

ALEC

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

MEMORANDUM

TO: HEALTH AND HUMAN SERVICES TASK FORCE MEMBERS
FROM: CHRISTIE HERRERA, HHS TASK FORCE DIRECTOR
RE: **UPDATED** 35-DAY MAILING—HHS TASK FORCE MEETING AT ALEC'S 2011 SPRING TASK FORCE SUMMIT, CINCINNATI, OH.
DATE: MARCH 31, 2011

Welcome Our New HHS Task Force Chairs!

Last month, all ALEC Task Forces were appointed with new chairs for the 2011-12 term. And so I'm happy to announce that Wisconsin Senator Leah Vukmir will serve as ALEC's new HHS Task Force Public Sector Chair, and that Guarantee Trust Life Insurance Company's Marianne Eterno will serve as ALEC's new HHS Task Force Private Sector Chair. I'm looking forward to the leadership that Senator Vukmir and Marianne will provide. Please join me in welcoming them in their new ALEC roles.

Overview of ALEC's 2011 Spring Task Force Summit

The American Legislative Exchange Council will hold its 2011 Spring Task Force Summit on Friday, April 29 at the Hilton Cincinnati Netherland Plaza in Cincinnati, Ohio. A STFS [agenda](#) and [registration](#) page are now online.

The deadline to register and get housing for ALEC's Spring Task Force Summit in Cincinnati on April 28-29 has been extended. You have until **April 6th** to get a room at the conference rate and receive a \$50 discount on registration. Visit [ALEC's website](#) today to sign up for this event, arrange housing, and learn about exciting things to do in Cincinnati!

Legislator Scholarships for ALEC's 2011 Spring Task Force Summit

Any ALEC legislator who has been appointed to serve on the HHS Task Force for the 2011-12 term is eligible for \$350 in travel reimbursement and a two nights' stay (room and taxes only) at the Hilton Cincinnati Netherland Plaza. Registration fees for ALEC legislators are not covered; however, ALEC legislative task force members may submit registration expenses for payment from their state scholarship account upon approval of the state chair.

If you are a legislator and have questions about ALEC's scholarship policy, please contact Monica Mastracco at 202-742-8525 or at mmastracco@alec.org. Also, if flights from your state exceed the \$350 limit, please contact Monica and we can work with you on covering your extra costs.

About the HHS Task Force Meeting at ALEC's 2011 Spring Task Force Summit

ALEC's 2011 Spring Task Force Summit will function a bit differently this year. Instead of a large, plenary luncheon, each task force will host a working policy luncheon prior to the start of the task force meeting.

The HHS Task Force has a terrific task force luncheon, “Chronic Disease 101,” planned on Friday, April 29, from 12:30-1:45 p.m. We’ll learn about the prevalence of chronic disease, and also discuss how conservative-minded legislators can approach chronic disease issues from a “non mandate” perspective.

The HHS Task Force meeting will then meet on Friday, April 29, from 2:00-5:00 p.m. We’ll kick off the meeting with a few words from our new HHS Task Force chairs, and then we’ll have a roundtable discussion on exchanges with two highly-regarded national experts. Finally, we’ll debate three proposed model bills on health care sharing ministries, health compacts, and scope of practice issues. Please see the enclosed HHS Task Force Tentative Agenda for additional information.

About ALEC’s 35-Day Mailing

In addition to this electronic-only 35-Day Mailing, all materials can be accessed online at the [HHS Task Force Member Area](#) on ALEC’s website. Once you are logged in, click the “HHS 35 Day Mailing” document at the top of the page to find the 35-Day Mailing in one complete PDF, or click on the “2011 Spring Task Force Summit” folder to access the mailing’s individual documents.

Keep in mind that you will need your ALEC username and password to access the 35-Day Mailing online. Conversely, if you choose to receive 35-Day Mailings via “snail mail,” please contact Monica Mastracco at 202-742-8525 or at mmastracco@alec.org. We will assume that you prefer the 35-Day Mailing e-mailed to you unless you indicate otherwise.

Enclosed Materials

Please find the following HHS briefing materials enclosed:

- Faxable registration form for ALEC’s 2011 Spring Task Force Summit
- Agenda-At-A-Glance for ALEC’s 2011 Spring Task Force Summit
- Tentative Agenda for the HHS Task Force Meeting at ALEC’s 2011 Spring Task Force Summit
- Potential Model Legislation:
 - Amendments to ALEC’s *Health Care Sharing Ministries Freedom to Share Act*, sponsored by Joe Guarino, Alliance of Health Care Sharing Ministries
 - *Health Freedom Compact Act*, sponsored by Goldwater Institute’s Nick Dranias
 - Supplements to the *Health Freedom Compact Act*: Compact Q&A, Talking Points on Compacts, and the Constitutionality of Compacts (for information purposes only)
 - *Health Professional Modernization Act*, sponsored by Texas Public Policy Foundation’s Arlene Wohlgemuth
- HHS Task Force Roster
- Draft Minutes from the HHS Task Force Meeting at ALEC’s 2010 States and Nation Policy Summit
- ALEC’s Mission Statement/Scholarship Policy by Meeting/Task Force Operating Procedures

Questions?

I look forward to seeing everyone in Ohio. If you have any questions or comments regarding the meeting, please contact me at (202) 742-8505 or at christie@alec.org. Thank you for all you do to make ALEC a great organization for great health care policy!

ATTENDEE REGISTRATION / HOUSING FORM

Hilton Cincinnati Netherland Plaza -
Cincinnati, OH



Early Registration deadline is March 23, 2011
Housing cut-off date is March 23, 2011

April 28-29, 2011

Online www.alec.org
 Fax (credit cards only) 202.331.1344
 Phone / Questions • Mon-Fri, 9am-5:30 pm Eastern
 Registration: 202.742.8538 / Housing: (800) 221-3531
 Mail • ALEC Registration & Housing
 P.O. Box 96754 • Washington, DC 20090-6754

ATTENDEE INFORMATION

Prefix (required) Sen Rep Del Mr Mrs Ms Other _____
 Last Name _____ First Name _____ Middle Initial _____ Badge Nickname _____
 Title _____
 Organization (required) _____
 Address _____ Suite # _____
 City _____ State/Province _____ Country _____ ZIP/Postal code _____
 Daytime phone _____ Fax _____ Alternate phone _____
 Email (confirmation will be sent by email) _____

Spouse / Guest: If registering a spouse or guest, please complete the spouse/guest registration form.

REGISTRATION

****Save \$50 on registration by booking your hotel room in ALEC's headquarter hotel****

DISCOUNTED REGISTRATION FEES are extended only to registrants booking ALEC's headquarter hotel. ALEC will reimburse \$50 when your accommodations are confirmed.

Note: Member fees are subject to verification

	Early Until 03/23	On-Site Begin 03/24	Amount
<input type="checkbox"/> I have already registered # _____			
<input type="checkbox"/> ALEC Legislative Task Force Member	\$ 150	\$ 150	\$ _____
<input type="checkbox"/> ALEC Private Sector Task Force Voting Member	\$ 250	\$ 250	\$ _____
<input type="checkbox"/> ALEC Legislative Member/ Non-Task Force Member	\$ 400	\$ 500	\$ _____
<input type="checkbox"/> Private Sector Member/ Non-Task Force Member	\$ 550	\$ 700	\$ _____
<input type="checkbox"/> Legislative/ Non-Member	\$ 525	\$ 625	\$ _____
<input type="checkbox"/> Private Sector/ Non-Member	\$ 875	\$ 1,025	\$ _____
<input type="checkbox"/> ALEC Non-Profit Member (501(c)(3) status required)	\$ 475	\$ 575	\$ _____
<input type="checkbox"/> Non-Profit Non-Member (501(c)(3) status required)	\$ 625	\$ 725	\$ _____
<input type="checkbox"/> Legislative Staff / Government	\$ 400	\$ 500	\$ _____
<input type="checkbox"/> ALEC Legacy Member	\$ 0	\$ 0	\$ _____

Promo Code _____

TOTAL REGISTRATION FEES: \$ _____

Note: Registration forms with enclosed payments must be postmarked by **March 23, 2011**, to be eligible for early registration rates. Forms and/or payments received after **March 23, 2011**, will be subject to the on-site registration rate. If registering after **March 23, 2011**, please bring completed form and payment to register on-site.

REGISTRATION CONFIRMATION INFORMATION

Online registrants will receive immediate email confirmation. If registering by form, confirmation will be emailed, faxed, or mailed within 72 hours of receipt of payment.

REGISTRATION CANCELLATION / REFUND INFORMATION

Registrations cancelled prior to 5pm *Eastern* **March 23, 2011** are subject to a \$100 cancellation fee. Registrations are non-refundable after 5pm *Eastern* **March 23, 2011**.

HOUSING

RESERVATION CUTOFF FOR ALEC DISCOUNTED RATE IS March 23, 2011

****Save \$50 on registration by booking your hotel room in ALEC's headquarter hotel****

I do not require a reservation at this time.

Arrival Date _____ Departure Date _____

Sharing room with _____

Room type

<input type="checkbox"/> Single	(1 person - 1 bed)	\$ 169
<input type="checkbox"/> Double	(2 persons - 1 bed)	\$ 199
<input type="checkbox"/> Db/Db	(2 persons - 2 beds)	\$ 199
<input type="checkbox"/> Triple	(3 persons - 2 beds)	\$ 229
<input type="checkbox"/> Quad	(4 persons - 2 beds)	\$ 259

Government rate Not Available

*All rates DO NOT include 17% STATE tax/ CITY OCCUPANCY tax. (subject to change)

Suites and upgraded accommodations are available upon request. Please call (800) 221-3531 for additional information.

Special requests

ADA room required:
 _____ Audio _____ Visual _____ Mobile
 Rollaway / crib: _____
 Other: _____

METHOD OF HOUSING RESERVATION

Please use the same method of payment as above.

Credit Card: Credit cards will be used to guarantee the reservation.

Amer Express Visa MasterCard Discover

Card # _____

Cardholder (please print) _____

Exp Date (mm/yy) _____ Security Code _____

Signature _____

Checks: Payment must be in U.S. currency drawn on a U.S. bank. Please make check payable to ALEC and send to above address.

Note: Cutoff for reservations at the ALEC rate is **March 23, 2011**. After **March 23, 2011**, every effort will be made to accommodate new reservations, based on availability and rate.

HOUSING CONFIRMATION INFORMATION

Online reservations will receive immediate email confirmation. Reservations received by form will be confirmed via email, fax, or mail within 72 hours of receipt.

HOUSING CANCELLATION / REFUND INFORMATION

Credit cards will be charged one night room and tax in the event of a no show or if cancellation occurs within 72 hours prior to arrival. Departures prior to the departure date confirmed by the hotel at check-in will result in a charge of early departure fee \$100. Please obtain a cancellation number when your reservation is cancelled.

2011 ALEC Spring Task Force Summit

Tentative Agenda as of March 2011

Thursday, April 28

Registration 1:00 p.m. - 5:30 p.m.

Friday, April 29

Registration 8:00 a.m. - 4:00 p.m.

ALEC Joint Board of Directors Meeting 8:00 a.m. - 12:15 p.m.

Task Force Subcommittee Meetings 8:00 a.m. - 11:00 a.m.

Workshop: Budget Transparency 11:00 a.m. - 12:15 p.m.

Task Force Meetings 12:30 p.m. - 5:00 p.m.

- Civil Justice
- Commerce, Insurance and Economic Development
- Education
- Energy, Environment and Agriculture
- Health and Human Services
- Public Safety and Elections
- Tax and Fiscal Policy
- Telecommunications and Information Technology

Spring Task Force Summit Reception 5:00 p.m. - 6:30 p.m.

Board of Directors Dinner 7:00 p.m. - 9:00 p.m.

(by invitation only)



COMMON CAUSE
Holding Power Accountable

ALEC

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

**Health and Human Services Task Force Meeting
ALEC's 2011 Spring Task Force Summit
Friday, April 29, 2011
12:30 – 5:00 p.m.
Hilton Cincinnati Netherland Plaza**

TENTATIVE AGENDA

12:30 p.m. HHS Task Force Working Luncheon: “Chronic Disease 101”
Chronic diseases—ongoing, generally-incurable illnesses like heart disease or diabetes—affect a staggering 45% of Americans. And while the Centers for Disease Control estimates that chronic disease accounts for about 75% of health spending, in government-run healthcare programs it consumes even more—96 cents per dollar for Medicare and 83 cents per dollar for Medicaid. With stakes this high, it is imperative that policymakers raise awareness about the fiscal and health effects of chronic disease; that the private sector establish voluntary, market-friendly wellness programs for health care consumers; and that individuals assume personal responsibility for their own health in order to stop chronic diseases before they start.

