredited source possible, a broad array of new, unproven, untested, concepts, basically experiments in medical care delivery and payment reform whose success in any portion is highly uncertain, while its mission is already an admitted failure, since 30 million Americans will still be without "insurance," yet 30 million illegal immigrants will be insured, an unacceptable outcome for this State.

However, as Medicare's own historical transformation from

passive bill reimburser to colossus of prospective payment clearly demonstrates, once the Federal Government begins paying for medical services, the political equation changes to unqualified, uncredible intervention exacerbating all existing problems exponentially, ad infinitum, ad nauseum.

Cost-containment measures intensify as policymakers struggle with the fiscal consequences of health insurance programs. Ongoing pressures to curtail the federal budget deficit will only strengthen the resolve to hold down spending under the ACA.

Only 40 percent of existing doctors accept Medicare or Medicaid because of ridiculous low payments for their highly skilled and well trained services.

Association of American Physicians and Surgeons (AAPS) surveys promise (not a baseless projection) no more than 25 percent will accept ACA payment rates or Medicare rates, leaving our state residents with a health care system 75 percent of physicians and surgeons reject entirely.

Section 4. CIVIL AND CRIMINAL PENALTIES

Any person(s) who conspire or act to interfere with interposition or undermine interposition in this cause whether detailed in this Act or not, will be prosecuted by the State to recover all compensatory damages and treble that amount in punitive damages in civil courts, in addition to any and all criminal actions, which are punishable as a felony, with a minimum sentence of no less than 12 months and maximum of 36 months in a state penitentiary.

Section 5. SEVERABILITY

If any provision of this Act or the application thereof to any person, entity or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons, entities or circumstances shall not be affected thereby.

Section 6. CONCLUSION OF LAW

For all the aforementioned reasons stated herein, this Act shall take effect upon becoming a law, the public welfare requiring it.