At this ALEC HHS Task Force luncheon, you'll learn about the impact of chronic disease on state budgets and patients and discuss legislative strategies for raising awareness about disease issues.

Moderators: Wisconsin Senator Leah Vukmir, HHS Public Sector Chair
Marianne Eterno, Guarantee Trust Life Insurance, HHS Private Sector Chair

Speakers: Stephen Sander, Associate Director of Health Outcomes Research,
Boehringer-Ingelheim Pharmaceuticals

Former New Mexico Senator Steve Komadina, Past President of the
New Mexico Medical Society

1:45 p.m. BREAK

**2:00 p.m. Welcoming Remarks
Roundtable Introduction of Task Force Members and Guests
Recognition of New and Returning ALEC Private Sector Members
Approval of Minutes from ALEC's 2010 States and Nation Policy Summit
Wisconsin Senator Leah Vukmir, HHS Public Sector Chair
Marianne Eterno, Guarantee Trust Life Insurance, HHS Private Sector Chair**

**2:15 p.m. ROUNDTABLE DISCUSSION
To Exchange or Not to Exchange?
Ed Haislmaier, Senior Research Fellow in Health Policy Studies, Heritage Foundation*
Brian McManus, Director, Washington Office, Office of Florida Governor Rick Scott***

3:45 p.m. MODEL LEGISLATION: DISCUSSION AND VOTING
Amendments to ALEC's *Health Care Sharing Ministries Freedom to Share Act*
Sponsored by Joe Guarino, Alliance of Health Care Sharing Ministries

4:00 p.m. *Health Freedom Compact Act*
Sponsored by Nick Dranias, Goldwater Institute

4:30 p.m. *Health Professional Modernization Act*
Sponsored by Arlene Wohlgemuth, Texas Public Policy Foundation

5:00 p.m. Good of the Order/Adjournment

*** - *Invited***



COMMON CAUSE
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AMENDMENTS TO ALEC's Health Care Sharing Ministries Freedom to Share Act
(DRAFT, APRIL 29, 2011)

FINDINGS AND PURPOSE

~~Members~~ **Participants** of health care sharing ministries financially assist fellow ~~members~~ **participants** with large medical expenses with a result usually provided by health insurance. Due to their voluntary and ministerial nature, these ministries should be recognized in the insurance code as ministries and not as health insurance companies.

A health care sharing ministry (HCSM) is a health care cost sharing arrangement among persons of similar and sincerely held beliefs, administered by a not-for-profit religious organization. Those sharing through HCSMs are called ~~members~~ **participants**, and the money sent by ~~members~~ **participants** to other ~~members~~ **participants** to help pay for their medical expenses is called a share. The sharing is accomplished through ~~members'~~ **participants'** monthly gifts directed to families in financial distress and not to an insurance reserve fund. In addition to addressing the financial needs of those facing health challenges, HCSMs also seek to help meet spiritual and emotional needs as of part the sense of community which exists among ~~members~~ **participants**.

As of 2010, HCSMs represent over ~~100,000~~ **110,000** ~~members~~ **individual lives** in all fifty states. HCSMs share over ~~60~~ **\$75** million dollars per year for health care costs.

Since 1981, formalized HCSMs have played a vital role in assisting tens of thousands of individuals emotionally, spiritually, and financially through medical crises and the accompanying expenses.

Since HCSMs engage in voluntary sharing and not a contractual transfer of risk, they are not insurance. The regulatory requirements of insurance, if imposed on HCSMs, would destroy the voluntary, ministerial nature of the organizations. The public good would be served by explicitly acknowledging this through a specific exemption in the state's insurance code to avoid uncertainty and waste of legal expenses.

HCSMs are under the oversight and general regulation of both the Internal Revenue Service and the states' attorneys general since they are 501(c)(3) charities.

~~Ten~~ **Eleven** states have already exempted HCSMs from their insurance codes, including **Florida**, Iowa, Kansas, Kentucky, Maryland, Missouri, Oklahoma, Pennsylvania, Utah, Virginia, and Wisconsin.

This legislation is designed so that the state insurance code specifically recognizes HCSMs as ministries and not insurance, and not subject to the additional requirements of the state insurance code.

MODEL LEGISLATION

Section 1. Short Title. This Act shall be known as the "Health Care Sharing Ministries Freedom to Share Act."

Section 2. Exemption of Health Care Sharing Ministries from the Insurance Code.

A. A health care sharing ministry shall not be considered to be engaging in the business of insurance for purposes of this {insert code, title, chapter, or appropriate description that describes the state’s regulation of health insurance statutes}.

Section 3. Definitions. ~~As used in this Act, the following definition applies:~~ **“Health care sharing ministry” means a faith-based, non-profit organization that is tax exempt under the Internal Revenue Code which:**

~~A. “Health care sharing ministry” means a health care cost sharing arrangement among persons of the same religion based on their sincerely held religious beliefs, administered by a not for profit religious organization.~~

~~(Drafting Note: The following language may be used as an alternate Paragraph A.)~~

~~A. “Health Care Sharing Ministry” means a faith based, non profit organization that is tax exempt under the Internal Revenue Code which:~~

1. Limits its ~~membership~~ **participants** to those who are of a similar faith;
- ~~2. Acts as an organizational clearinghouse for information about members/subscribers who have financial, physical or medical needs, matching them with members/subscribers with the present ability to assist those with financial or medical needs, all in accordance with the organization’s criteria;~~
- 2. Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;**
3. Provides for the financial or medical needs of a ~~member/subscriber~~ **participant** through ~~payments~~ **contributions** directly from one ~~member/subscriber~~ **participant** to another. ~~The requirements of this Subsection can be satisfied by a trust established solely for the benefit of members/subscribers, which is audited annually by an independent auditing firm;~~
4. Provides amounts that ~~members/subscribers~~ **participants** may contribute with no assumption of risk or promise to pay among the ~~members/subscribers~~ **participants** and no assumption of ~~the~~ risk or promise to pay by ~~such organization~~ **the health care sharing ministry** to the ~~members/subscribers~~ **participants**;
5. Provides a written monthly statement to all ~~members/subscribers~~ **participants**, ~~listing~~ **that lists** the total dollar amount of qualified needs submitted to ~~such organization~~ **the health care sharing ministry**, as well as the amount actually published or assigned to ~~members/subscribers~~ **participants** for their contribution; and
6. Provides ~~in substance the following~~ a written disclaimer on or accompanying all ~~promotional documents~~ **applications and guideline materials** distributed by or on behalf of the organization, ~~including applications, and guideline materials~~ **that reads, in substance:**

“Notice: ~~This publication~~ The organization facilitating the sharing of medical expenses is not an insurance company, ~~nor is it offered through an insurance company~~ and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary, ~~as~~ because no other ~~subscriber or member~~ participant will be compelled by law to contribute toward your medical bills. As such, ~~this publication~~ participation in the organization or a subscription to any of its documents should never be considered to be insurance. ~~Regardless of~~ Whether you receive any payments for medical expenses ~~and or~~ whether ~~or not this publication~~ this organization continues to operate, you are always personally responsible for the payment of your own medical bills.”

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

Original model bill approved by the Health and Human Services Task Force on May 17, 2008.



COMMON CAUSE
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HEALTH FREEDOM COMPACT ACT (DRAFT, APRIL 29, 2011)

FINDINGS AND DECLARATION OF POLICY

A. Unites States Code Section 112 gives Congressional consent “to any two or more states to enter into agreements or compacts for cooperative effort and mutual assistance in the prevention of crime and the enforcement of their respective criminal laws and policies, and to establish such agencies, joint or otherwise, as they may deem desirable for making effective such agreements and compacts.”

B. Pursuant to their police powers to protect public health, safety, welfare, and morals, the party states have enacted or anticipate enacting laws or constitutional provisions to protect and guarantee their residents’ rights and freedom to pay or not to pay directly for health care services and to participate or not participate in health plans and health systems.

C. The party states have enacted or anticipate enacting laws that make it a crime in their state for anyone to interfere with their residents’ enjoyment of the rights and freedoms guaranteed by their respective health care freedom laws.

D. The party states find it necessary and deem it desirable for making effective their respective current or anticipated health care freedom criminal laws, as well as this agreement and compact, to do the following:

1. Prohibit any governmental agent from depriving any resident of any party state of the rights and freedoms guaranteed under their respective current or anticipated health care freedom laws.
2. Prohibit any governmental agent from penalizing any resident of any party state for exercising the rights and freedoms guaranteed under their respective current or anticipated health care freedom laws.
3. Cooperate with each other and to give each other mutual assistance in the prevention of crimes under the health care freedom criminal laws of any party state.
4. Cooperate with each other and to give each other mutual assistance in the criminal prosecution of anyone who violates the health care freedom criminal laws of any party state.

MODEL LEGISLATION

Section 1. Short Title. This Act shall be known as the “Health Freedom Compact Act.”

Section 2. Definitions. As used in this compact, unless the context clearly indicates otherwise:

A. “Compel” includes legal mandates, penalties, or fines.

B. “Health care freedom laws” means any state law or constitutional amendment that protects and guarantees a resident’s freedom to pay or not to pay directly for lawful health care services and to participate or not to participate in health care plans and health care systems.

C. “Health care freedom criminal laws” means any state law that makes it a crime for anyone to interfere with a resident’s enjoyment of the freedoms protected and guaranteed by the state’s respective health care freedom laws.

D. “Health care plan” means any legally binding arrangement under which at least one person or entity promises and undertakes, in exchange for consideration of a set or assessed amount of money, to make a payment to another party or a third party if a specified event occurs involving the provision of health care services.

E. “Health care system” means any public or private entity whose function or purpose is the management of, processing of, enrollment of individuals in health care plans, or payment for, in full or in part, health care services or health care data or health care information for its participants.

F. “Lawful health care services” means any health-related service or treatment to the extent that the service or treatment is permitted or not prohibited by law or regulation and that may be provided by persons or businesses otherwise permitted to offer such services.

G. “Pay directly” means payment for lawful health care services without a public or private third party, not including an employer, paying for any portion of the service.

H. “Penalty” means any civil penalty, criminal fine, tax, salary, or wage withholding or surcharge or any named fee with a similar effect established by law or rule by a government established, created, or controlled agency that is used to punish or discourage the exercise of rights protected under this state’s health care freedom law.

I. “State” means a state of the United States.

Section 3. Terms. Notwithstanding any state or federal law to the contrary:

A. Each party state shall give full faith and credit to the health care freedom criminal laws and health care freedom laws of every party state.

B. Governmental agents shall not deprive residents of party states of the rights and freedoms protected under their respective state’s health care freedom criminal laws and guaranteed by their respective state’s health care freedom laws.

C. Governmental agents shall not penalize residents of party states for exercising the rights and freedoms protected under their respective state’s health care freedom criminal laws and guaranteed by their respective state’s health care freedom laws.

D. The party states shall cooperate with each other and give each other mutual assistance in the prevention of crimes under the health care freedom criminal laws of any party state.

E. The party states shall cooperate with each other and give each other mutual assistance in the criminal prosecution of any person who violates the health care freedom criminal laws of any party state.

Section 4. Enforcement. Notwithstanding any state or federal law to the contrary:

A. The chief law enforcement officer of each party state shall enforce this agreement and compact.

B. A taxpaying resident of any party state has standing in the courts of any party state to require the chief law enforcement officer of any party state to enforce this agreement and compact.

Section 5. Compact Administrator and Interchange of Information.

A. The governor of each party state or the governor's designee is the compact administrator. The compact administrator shall:

1. Maintain an accurate list of all party states.
2. Consistent with Paragraphs C and D, transmit in a timely fashion to other party states citations of all current health care freedom laws and current health care freedom criminal laws of the compact administrator's respective state.
3. Receive and maintain a complete list of the health care freedom laws and health care freedom criminal laws of each party state.
4. Formulate all necessary and proper procedures to effectuate this compact.
5. Delegate needed tasks to other state agencies.

B. The compact administrator of each party state shall furnish to the compact administrator of each party state any information or documents that are reasonable necessary to facilitate the administration of this compact.

C. Within ten days after executing this agreement and compact, and thereafter on the close of each of their respective succeeding legislative sessions, the party state shall notify each other in writing and by appropriate citation of each of their current health care freedom laws, which shall be deemed within the subject matter of this agreement and compact, unless the compact administrator of one or more party states gives specific notice in writing to all other party states within sixty days of such notice that it objects to the inclusion of such law or laws in this agreement and compact.

D. Within ten days after executing this agreement and compact, and thereafter on the close of each of their respective succeeding legislative sessions, the party states shall notify each other in writing and by appropriate citation of each of their current health care freedom criminal laws, which shall be deemed within the subject matter of this agreement and compact, unless the compact administrator or one or more party states gives specific notice in writing to all other party states within sixty days of such notice that it objects to the inclusion of such law or laws in this agreement and compact.

Section 6. Entry into Effect and Withdrawal.

A. This compact is deemed accepted when at least two states deliver a notice of confirmation, which is duly executed by their respective authorized representative and which acknowledges complete agreement to the terms of this compact, to each other's governor, the Office of the Clerk of the United States House of Representatives, the Office of the Secretary

of the United States Senate, the President of the United States Senate, and the Speaker of the United States House of Representatives. Thereafter, the compact is deemed accepted by any state when a respective notice of confirmation, which is duly executed by the state's respective authorized representative and which acknowledges complete agreement to the terms of this compact, is delivered to each party state's compact administrator, the Office of the Clerk of the United States House of Representatives, the Office of the Secretary of the United States Senate, the President of the United States Senate, and the Speaker of the United States House of Representatives.

B. Four years after this compact first becomes effective, any party state may withdraw from this compact by enacting a joint resolution declaring such withdrawal and delivering notice of the withdrawal to each other party state. A withdrawal does not affect the validity or applicability of the compact to states remaining party to the compact.

Section 7. Construction and Severability.

A. This compact shall be liberally construed so as to effectuate its purposes.

B. The compact is not intended to:

1. Affect which health care services a health care provider or hospital is required to perform or provide under state or federal law.
2. Affect which health care services are permitted by state or federal law.

C. This compact is intended to operate as the law of the nation with respect to the party states under 4 United States Code Section 112, to supersede any inconsistent state and federal law and to establish vested rights in favor of residents of the party states in the enjoyment of the rights and freedoms protected by their respective health care freedom criminal laws and guaranteed by their respective health care freedom laws.

D. If any phrase, clause, sentence, or provision of this compact is declared in a final judgment by a court of competent jurisdiction to be contrary to the Constitution of the United States or is otherwise held invalid, the validity of the remainder of this compact shall not be affected.

E. If the applicability of any phrase, clause, sentence, or provision of this compact to any government, agency, person, or circumstance is declared in a final judgment by a court of competent jurisdiction to be contrary to the Constitution of the United States or is otherwise held invalid, the validity of the remainder of this compact and the applicability of the remainder of this compact to any government, agency, person, or circumstance shall not be affected.

F. If this compact is held to be contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the affected party state as to all severable matters.

1. What is an Interstate Compact?

An interstate compact is a contractual agreement between states that is similar to a treaty. It binds states contractually and the obligation created by a compact is protected from impairment by the “contracts clause” of the Constitution.

2. What would the Interstate Health Care Freedom Compact do?

The Interstate Health Care Freedom Compact would support a strong legal argument that it is a federal crime for anyone, including federal officials, to interfere with a state’s health care freedom laws, such as a law modeled on ALEC’s Health Care Freedom Act. Enforcing the individual mandate of the Federal Health Reform law would be illegal within the compacting states.

3. Why an Interstate Health Care Freedom Compact?

Because it can actually work. Unlike efforts to “nullify” the individual mandate of the Federal Health Reform law, the Interstate Health Care Freedom Compact would have the ability to displace the individual mandate as a matter of state *and* federal law. This is because the Compact is authorized by an existing federal statute that gives preapproval to interstate compacts that coordinate criminal laws. Federal courts have ruled that Congress can effectively pre-approve interstate compacts. Federal courts have also ruled that congressionally-approved interstate compacts are the equivalent of federal law. These court rulings support a strong legal argument that the Interstate Health Care Freedom Compact will trump conflicting federal laws, such as the individual mandate, when the compact becomes effective. The Health Care Freedom Compact combines state sovereignty with the power of federal law to restrain the federal government.

4. What will make the Interstate Health Care Freedom Compact Effective?

For the Health Care Freedom Compact to be effective, a compacting state must a) enact a health care freedom law, b) make it a crime for anyone to interfere with its health care freedom law, c) authorize and direct the Governor to enter into the Interstate Health Care Freedom Compact with at least one other state (both states must agree to identical language), and d) lodge the compact with Congress, when at least two states adopt it. Steps a), b) and c) can take place in any order, but the Compact will be ineffective until they all take place in at least two compacting states.

5. How do we really know the Compact will work?

The compact is drafted carefully to assist law enforcement in reciprocally enforcing criminal laws prohibiting the violation of actual or anticipated Health Care Freedom Acts. It squarely falls within the very broad and unlimited congressional preapproval for criminal law enforcement compacts

under 4 U.S.C. § 112. The legislative history of 4 U.S.C. § 112 shows that it was intended to broadly authorize any and all types of criminal law enforcement compacts. *See* S. Rep. No. 1007, 73d Cong., 2d Sess., 1 (1934); H. R. Rep. No. 1137, 73d Cong., 2d Sess., 1-2 (1934) (“This bill seeks to remove the obstruction imposed by the Federal Constitution and allow the States cooperatively and by mutual agreement to work out their problems of law enforcement”). The lawfulness of Congress giving preapproval to interstate compacts that post-date the enactment of 4 U.S.C. § 112 *by decades* was specifically upheld in *Cuyler v. Adams*, 449 U.S. 433 (1981). The fact that 4 U.S.C. 112 is the only preapproval statute ever enacted without any sort of caveat prohibiting conflict between the compact it authorizes and federal law (and there are more than a dozen other such statutes with caveats) strongly indicates that it means what it says—it authorizes an interstate compact that could very well displace prior federal law.

6. What is the “Interstate” Component of the Compact?

The compact protects state law rights with reciprocal criminal law enforcement guarantees. The mutual guarantee of the continued protection of state law rights and privileges as a proper subject of interstate compacts has been recognized since *Green v. Biddle*, 21 U.S. 1, 39-40 (1823), which sustained an interstate compact that reciprocally guaranteed the continued protection of existing property and contract rights from “any law which rendered those rights less valid and secure.”

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Interstate Compact General Strategic Overriding Communication Objective (“SOCO”)

An interstate compact is a contractual agreement between states that is similar to a treaty. Federal courts have ruled that congressionally-approved interstate compacts are the equivalent of federal law. An existing federal statute gives preapproval to interstate compacts that coordinate criminal laws. Therefore, interstate compacts that coordinate criminal law enforcement of state laws have the status of federal law.

Interstate Compact [Fill in the Blank] SOCOs

The Interstate [_____] Freedom Compact establishes that it is both a state and federal crime for anyone, including federal officials, to interfere with state laws that guarantee [_____] freedom for their citizens, such as Arizona’s [_____] Freedom Act. Enforcing the [specify conflicting federal law or policy] would be illegal within the compacting states.

The Interstate [_____] Freedom Compact would have the ability to displace [specify conflicting federal law or policy] as a matter of state and federal law. This is because the Compact is authorized by an existing federal statute that gives preapproval to interstate compacts that coordinate criminal laws. Federal courts have ruled that Congress can effectively pre-approve interstate compacts. Federal courts have also ruled that congressionally-approved interstate compacts are the equivalent of federal law. These court rulings support a strong legal argument that the Interstate [_____] Freedom Compact will trump conflicting federal laws, such as [specify conflicting federal law/policy], when the compact becomes effective. The Interstate [_____] Compact combines state sovereignty with the power of federal law to restrain the federal government.

Interstate Health Care Freedom Compact Specific SOCOs

The Obama Administration is pressing forward to implement the individual mandate to force citizens into health care collectives, which are called health care exchanges. This is despite the fact that two federal courts have held the individual mandate of the Federal Health Reform law unconstitutional. Arizona and its sister states must use their sovereign power to make it a crime to enforce the unconstitutional individual mandate. And they must coordinate their law enforcement efforts under the authority of existing federal law. The Interstate Health Care Freedom Compact is the vehicle for this effort. It will render any enforcement of the individual mandate within Arizona and other compacting states the equivalent of a federal crime.

In the years leading up to the civil war, Northern states criminalized efforts by southern slaveholders to capture escaped slaves within their territory. The Interstate Health Care Freedom Compact is in the same spirit—but this time the fight for freedom will not fail. The Interstate Health Care Freedom Compact will allow Arizona and its sister states to lawfully criminalize enforcement of the unconstitutional individual mandate and coordinate their law enforcement efforts. When the Interstate Health Care Freedom Compact becomes law, state and federal law will shield Arizonans from being forced into federal health care collectives.

At least 27 states, including Arizona, are parties to the two recent federal court decisions striking down the Federal Health Reform law’s individual mandate. The rule of law requires the Obama Administration to stop enforcing the individual mandate in those 27 states. But the Obama Administration is pressing forward to implement the individual mandate to force citizens into health care collectives anyway. Arizona and its sister states will not let this happen. They have agreed to resist the unconstitutional individual mandate by adopting

the Interstate Health Care Freedom Compact, which makes it the equivalent of a federal crime to enforce the unconstitutional individual mandate within the jurisdiction of the compacting states.

General Interstate Compact Facts

1. An interstate compact is a contractual agreement among states, typically evidenced by an enabling act authorizing state officials to reach the agreement, a statute that memorializes the agreement and its terms, and a confirmatory writing manifesting the consent of signatory states to the agreement.
2. Although the Constitution provides that states may not enter into compacts without the “consent” of Congress, the Supreme Court ruled in *U.S. Steel v. Multistate Tax Commission* that congressional consent is only required for an interstate compact that attempts to enhance “states . . . [relative to] the federal government.” This means that congressional consent is not required for compacts that merely exercise the sovereign powers of the states without purporting to augment those powers relative to those of the federal government.
3. Today there are approximately 200 interstate compacts in effect, including water allocation and conservation compacts (37), energy and low-level radioactive waste disposal (15), criminal law enforcement (18), and education and child welfare compacts (13). The average state is a party to 25 interstate compacts. Perhaps the most aggressive effort to coordinate multistate regulatory power is the Regional Greenhouse Gas Initiative, in which 10 states have agreed to apply “cap and trade” carbon regulations to themselves.
4. Congressionally-approved interstate compacts are recognized as equivalent to federal law under the Supremacy Clause and as a potential source of vested rights that are protected against federal regulatory action. In fact, the Circuit Court of Appeals for the District of Columbia held in 1987 that the liability provisions of the previously enacted Federal Employee Liability Act were displaced by the contrary provisions of the Washington Metropolitan Area Transit Authority (WMATA) interstate compact. Additionally, in 1980, the Supreme Court protected water rights guaranteed by the Colorado River Compact against a federal agency’s efforts to undermine those rights by enforcing an inconsistent federal law. These cases mean that states can leverage congressionally approved interstate compacts to supersede prior federal laws and to protect themselves and their residents against the reach of future federal laws through the creation of vested rights protected by interstate compact.
5. The federal statute, 4 U.S.C. § 112, gives blanket consent “to any two or more States to enter into agreements or compacts for cooperative effort and mutual assistance in the prevention of crime and in the enforcement of their respective criminal laws and policies, and to establish such agencies, joint or otherwise, as they may deem desirable for making effective such agreements and compacts.” Such blanket congressional consent contrasts with more than a dozen prior, contemporaneous, and subsequent consent-in-advance laws that only give consent to interstate compacts that do not conflict with federal law. 4 U.S.C. § 112 thus provides the legal basis for states to enter into interstate compacts that mutually guarantee the protection of existing state law rights with the promise of criminal prosecution against anyone who would violate them. Under existing federal law, these compacts will be the equivalent of federal law and will override any prior conflicting federal law.

The Constitutionality of the Interstate Health Care Freedom Compact

Per the request of several state legislators, this memorandum furnishes a scholarly explanation as to why the Interstate Health Care Freedom Compact would be constitutional under current legal precedent concerning interstate compacts and the Supremacy Clause.

It is black letter law that a congressionally-approved interstate compact has the functional status of federal law. *New Jersey v. New York*, 523 U.S. 767, 811 (1988) (holding that congressional approval “transforms an interstate compact within [the Compact Clause] into a law of the United States”). Now, of course, a congressionally-approved compact is not literally a federal law. Nevertheless, although the theoretical underpinnings are somewhat hazy, the case law is very clear that a congressionally-approved compact can override prior federal laws and create vested rights that are protected from federal interference. *See, e.g., Bryant v. Yellen*, 447 U.S. 352, 369 (1980); *McKenna v. Washington Metropolitan Area Transit Authority*, 829 F.2d 186 (D.C. Cir. 1987).

As I see it, the best theoretical explanation of this rule of law is that, by consenting to an interstate compact, Congress is ceding jurisdiction over the subject matter of the compact to the states who are parties to the compact. In other words, by consenting to a compact, Congress is waiving any possible conflict between the Supremacy Clause and the exertion of state sovereignty in question, and affirmatively yielding to the exclusive sovereignty of the states over the compact’s subject matter. Of course, Congress can retract its approval for the compact by rescinding it through appropriate action, which would render the compact invalid under the Supremacy Clause to the very extent it purported to displace valid federal law (unless the compact created vested rights, but even then, only those possessing the vested rights would be protected from the rescission of congressional consent—*see* Joseph Zimmerman, *Accounting Today: Regulation of Professions by Interstate Compact*, *The CPA Journal* (March 15-April 4, 2004) (observing, “What effect would a new congressional statute with conflicting provisions have on an interstate compact previously granted consent by Congress? The conflicting provisions in the consent would be repealed, with the exception of any vested rights protected by the Fifth Amendment to the U.S. Constitution”)). But the bottom line is, so long as an interstate compact has congressional approval, it cannot violate the Supremacy Clause.

An opinion that there is some sort of clash between the Interstate Health Care Freedom Compact and the Supremacy Clause, therefore, assumes that the compact lacks congressional approval. That assumption is mistaken. There is no question that this compact is premised on congressional approval. It is based on the explicit grant of advance consent contained in 4 U.S.C. § 112. The power of Congress to give advance consent to interstate compacts has been upheld for nearly 200 years. *See, e.g., Green v. Biddle*, 21 U.S. 1, 39-40 (1823). 4 U.S.C. § 112 itself was specifically upheld by the Supreme Court as effectively giving advance consent to an interstate compact reached decades after the statute's original enactment. *Cuyler v. Adams*, 449 U.S. 433 (1981). Therefore, 4 U.S.C. § 112 is a perfectly viable basis for regarding an interstate compact that is within its parameters as having been congressionally-approved.

There is no reason to look beyond the plain language of 4 U.S.C. § 112 to conclude that the Interstate Health Care Freedom Compact enjoys advance consent from Congress. An unambiguous statute must be interpreted based on its text. On its face, the grant of advance consent in 4 U.S.C. § 112 is very broad and totally unlimited. So long as the compact in question coordinates criminal laws and creates convenient administrative structures that are within the power of the compacting states to enact, the compact falls within the scope of the plain language of 4 U.S.C. § 112. This is precisely what the Interstate Health Care Freedom Compact does.

Even if one thought that 4 U.S.C. § 112 were ambiguous (I concede that it is being applied in an unusual way), the legislative history shows that it was in fact meant to avoid the restrictions placed by the Federal Constitution on viable interstate compacts. *See* S. Rep. No. 1007, 73d Cong., 2d Sess., 1 (1934); H. R. Rep. No. 1137, 73d Cong., 2d Sess., 1-2 (1934) (“This bill seeks to remove the obstruction imposed by the Federal Constitution and allow the States cooperatively and by mutual agreement to work out their problems of law enforcement”). I see no reason why this legislative history is inconsistent with the Interstate Health Care Freedom Compact. The legislative history merely confirms that Congress really meant to give wide open consent to any sort of compact that fell within its broad terms.

Moreover, if one looks outside of the text and legislative history to other grants of advance consent to interstate compacts by Congress, one will discover that all other such statutes specifically disclaim any grant of power to the compacting states to displace federal law. *See* 15 U.S.C. § 1358; 15 U.S.C. § 8201; 16 U.S.C. § 824p; 23 U.S.C. § 129; 23 U.S.C. § 401; 23 U.S.C. § 601; 29 U.S.C. § 2941; 33 U.S.C. § 1253; 42 U.S.C. § 2021d; 42 U.S.C. § 4727; 42 U.S.C. § 7402; 49 U.S.C. § 5303; 49 U.S.C. § 5304. In fact, 4 U.S.C. § 112 is the only advance consent statute in relatively recent history (to my knowledge after considerable research) that does not contain this caveat. In view of such legislative drafting custom and practice, and the absence of any express caveats precluding displacement of federal law, one

must assume that 4 U.S.C. § 112 was intended by Congress to authorize even interstate compacts that might displace existing federal law.

Thus, in asserting that its terms displace contrary state and federal law, the Interstate Health Care Freedom Compact does no more than what 4 U.S.C. § 112 authorizes under current case law that deems a congressionally-approved interstate compact functionally equivalent to federal law. Certainly Congress is free to decide, under the Supremacy Clause, that a congressionally-approved compact displaces conflicting federal law. This is not a novel possibility. History shows that President Roosevelt was contemporaneously engaged in repeated political battles over interstate compacts that attempted to displace federal power at the time. See Frederick L. Zimmerman & Mitchell Wendell, *The Interstate Compact Since 1925*, 16 & n. 78, 38 & n.162 (1951). It would be ahistorical to declare, against this historical backdrop, that 4 U.S.C. § 112 should *not* be interpreted to authorize compacts that could displace federal law.

Of course, one might be concerned that the underlying state laws that the Interstate Health Care Freedom Compact might incorporate could violate the Supremacy Clause. This concern, although understandable, is not relevant to the merits of the compact itself. The compact cannot be impeached on the basis of state laws that have not yet been incorporated into it. Moreover, one should not presume, sight unseen, that the state laws the compact might coordinate would be unconstitutional.

Of course, the Interstate Health Care Freedom Compact is designed to incorporate state laws that criminalize interference with Health Care Freedom laws, such as the ALEC's model Health Care Freedom Act. Such criminal laws could be construed to prohibit enforcement of the individual mandate of Federal Health Care Reform. But this potential clash between Health Care Freedom criminal laws and Federal Health Care Reform does not mean there is a clash between such state laws and the Supremacy Clause.

As I am sure you are aware, a federal district court has declared Federal Health Care Reform, including the individual mandate, unconstitutional in a final judgment. *Florida v. U.S. Department of Health and Human Services*, 3:10-cv-91-RV (N.D. Fla. 2011). So long as the judgment is not reversed (as is currently the case), party states that criminalize enforcement of Federal Health Care Reform, including the individual mandate, can advance a plausible legal argument that Health Care Freedom criminal laws do not violate the Supremacy Clause. The Supremacy Clause, after all, does not say that *unconstitutional* federal laws are the supreme law of the land.

States have the inherent police power to criminalize unconstitutional conduct *by anyone*, including federal agents. This is because federal agents who act unconstitutionally are, by definition, acting in a personal capacity, not on behalf of the federal government. See *United*

States v. Lee, 106 U.S. 196 (1882); *see also Leedom v. Kyne*, 358 U.S. 184, 188 (1958); *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 690 (1949). So long as States defer to the ultimate adjudicative supremacy of the U.S. Supreme Court over disputed constitutional issues, they are not engaging in “nullification” by criminalizing the enforcement of federal laws by federal agents *after federal courts deem those laws unconstitutional*. Likewise, an interstate compact, such as the Interstate Health Care Freedom Compact, that would incorporate state laws that criminalize the enforcement of unconstitutional federal laws is perfectly constitutional and consistent with the Supremacy Clause.

It is important to emphasize, however, that congressional approval of the Interstate Health Care Freedom Compact does not concede that the federal government has power to regulate intrastate health care. The compact itself does not regulate health care; it regulates the interstate criminal enforcement of state laws that will protect the right to health care freedom. Even if it were conceded that the federal government has the power to regulate interstate agreements criminalizing interference with health care freedom, there is no inconsistency between that proposition and the claim that the feds lack the power to mandate the purchase of health care under the commerce clause. Moreover, Congress’ power to consent to interstate compacts can be used to effectuate enumerated powers and it can also be used simply to get out of the way of, and give federal sanction to, dealings between the states that are otherwise within their sovereign powers. In the latter usage, invoked by the Interstate Health Care Freedom Compact, Congress is not making law *per se*, it is yielding to state sovereignty and waiving any possible conflict with federal law on the same subject.

Lastly, I emphasize that even if there were a clash between the Supremacy Clause and a state law that criminalized enforcement of the Federal Health Care Reform’s individual mandate within state boundaries, a plausible legal argument can be made that the clash renders the conflicting state law *voidable*, not void, until the state law is actually challenged and struck down in court (so long as the state law is otherwise within the inherent sovereign power of the state to enact it). *Cf. Massachusetts v. Oakes*, 491 U.S. 576, 584 (1989).

By incorporating a voidable state law into a congressionally-approved compact before it is struck down, one can make an argument that Congress has ratified it. Just as a voidable contract can be made effective through ratification, congressional ratification of a voidable state law would arguably give the state law the status of federal law (as per the general rule that treats congressionally-approved interstate compacts as equivalent to federal law). And if the only defect in the state law was that it clashed with the Supremacy Clause, that defect would be waived by virtue of the state law acquiring the status of federal law.

Thus, an interesting extension of current case law is that Congress can waive conflicts between the Supremacy Clause and state laws by incorporating those state laws into a congressionally-approved interstate compact before they are struck down. But even if this argument were ultimately to fail, the savings clause contained in the Interstate Health Care Freedom Compact would protect the compact itself from being tainted by the incorporation of unconstitutional state laws, because they would be severed.

For all of the foregoing reasons, my research shows that the Interstate Health Care Freedom Compact would be constitutional under the Supremacy Clause if enacted into law.

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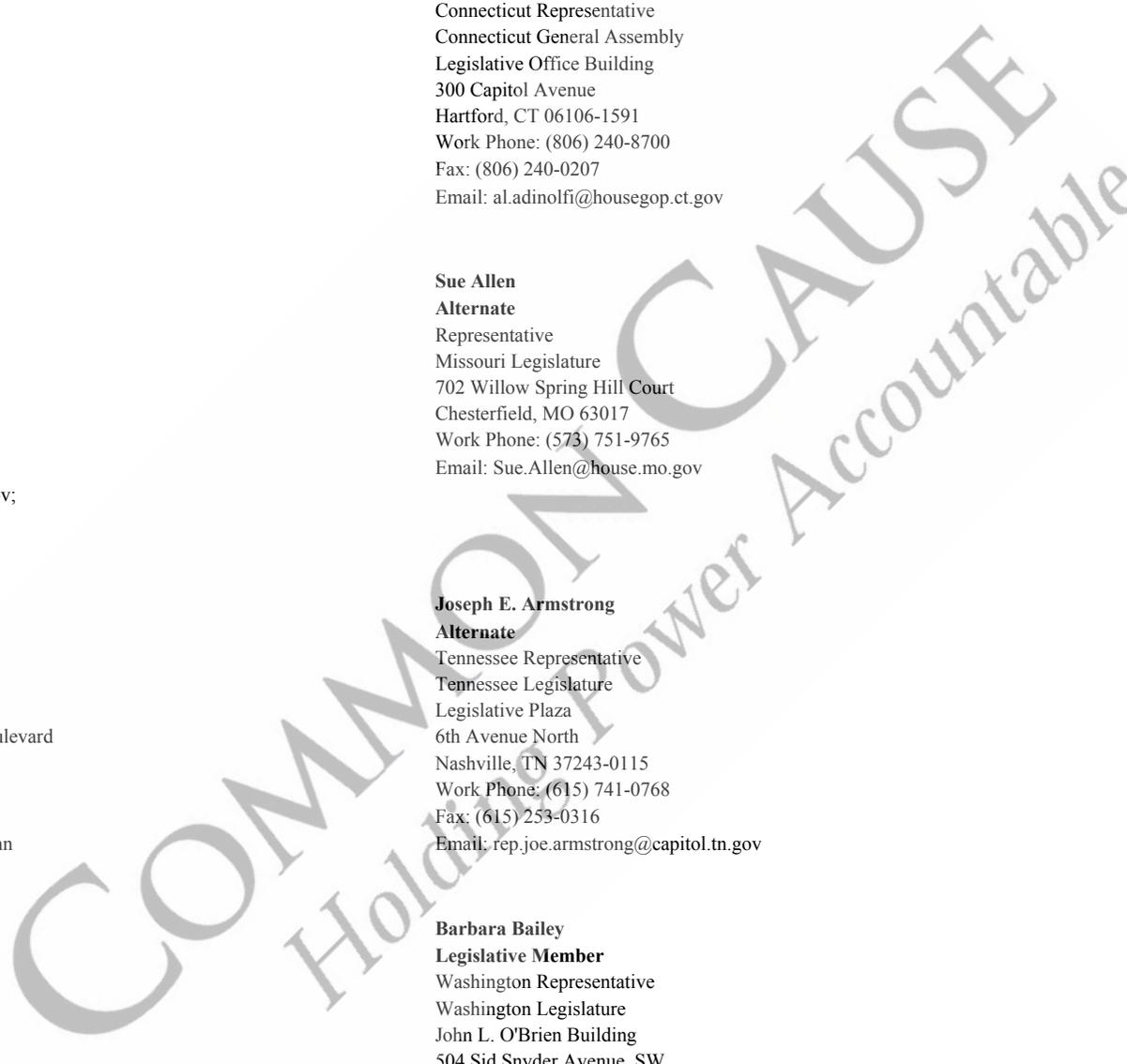
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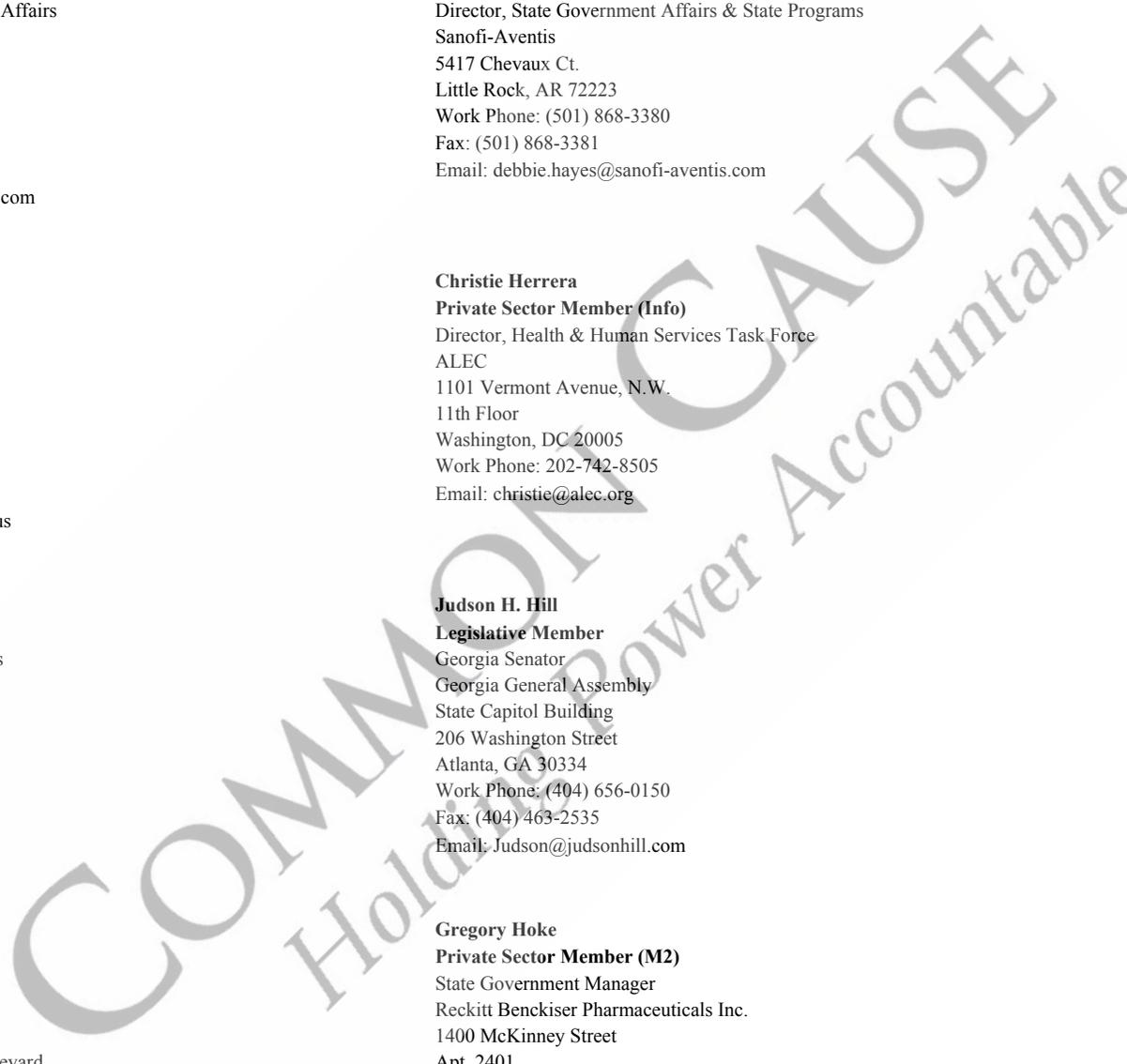
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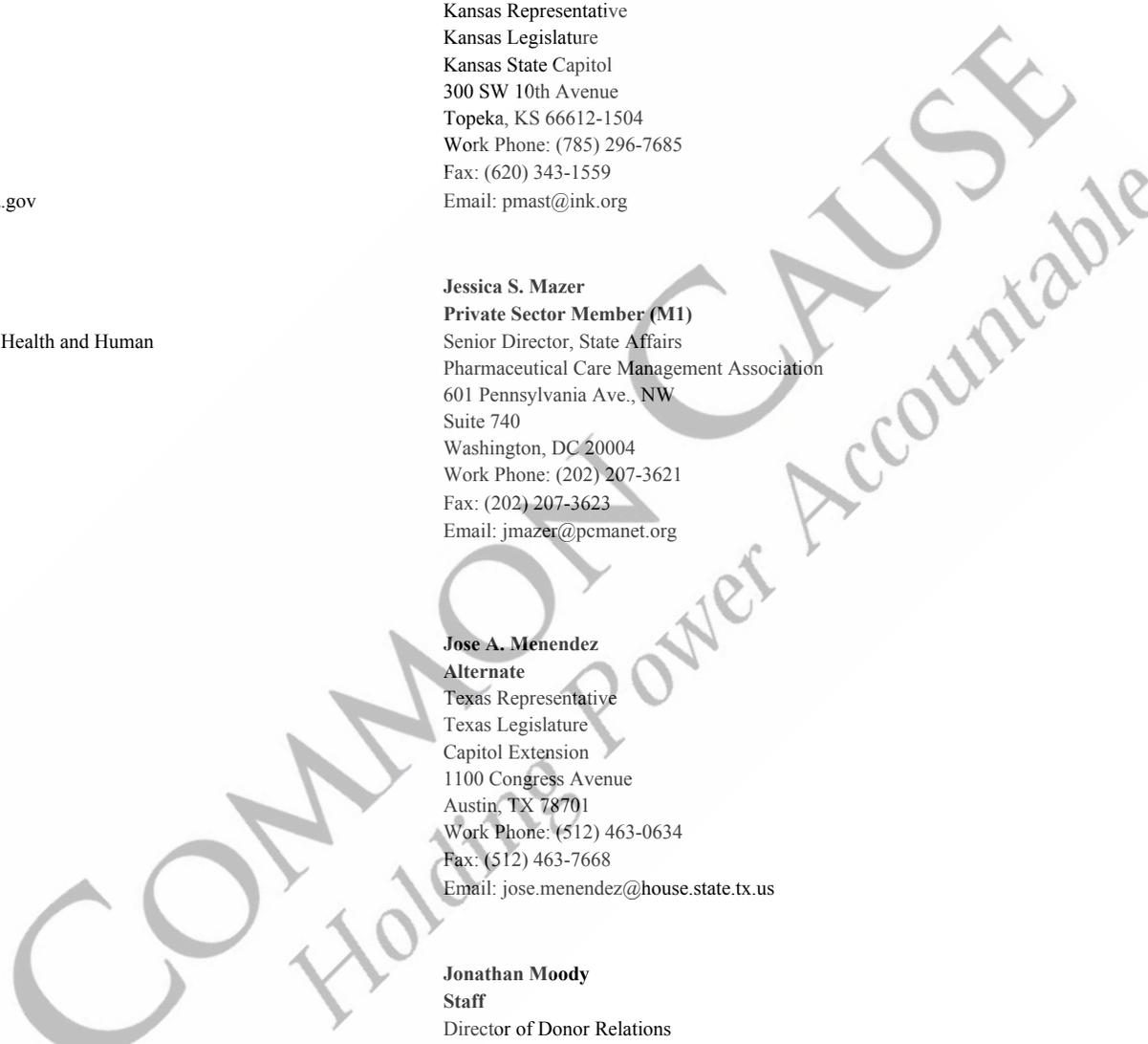
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HEALTH PROFESSIONAL MODERNIZATION ACT
(DRAFT, APRIL 29, 2011)

SUMMARY

The *Health Professional Modernization Act* addresses a problem that plagues states all over the country: lack of access to quality primary care. Generally, people think of their physicians when they talk about primary care providers, but there is a myriad of other avenues to quality primary care. For example, nurse practitioners are trained to handle the vast majority of basic primary care needs, but throughout many states, they are limited in their ability to do so by overly restrictive scope of practice laws.

By freeing primary care providers to practice to the full extent of their education and training, states can increase their citizens' access to quality primary care. The *Act* also protects citizens by putting all primary care providers underneath the authority of their respective boards in their states. Also, the *Act* puts the regulation of these primary care providers underneath the authorities that understand them best but that still operate subject to the will of the legislature.

America's doctors are the best in the world, and they should be dealing with world class issues of care. The basic primary care needs can be served more cost effectively by freeing all of our primary care providers to practice to the full extent of their knowledge and training.

MODEL LEGISLATION

Section 1. Short Title. This Act shall be known as the "Health Professional Modernization Act."

Section 2. Definitions.

A. In this Act, "primary care provider" means a registered provider who holds a license issued under {insert state licensing statute} and who:

1. Has successfully completed a graduate-level education program accredited by a national accrediting organization recognized by the respective board that prepares the provider to function as a primary care provider;
2. If the education program required under Paragraph 1 was completed after January 1, 1996, has met requirements established or recognized by the respective board for national certification;
3. Is licensed by the respective board to provide primary care in an area with a targeted population group recognized and approved by the respective board; and
4. Meets requirements established by the respective board for continued competence.

Section 3. Scope of Practice.

A. Primary care by a primary care provider is based on:

1. Knowledge and skills acquired in basic education;
2. Licensure in their specific field;

3. Successful completion of a graduate-level program accredited by a national accrediting organization recognized by the respective board;
4. Current certification in accordance with **{insert reference to state occupations code or similar chapter}** by a national certifying body recognized by the respective board in the appropriate primary care role approved by the respective board; and
5. Primary care provided in an area with at least one targeted population group recognized and approved by the respective board.

B. Practice as a primary care provider is an expanded scope of practice in a role approved by the respective board and in an area with a targeted population group recognized and approved by the respective board, with or without compensation or other personal profit, and includes the scope of practice of a primary care provider.

C. The scope of practice of a primary care provider includes, but is not limited to, advanced assessment, diagnosing, prescribing, and ordering.

D. A primary care provider may serve as a primary care provider of record.

Section 4. Applicability to Primary Care Providers.

A. This Act does not limit or modify the scope of practice of a primary care provider who is not a primary care provider approved by the board.

B. The scope of practice of a primary care provider includes any act of professional primary care the provider is authorized to perform under this Act.

Section 5. Licensure. A person may not practice or offer to practice primary care in this state unless the person is licensed as a primary care provider under this Act.

Section 6. Application. An applicant for a primary care provider license shall submit to the respective board an application on the form prescribed by the respective board, any required fee, and any other information required by the respective board.

Section 7. Practice by Primary Care Provider.

A. A primary care provider who holds a license issued under this Act may:

1. Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources; and
2. Plan and initiate a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, and diagnostic and supportive services, including home health care, hospice, physical therapy, and occupational therapy.

B. A primary care provider shall practice as a licensed independent practitioner in accordance with standards established and recognized by the respective board to protect the public health and safety.

C. A primary care provider is accountable to patients, the profession, and the respective board for:

1. Complying with the requirements of this Act;
2. Providing quality primary care;
3. Recognizing the provider's limits of knowledge and experience;
4. Planning for the management of situations beyond the provider's expertise; and
5. Consulting with or referring patients to other health care providers as appropriate.

Section 8. Prescribing and Ordering Authority.

A. The respective board may grant prescribing and ordering authority in accordance with this Act through the issuance of a primary care provider license to a primary care provider approved by the respective board to practice as a primary care provider

B. As authorized by the respective board, a primary care provider may prescribe, procure, administer, and dispense dangerous drugs and controlled substances.

Section 9. Notwithstanding {insert section of state occupations code}, as added by this Act, a primary care provider who has been approved by the respective board to provide primary care is not required to hold a license as a primary care provider until {insert date}.

Section 10. {Severability Clause}

Section 11. {Repealer Clause}

Section 12. {Effective Date}

ALEC

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

**Health and Human Services Task Force Meeting
ALEC's 2010 States and Nation Policy Summit
Thursday, December 2, 2010
2:30 - 5:30 p.m.
Meeting Minutes**

Legislative Members in Attendance (26)

Rep. Sue Allen, Missouri
Rep. Cecil Ash, Arizona
Sen. Nancy Barto, Arizona
Rep. Whit Betts, Connecticut
Rep. Eric Burlison, Missouri
Rep. Charlice Byrd, Georgia
Rep. Kristin Conzet, South Dakota
Rep. Cynthia Davis, Missouri
Rep. Brad Daw, Utah
Sen. Dan Dockstader, Wyoming
Del. Addie Eckardt, Maryland
Rep. David Heaton, Iowa
Sen. Judson Hill, Georgia
Rep. Eric Hutchings, Utah
Rep. Gary MacLaren, Montana
Sen. Stephen Martin, Virginia
Rep. Dolores Mertz, Iowa
Rep. Linda Miller, Iowa
Sen. Leslie Nutting, Wyoming
Rep. Patty O'Donnell, Vermont
Rep. Barbara Sears, Ohio
Rep. Amy Stephens, Colorado
Rep. Renee Unterman, Georgia
Rep. Linda Upmeyer, Iowa
Rep. Leah Vukmir, Wisconsin
Rep. Fran Wendelboe, New Hampshire

Legislative Alternates in Attendance (2)

Rep. Julia Hurley, Tennessee
Sen. Michael Watson, Mississippi

Private Sector Members in Attendance (38)

1-800 Contacts: Jay Magure
Allergan: Nate Elias
Alliance of Health Care Sharing Ministries: Jon Creath, Joe Guarino, Martin Hoyt, James Lansberry
American Physical Therapy Association: Angela Chasteen

America's Health Insurance Plans: Dianne Bricker
American Optometric Association: Jerald Combs
AMERIGROUP: Kathleen Loughran
Association of American Physicians & Surgeons: Jane Orient
AstraZeneca/MedImmune: Kevin Johnson, Joel Batten
Bayer HealthCare: Gary Barrett, Mike Birdsong, Julie Corcoran, Tom Freen, Kevin Fuller
Boehringer Ingelheim Pharmaceuticals: Andrew Zebrak
Bristol-Myers Squibb: Alan Tubbs
Celgene: Greg Chesmore
CVS Caremark: Lauren Baldwin
Daiichi Sankyo.: Holli Hill, Julie Vojtech
GlaxoSmithKline: Jan Burrus, Spencer Guthrie, Mary Koenecke, Gaspar Laca
Goldwater Institute: Byron Schломach
Guarantee Trust Life Insurance: Marianne Eterno
John Locke Foundation: Joe Coletti
Johnson & Johnson: Jeff Buel
Mackinac Center for Public Policy: Jack McHugh
Merck: Marlene Sanders, Jim Vance
National Center for Policy Analysis: Devon Herrick
Novartis: Don Stecher
Pacific Research Institute: John Graham
Pharmaceutical Care Management Association: Jessica Mazer
PhRMA: Kristin Parde, Jeff Whithouse
Pfizer: Josh Brown
Purdue Pharma: Melissa Petro, Brian Rosen
Reynolds American: Jacob McConnico, Greg Osmon
Sanofi-Aventis: Jay Jennings, John Valenti
Takeda: Matt Johnson, John Schlatter, Marilyn Vetter
Teva: Jerry Moore
Texas Public Policy Foundation: Vikrant Reddy
UnitedHealth: Jeff Drozda, Jake Logan, Kelsey Lundy
U.S. Oncology: Ben Jones
Walgreens: Erik Woehrmann
Wal-Mart: Laurie Smalling

Invited Guests in Attendance (1)

Association of American Physicians and Surgeons: Larry Joseph

Others in Attendance (22)

Sen. Spencer Berry, North Dakota
Sen. Missy Thomas Irvin, Arkansas
Rep. Jim Kasper, North Dakota
Rep. Wes Keller, Alaska
Rep. Tim LeGeyt, Connecticut
Rep. Cleve Loney, Montana
Rep. Kate Brophy McGee, Arizona

Rep. Sam Teasley, Georgia
Office of Alaska Governor Sean Parnell: Heather Brakes
American Council of Life Insurers: Joann Waiters
Cato Institute: Brandon Arnold
Centerpoint 360: Preston Baldwin, ALEC Private Enterprise Board Chairman
Cerner Corporation: Carrie Clayton
Council for Affordable Health Insurance: J.P. Wieske
Coventry Health Care: Harry Monroe
Institute for Humane Studies: Sarah Friederich
Institute for Policy Innovation: Merrill Matthews
Kraft Foods: Derek Crawford
National Federation of Independent Business: Tim Goodrich
Reed Elsevier: David Foy, Teresa Jennings
ResCare: Daryn Demeritt
Sunovion Pharmaceuticals: Robert Curley, April Grant

Staff in Attendance (2)

Christie Herrera, ALEC HHS Task Force Director
Monica Mastracco, ALEC HHS Legislative Assistant

* * *

Meeting began at 2:30 p.m.

The meeting began with a welcoming remarks to the HHS Task Force by Chairs, Iowa Representative Linda Upmeyer and Julie Corcoran, Bayer Healthcare; roundtable introductions of HHS Task Force meeting attendees; recognition of new and returning ALEC private sector members; and approval of the minutes from ALEC's 2010 Annual Meeting.

Public Sector Chair Linda Upmeyer explained to the task force how task force chair succession works, as her term was ending and an announcement on the next task force chair would be made early in 2011.

The HHS Task Force saw several presentations from other members and invited guests. Joe Coletti from the John Locke Foundation discussed health care providers and health care reform. Larry Joseph, an attorney for the Association of American Physicians and Surgeons, was invited to speak on the pending lawsuits surrounding the *Patient Protection and Affordable Care Act*. James Lansberry with the Alliance of Health Care Sharing Ministries spoke on his private charity initiative.

HHS Task Force Members considered the *Unintended Consequences Prevention Act*, sponsored by Senator Judson Hill of Georgia. After discussion, the public sector vote was 18 Yes, 0 No; the private sector vote was 21 Yes, 0 No. The *Unintended Consequences Prevention Act* was approved.

HHS Task Force Members considered the *Insurance Compact Enabling Act*, sponsored by Byron Schlomach of the Goldwater Institute. This piece of legislation was dual referred to the HHS

and CIED Task Forces. After discussion, the *Insurance Compact Enabling Act* was tabled for discussion at a later meeting.

Finally, HHS Task Force Members considered the *Wellness Promotion Act*, sponsored by Senator Judson Hill of Georgia. After discussion, the *Wellness Promotion Act* was tabled for discussion at a later meeting.

The meeting adjourned at 5:30 p.m.

* * *

COMMON CAUSE
Holding Power Accountable

ALEC

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

Mission Statement

The American Legislative Exchange Council's mission is...

To advance the Jeffersonian Principles of free markets, limited government, federalism, and individual liberty through a nonpartisan public-private partnership among America's state legislators, concerned members of the private sector, the federal government, and the general public.

To promote these principles by developing policies that ensure the powers of government are derived from, and assigned to, first the People, then the States, and finally the Federal Government.

To enlist state legislators from all parties and members of the private sector who share ALEC's mission.

To conduct a policy making program that unites members of the public and private sector in a dynamic partnership to support research, policy development, and dissemination activities.

To prepare the next generation of political leadership through educational programs that promote the principles of Jeffersonian democracy, which are necessary for a free society.

SCHOLARSHIP POLICY BY MEETING

ALEC Spring Task Force Summit:

1. ***Spring Task Force Summit Reimbursement Form:*** ALEC Task Force Members are reimbursed by ALEC up to \$350.00 for travel expenses. Receipts must be forwarded to the ALEC Policy Coordinator and approved by the Director of Policy.
2. ALEC Task Force Members' room & tax fees for up to a two-night stay at the host hotel are covered by ALEC.
3. Registration fees are not covered; however, Task Force Members may submit registration expenses for payment from their state scholarship account upon approval of the State Chair.
4. *Official Alternate Task Force Members* (chosen by the State Chair and whose names are given to ALEC more than 35 days prior to the meeting to serve in place of a Task Force Member who cannot attend) are reimbursed in the same manner as Task Force Members.
5. ***State Scholarship Reimbursement Form:*** Any fees above the set limit, or expenses other than travel and room expenses can be submitted by Task Force Members for payment from their state scholarship account upon the approval of the State Chair. Receipts must be submitted to the State Chair, who will submit the signed form to the Director of Membership.
6. *Non-Task Force Members* can be reimbursed out of the state scholarship fund upon State Chair approval. Receipts must be submitted to the State Chair, who will submit the appropriate signed form to the Director of Membership.

ALEC Annual Meeting:

State Scholarship Reimbursement Form: State scholarship funds are available for reimbursement by approval of your ALEC State Chair. Expenses are reimbursed after the conference, and may cover the cost of travel, room & tax, and registration. Receipts are to be submitted to the State Chair, who will then submit the signed form to the Director of Membership.

ALEC States & Nation Policy Summit:

1. ***States & Nation Policy Summit Reimbursement Form:*** ALEC offers two scholarships per state to cover the cost of travel, room & tax, and registration not to exceed \$1,000.00 per person for a total of \$2,000.00 per state. ALEC scholarship recipients must be named by the ALEC State Chair. Expenses are submitted to the State Chair and reimbursed after the conference. The State Chair submits the signed form to the Director of Membership.
2. ***State Scholarship Reimbursement Form:*** Any other fees or payments must come out of the state scholarship account, with the approval of the State Chair. Receipts must be submitted to the State Chair, who submits the signed form to the Director of Membership.

ALEC Academies:

Academy Reimbursement Form: Attendees of ALEC Academies are reimbursed by the Task Force Committee hosting the Academy. Attendees will receive a form at the Academy, and will be reimbursed up to \$500.00 for travel, and room & tax fees for a two-night stay by ALEC. Receipts must be forwarded to the appropriate Task Force Director and approved by the Director of Policy.

**American Legislative Exchange Council
TASK FORCE OPERATING PROCEDURES**

I. MISSION OF TASK FORCES

Assume the primary responsibility for identifying critical issues, developing ALEC policy, and sponsoring educational activities which advance the Jeffersonian principles of free markets, limited government, federalism, and individual liberty. The mission will be accomplished through a non-partisan, public and private partnership between ALEC's legislative and private sector members in the specific subject areas assigned to the Task Force by the Board of Directors.

II. TASK FORCE RESPONSIBILITIES

- A. Task Forces have the primary responsibility for identifying critical issues and developing ALEC's official policy statements and model legislation appropriate to the specific subject areas of the Task Force.
- B. Task Forces serve as forums for an exchange of ideas and sharing of experiences between ALEC's state legislator and private sector members.
- C. Task Forces are responsible for developing and sponsoring the following educational activities appropriate to the specific subject area of the Task Force:
- publications that express policy positions, including, but not limited to State Factors and Action Alerts;
 - educational communication and correspondence campaigns;
 - issue specific briefings, press conferences and press campaigns;
 - witness testimony and the activities of policy response teams;
 - workshops at ALEC's conferences; and
 - specific focus events.
- D. ~~The Executive Director is to~~ Task Forces are responsible for developing an annual budgets, which shall include expenses associated with Task Force meetings and educational activities. A funding mechanism to finance all meetings and educational activities proposed by Task Forces must be available before they can be undertaken.

III. GENERAL PROCEDURES

- A.** Requests from ALEC members for policy statements, model legislation and educational activities shall be directed by the Executive Director to the appropriate Task Force, or the Board of Directors if the issue does not fall within the jurisdiction of any Task Force. The appropriate Public and Private Sector Task Force Co-Chairs determine the agenda for each Task Force meeting, and the meetings will be called and conducted in accordance with these Operating Procedures.

The Director of Policy with the consent of the Executive Director assigns a model bill or resolution to the most appropriate Task Force based on Task Force content and prior jurisdictional history 35 days before a Task Force Meeting. All Task Force Co-Chairs will be provided an email or fax summary of all model bills and resolutions 35 days before the Task Force meeting

If both the Co-Chairs of a Task Force are in agreement that they should have jurisdiction on model legislation or a resolution, the legislation or resolution will be considered by the Task Force. If the other Task Force Co-Chairs believe they should have jurisdiction or if the author of the model bill or resolution does not agree on the jurisdictional assignment of the bill, they will have 10 days after the 35-day mailer deadline to submit in writing or by electronic appeal to the Director of Policy their intent to challenge the jurisdiction assignment. The Director of Policy will notify the Executive Director who will in turn notify the National Chair and the Private Enterprise Board Chair. The National Chair and the Private Enterprise Board Chair will in turn refer the matter in question to the Board of Directors Task Force Board Committee. The Director of Policy will establish a conference call for the Task Force Board Committee co- chairs, the author, the affected Task Force Co-Chairs and the Director of Policy at a time convenient for all participants.

The Task Force Board Committee Co-Chairs shall listen to the jurisdictional dispute by phone or in person within 10 days of the request. If both Task Force Board Committee Co-Chairs are in agreement that the Director of Policy made an incorrect jurisdictional referral, only then will the model bill or resolution be reassigned to a committee as they specify once agreed upon by the National Chair and the Private Enterprise Board Chair. The bill or model resolution is still eligible to be heard in whatever Task Force it is deemed to be assigned to as if submitted to the correct Task Force for the 35-day mailer. The National Chair and the Private Enterprise Board Chair decision is final on this model bill or resolution.

Joint referral of model legislation and/or resolutions are allowed if all the affected Task Force Co-Chairs agree. All model legislation and resolutions that have been referred to, more than one Task Force must pass the identical language in both Task Forces within two consecutive Task Force meetings. It is at the Task Force

Co-Chairs discretion how they will handle the hearings of the model legislation or resolution. Both sets of co-chairs have the ability to call a working group, subcommittee, or simply meet consecutively or concurrently if necessary.

If the Task Force co-chairs both agree to waive jurisdiction, they may do so as long as another Task Force still has jurisdiction.

The National Chair and the Private Sector Board Chair will rely upon the Task Force Board Committee Co-Chairs for advice and recommendations on model legislation or resolutions when no jurisdiction in any of the existing Task Forces in operation can be found. The Task Force Board Committee Co-Chairs will work with the Executive Director and the Director of Policy to identify public and private sector Task Force members (not alternates) from the existing Task Forces should their expertise be of assistance to the Task Force Board Committee in reaching a determination and recommendation for approval by the National Chair and the Private Enterprise Board Chair.

- B. The National Chair and the Private Sector Board Chair will rely upon the Task Force Board Committee Co-Chairs for advice and recommendations on model legislation or resolutions when no jurisdiction in any of the existing Task Forces in operation can be found. The Task Force Board Committee Co-Chairs will work with the Executive Director and the Director of Policy to identify public and private sector Task Force members (not alternates) from the existing Task Forces should their expertise be of assistance to the Task Force Board Committee in reaching a determination and recommendation for approval by the National Chair and the Private Enterprise Board Chair.
- C. The Board of Directors shall have ultimate authority over Task Force procedures and actions including the authority to create, to merge or to disband Task Forces and to review Task Force actions in accordance with these Operating Procedures. Nothing in these Operating Procedures prohibits the Board of Directors from developing ALEC policy; however, such a practice should be utilized only in exceptional circumstances. Before the policy is adopted by the Board of Directors, it should be sent to the Public and Private Sector Task Force Co-Chairs under whose jurisdiction the matter falls for review and comment back to the Board of Directors.
- D. The operating cycle of a Task Force is two years. A new operating cycle begins on January 1 of each odd numbered year and ends on December 31 of the following even numbered year. Task Force activities shall be planned and budgeted on an annual basis within each two-year operating cycle.
- E. ~~At the ALEC Annual Meeting, each Task Force will be responsible for determining an operating budget for the succeeding calendar year. The Executive Director will notify the Task Force Co-Chairs, at the ALEC Annual Meeting, what inflation factor will be used by the Task Force to determine the operating~~

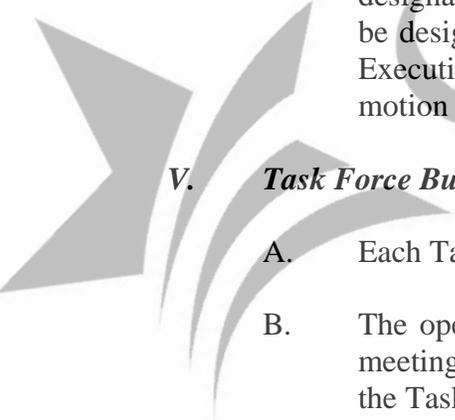
~~and programming budgets. Task Force membership and budget information will be reported to the Executive Director by the Public and Private Sector Task Force Co-Chairs. The Executive Director will present this information to the Board of Directors at its regular fall meeting.~~

- F. If a Task Force is unable to develop an operating budget, the Board of Directors will determine whether to continue the operations of the Task Force. This determination will be made according to: (1) the level of membership on the Task Force, and (2) the need for continued services developed by the Task Force for ALEC.
- G. The Board of Directors shall have the authority to allocate limited general support funds to finance the annual operating budget of Task Forces that meet the requirements prescribed in Section III (E). The Executive Director shall determine, and report to the Board of Directors, the amount of general support funds available to underwrite such Task Forces.

IV. MEMBERSHIP AND MEMBER RESPONSIBILITIES

- A. The membership of a Task Force consists of legislators who are members in good standing of ALEC and are duly appointed to the Task Force, in accordance with Section VI (A) and private sector organizations that are full members of ALEC, contribute to the assessment for the Task Force operating budget, and are duly appointed to the Task Force, in accordance with Section VI (B). Private sector organizations that were full members of ALEC and contributed the assessment for the Task Force's operating budget in the previous year, can be appointed to the Task Force for the current year, conditional upon renewal of full ALEC membership and receipt of the current year's assessment for the Task Force operating budget prior to March 31st, unless an alternative date has been approved by the Executive Director.
- B. Each Task Force shall have least two Co-Chairs; a Public Sector Task Force Co-Chair and a Private Sector Task Force Co-Chair. The Public Sector Task Force Co-Chair must be a member of the Task Force and appointed in accordance with Section VI (A). The Private Sector Co-Chair must represent a private sector member of the Task Force and be appointed in accordance with Section VI(B). The Co-Chairs shall be responsible for:
 - (1) calling the Task Force and the Executive Committee meetings to order, setting the agenda and co-chairing such meetings;
 - (2) appointing and removing legislators and private sector members to and from the Task Force Executive Committee and subcommittees;
 - (3) creating subcommittees, and determining each subcommittee's mission, membership limit, voting rules, deadlines, and term of service; and

- (4) selecting Task Force members to provide support for and against Task Force policies during formal Board reviews.
- C. Each Task Force shall have an Executive Committee appointed by the Public and Private Sector Task Force Co-Chairs that is appropriate in number to carry out the work product and strategic plan of ALEC and the Task Force. The Executive Committee shall consist of the Public Sector Task Force Co-chair, the Private Sector Task Force Co-Chair, the subcommittee co-chairs, and the remainder will be an equal number of legislative and private sector Task Force members. The Executive Committee will be responsible for determining the operating budget and proposing plans, programs and budgets for the succeeding year in accordance with (Section V (B); determining if a proposed educational activity conforms to a previously approved model bill, resolution or policy statement in accordance with (Section IX (F); and determining if an emergency situation exists that justifies waiving or reducing appropriate time limits in accordance with (Section VIII (H)).
- D. Each Task Force may have any number of subcommittees, consisting of Task Force members and advisors to focus on specific areas and issues and make policy recommendations to the Task Force. The Task Force Co-chairs, shall create subcommittees and determine each subcommittee's mission, membership limit, voting rules, deadlines, and term of service. Any model bill, resolution or policy statement approved by a subcommittee must be approved by the Task Force before it can be considered official ALEC policy.
- E. Each Task Force may have advisors, appointed in accordance with Section VI (G). Advisors shall assist the members and staff of the Task Force. They shall be identified as advisors on official Task Force rosters, included in all official Task Force mailings and invited to all Task Force meetings. Advisors may also have their expenses paid at Task Force meetings covered by the Task Force operating budget with the approval of the Task Force Co-Chairs. An advisor cannot be designated as the primary contact of a private sector Task Force member, cannot be designated to represent a private sector Task Force member at a Task Force, Executive Committee, or subcommittee meeting, and cannot offer or vote on any motion at a Task Force, Executive Committee, or subcommittee meeting.



V. ***Task Force Budgets***

- A. Each Task Force shall develop and operate a yearly budget to fund meetings.
- B. The operating budget shall be used primarily to cover expenses for Task Force meetings, unless specific funds within the budget are authorized for other use by the Task Force. The operating budget shall be assessed equally among the private sector members of the Task Force. The Executive Director, in consultation with the Task Force Co-Chairs shall determine which costs associated with each meeting will be reimbursed from the operating budget. Any funds remaining in a

Task Force's operating budget at the end of a year are transferred to ALEC's general membership account.

- C. The operating budget shall not be used to cover Task Force meeting expenses associated with alternate task force members' participation, unless they are appointed by their State Chair to attend the Spring Task Force Summit with the purpose to serve in place of a Task Force Member who is unable to attend. Task Force meeting expenses of alternate task force members shall be covered by their state's scholarship account.
- D. The programming budget shall be used to cover costs associated with educational activities. Contributions to the programming budget are separate, and in addition to operating budget contributions and annual general support/membership contributions to ALEC. The Executive Director shall determine the contribution required for each educational activity.

VI. *PROCESS FOR SELECTING TASK FORCE MEMBERS, CHAIRS, COMMITTEES AND ADVISORS*

- A. Prior to February 1 of each odd-numbered year, the current and immediate past National chairman will jointly select and appoint in writing three legislative members and three alternates to the Task Force who will serve for the current operating cycle, after receiving nominations from ALEC's Public and Private State Chairs, the Executive Director and the ALEC Public and Private Sector members of the Board. At any time during the year, the National Chairman may appoint in writing new legislator members to each Task Force, except that no more than three legislators from each state may serve as members of any Task Force, no legislator may serve on more than one Task Force and the appointment cannot be made earlier than thirty days after the new member has been nominated. In an effort to ensure the nonpartisan nature of each Task Force, it is recommended that no more than two legislators of any one political party from the same state be appointed to serve as members of any Task Force. A preference will be given to those ALEC legislator members who serve on or chair the respective Committee in their state legislature. A preference will be given to legislators who sponsor ALEC Task Force model legislation in the state legislature.
- B. Prior to January 10 of each odd-numbered year, the current and immediate past National Chairman will jointly select and appoint in writing the Task Force Chair who will serve for the current operating cycle, after receiving nominations from the Task Force. Nominations will be requested by the outgoing Task Force Chair and may be placed in rank order prior to transmittal to the Executive Director no later than December 1 of each even-numbered year. No more than five names may be submitted in nomination by the outgoing Task Force chair. The current and immediate past National Chairmen will jointly make the final selection, but

should give strong weight to the recommendations of the outgoing Task Force Chair. In an effort to empower as many ALEC leaders as possible, State Chairs and members of the Board of Directors will not be selected as Task Force Chairs. Task Force Chairs shall serve for one operating cycle term. Where special circumstances warrant, the current and immediate past National Chairmen may reappoint a Task Force Chair to a second operating cycle term.

- C. Prior to February 1 of each odd numbered year, the Public and Private Sector Task Force Co-Chairs will select and appoint in writing the legislative and private sector members of the Task Force Executive Committee, who will serve for the current operating cycle. The Public and Private Sector Task Force Co-Chairs will select and appoint in writing the legislative and private sector members and advisors to any subcommittee.
- D. Prior to February 1 of each year, the Private Enterprise Board Chair and the immediate past Private Enterprise Board Chair will select and appoint in writing the private sector members to the Task Force who will serve for the current year. The appointment letter shall be mailed to the individual designated as the primary contact for the private sector entity. At any time during the year, the Chair of the Private Enterprise Board may appoint in writing new private sector members to each Task Force, but no earlier than thirty days after the new member has qualified for full membership in ALEC and contributed the assessment for the appropriate Task Force's operating budget.
- E. Prior to January 10 of each odd-numbered year, the Chair of the Private Enterprise Board and the immediate past Private Enterprise Board Chair will select and appoint in writing the Task Force Private Sector Co-Chair who will serve for the current operating cycle, after receiving nominations from the Task Force. Nominations will be requested by the outgoing Task Force Private Sector Chair and may be placed in rank order prior to transmittal to the Chair of the Private Enterprise Board. The Chair and the immediate past Chair of the Private Enterprise Board will make the final selection, but should give strong weight to the recommendations of the outgoing Private Sector Task Force Co-Chair. In an effort to empower as many ALEC private sector members as possible, Private Enterprise State Chairs and members of the Private Enterprise Board will not be selected as Private Sector Task Force Co-Chairs. Private Sector Task Force Co-Chairs shall serve for one operating cycle term. Where special circumstances warrant, the current and immediate past Chair of the Private Enterprise Board may reappoint a Task Force Private Sector Chair to a second operating cycle term.
- F. Prior to February 1 of each odd-numbered year, the Task Force Private Sector Co-Chair will select and appoint in writing the private sector members of the Task Force Executive Committee, who will serve for the current operating cycle. The Task Force Private Sector Co-Chair shall select and appoint in writing the private sector members of any subcommittees.

- G. The Public and Private Sector Task Force Co-Chairs, may jointly appoint subject matter experts to serve as advisors to the Task Force. The National Chair and the Private Enterprise Board Chair may also jointly recommend to the Task Force Co-Chairs subject matter experts to serve as advisors to the Task Force.

VII. REMOVAL AND VACANCIES

- A. The National Chair may remove any Public Sector Task Force Co-Chair from his position and any legislative member from a Task Force with or without cause. Such action will not be taken except upon thirty days written notice to such Chair or member whose removal is proposed. For purposes of this subsection, cause may include failure to attend two consecutive Task Force meetings.
- B. The Public Sector Task Force Co-Chair may remove any legislative member of an Executive Committee or subcommittee from his position with or without cause. Such action shall not be taken except upon thirty days written notice to such member whose removal is proposed. For purposes of this subsection, cause may include failure to attend two consecutive meetings.
- C. The Chairman of the Private Enterprise Board may remove any Private Sector Task Force Co-Chair from his position and any private sector member from a Task Force with cause. Such action shall not be taken except upon thirty days written notice to such Chair or member whose removal is proposed. For purposes of this subsection, cause may include but is not limited to the non-payment of ALEC General Membership dues and the Task Force dues. .
- D. The Private Sector Task Force Co-Chair may remove any private sector member of an Executive Committee or subcommittee from his position with cause. Such action shall not be taken except upon thirty days written notice to such member whose removal is proposed. For purposes of this subsection, cause may include but is not limited to the non-payment of ALEC General Membership dues and the Task Force dues.
- E. The Public and Private Sector Task Force Co-Chairs may remove an advisor from his position with or without cause. Such action shall not be taken except upon thirty days written notice to such advisor whose removal is proposed.
- F. Any member or advisor may resign from his position as Public Sector Task Force Co-Chair, Private Sector Task Force Co-Chair, public or private sector Task Force member, Task Force advisor, Executive Committee member or subcommittee member at any time by writing a letter to that effect to the Public Sector and Private Sector Task Force Co-Chairs. The letter should specify the effective date of the resignation, and if none is specified, the effective date shall be the date on which the letter is received by the Public and Private Task Force Co-Chairs.

- G. All vacancies for Public Sector Task Force Co-Chair, Private Sector Task Force Co-Chair, Executive Committee member and subcommittee member shall be filled in the same manner in which selections are made under Section VI. All vacancies to these positions must be filled within thirty days of the effective date of the vacancy.

VIII. MEETINGS

- A. Task Force meetings shall only be called by the joint action of the Public and Private Sector Task Force Co-Chairs. Task Force meetings cannot be held any earlier than thirty-five days after being called, unless an emergency situation has been declared pursuant to Section VIII(H), in which case Task Force meetings cannot be held any earlier than ten days after being called. It is recommended that, at least once a year, the Task Forces convene in a common location for a joint Task Force Summit. Executive Committee meetings shall only be called by the joint action of the Public and Private Sector Task Force Co-Chairs and cannot be held any earlier than three days after being called, unless the Executive Committee waives this requirement by unanimous consent.
- B. At least forty-five days prior to a task force meeting any model bill, resolution or policy must be submitted to ALEC staff that will be voted on at the meeting. At least thirty-five days prior to a Task Force meeting, ALEC staff shall distribute copies of any model bill, resolution or policy statement that will be voted on at that meeting. This requirement does not prohibit modification or amendment of a model bill, resolution or policy statement at the meeting. This requirement may be waived if an emergency situation has been declared pursuant to Section VIII(H).
- C. All Task Force meetings are open to registered attendees and invited guests of ALEC meetings and conferences. Only regular Task Force Members may introduce any resolution, policy statement or model bill. Only Task Force members will be allowed to participate in the Task Force meeting discussions and be seated at the table during Task Force meetings, unless otherwise permitted by the Public and Private Sector Task Force Co-Chairs.
- D. ALEC private sector member organizations may only be represented at Task Force and Executive Committee meetings by the individual addressed in the appointment letter sent pursuant to Section VI(D) or a designee of the private sector member. If someone other than the individual addressed in the appointment letter is designated to represent the private sector member, the designation must be submitted in writing to the Public and Private Sector Task Force Co-Chairs before the meeting, and the individual cannot represent any other private sector member at the meeting.

- E. All Task Force and Executive Committee meetings shall be conducted under the guidelines of Roberts Rules of Order, except as otherwise provided in these Operating Procedures. A copy of the Task Force Operating Procedures shall be included in the briefing packages sent to the Task Force members prior to each meeting.
- F. A majority vote of legislative members present and voting and a majority vote of the private sector members present and voting, polled separately, are required to approve any motion offered at a Task Force or Executive Committee meeting. A vote on a motion to reconsider would be only with the sector that made the motion. Members have the right, in a voice vote, to abstain and to vote present by roll-call vote. In all votes a member can change their vote up until the time that the result of the vote is announced. Only duly appointed members or their designee as stated in Section VIII (D) that are present at the meeting may vote on each motion. No proxy, absentee or advance voting is allowed.
- G. The Public Sector Task Force Co-Chair and the Private Sector Task Force Co-Chair, with the concurrence of a majority of the Executive Committee, polled in accordance with Section VIII (F), may schedule a Task Force vote by mail or ~~fax~~ any form of electronic communication on any action pertaining to policy statements, model legislation or educational activity. The deadline for the receipt of votes can be no earlier than thirty-five days after notification of the vote is mailed or ~~faxed~~ notified by any form of electronic communication, unless an emergency situation is declared pursuant to Section VIII (H), in which case the deadline can be no earlier than ten days after notification is mailed or ~~faxed~~ notified by any form of electronic communication. Such votes are exempt from all rules in Section VIII, except: (1) the requirement that copies of model legislation and policy statements be mailed or ~~faxed~~ notified by any form of electronic communication with the notification of the vote and (2) the requirement that a majority of legislative members voting and a majority of the private sector members voting, polled separately, is required to approve any action by a Task Force.
- H. For purposes of Sections VIII(A), (B) and (G), an emergency situation can be declared by:
- (1) Unanimous vote of all members of the Task Force Executive Committee present at an Executive Committee meeting prior to the meeting at which the Task Force votes on the model bill, resolution or policy statement; or
 - (2) At least three-fourth majority vote of the legislative and private sector Task Force members (voting in accordance with Section VIII (F)) present at the meeting at which the members vote on the model bill, resolution or policy statement.

- I. Ten Task Force members shall constitute a quorum for a Task Force meeting. One-half of the legislative and one-half of the private sector members of an Executive Committee shall constitute a quorum for an Executive Committee meeting.

IX. **REVIEW AND ADOPTION PROCEDURES**

- A. All Task Force policy statements, model bills or resolutions shall become ALEC policy either: (1) upon adoption by the Task Force and affirmation by the Board of Directors or (2) thirty days after adoption by the Task Force if no member of the Board of Directors requests, within those thirty days, a formal review by the Board of Directors. General information about the adoption of a policy position may be announced upon adoption by the Task Force.
- B. The Executive Director shall notify the Board of Directors of the approval by a Task Force of any policy statement, model bill or resolution within ten days of such approval. Members of the Board of Directors shall have thirty days from the date of Task Force approval to review any new policy statement, model bill or resolution prior to adoption as official ALEC policy. Within those thirty days, any member of the Board of Directors may request that the policy be formally reviewed by the Board of Directors before the policy is adopted as official ALEC policy.
- C. A member of the Board of Directors may request a formal review by the Board of Directors. The request must be in writing and must state the cause for such action and a copy of the letter requesting the review shall be sent by the National Chairman to the appropriate Task Force Chair. The National Chairman shall schedule a formal review by the Board of Directors no later than the next scheduled Board of Directors meeting.
- D. The review process will consist of key members of the Task Force, appointed by the Task Force Chair, providing the support for and opposition to the Task Force position. Position papers may be faxed or otherwise quickly transmitted to the members of the Board of Directors. The following is the review and adoption procedures:
- Notification of Committee: Staff will notify Task Force Chairs and the entire task force when the Board requests to review one of the Task Forces' model bills or resolutions.
 - Staff Analysis: Will be prepared in a neutral fashion. The analyses will include:
 - History of Task Force action
 - Previous ALEC official action/resolutions
 - Issue before the board
 - Proponents arguments

- Opponents arguments
- Standardized Review Format: To ensure fairness, a set procedure will be used as the format to ensure the model bill/resolution has a fair hearing before the Board.
 - Task Force Chair(s) will be invited to attend the Board Review
 - Task Force Chair(s) will decide who will present in support and in opposition for the model bill/resolution before the Board.
 - Twenty minutes that is equally divided will be given for both sides to present before the Board.
 - It is suggested that the Board not take more than twenty minutes to ask questions of the presenters.
 - Presenters will then be excused and the Board will have a suggested twenty more minutes for discussion and vote.
 - All votes will be recorded for the official record.
- Notification of Committee: The Director of Policy will notify presenters immediately after the vote. If the Board votes to send the model bill/resolution back to the task force, the Board will instruct the Director of Policy or another board member what to communicate.

E. The Board of Directors can:

- (1) Vote to affirm the policy or affirm the policy by taking no action, or
- (2) Vote to disapprove the policy, or
- (3) Vote to return the policy to the Task Force for further consideration providing reasons therefore.

F. Task Forces may only undertake educational activities that are based on a policy statement, model bill or resolution that has been adopted as official ALEC policy, unless the Task Force votes to undertake the educational activity, in which case the educational activity is subjected to the same review process outlined in this Section. It is the responsibility of the Task Force Executive Committee to affirm by three-fourths majority vote conducted in accordance with Section VIII that an educational activity conforms to a policy statement, model bill or resolution.

X. EXCEPTIONS TO THE TASK FORCE OPERATING PROCEDURES.

Exceptions to these Task Force Operating Procedures must be approved by the Board of Directors.