SENATE BILL No. 1335

December 13, 1994, Introduced by Senator KELLY and referred to the Committee on Health Policy and Senior Citizens.

A bill to establish a Michigan standard health care benefit plan; to require certain residents of this state to enroll in the plan; to create a health care benefit plan commission; to provide for implementation of the standard health care benefit plan; to create regional alliances; to prescribe the powers and duties of certain state agencies and departments; to provide for the promulgation of rules; and to prescribe certain penalties.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

ARTICLE 1

Sec. 1. This act shall be known and may be cited as "the Michigan health care insurance and safety net act".

Sec. 3. As used in this act:

(a) "Administrative procedures act of 1969" means the administrative procedures act of 1969, Act No. 306 of the Public

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Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws.

(b) "Board" means a regional alliance board appointed under section 21.

(c) "Certified plan" means a health care coverage plan prepared by a health insurer; nonprofit health care corporation; health maintenance organization; prudent purchaser organization; or any other means of delivery of health care of health care coverage, certified pursuant to section 25, and that provides the standard health care benefit plan established in section 11 to residents in exchange for a prescribed premium or fee.

(d) "Child" means an individual less than 18 years of age or an individual less than 23 years of age if a full-time student.

(e) "Commission" means the health care benefit plan commission created in section 7.

(f) "Medicare" means benefits under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, and 1395w-4 to 1395ccc.

(g) "Provider" or "health care provider" means a person or facility that provides health care or medical care services in this state for a fee and that is regulated under the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(h) "Regional alliance" means a regional alliance created in section 21.

(i) "Regions" means the regions created in section 21.

(j) "Resident" means a person who is a resident of Michigan and who has been a resident of Michigan for a minimum of 6 months immediately before applying for enrollment in the Michigan standard health care benefit plan and who is less than 65 years of age.

(k) "Standard health care benefit plan" means the standard health care benefit plan created in section 11.

Sec. 5. (1) The Michigan standard health care benefit plan is created within the department of management and budget. The plan shall provide that all Michigan residents, except as provided in subsection (2), are eligible for certified standard health benefits.

(2) Each resident of this state who is not covered by medicare or an employer provided health care plan that provides at least the benefits provided in the certified standard health care benefit plan shall enroll in his or her region in a certified plan. A resident who is covered by or eligible for medicare is not eligible to enroll in a certified plan.

(3) An individual may purchase health care coverage in addition to the coverage required in subsection (2).

Sec. 7. (1) The health care benefit plan commission is created within the department of management and budget.

(2) The commission shall consist of 7 members and shall be appointed by the governor with the advice and consent of the senate.

(3) The members first appointed to the commission shall be appointed within 30 days after the effective date of this act.

(4) Members of the commission shall serve for terms of 4 years, or until a successor is appointed, whichever is later, except that of the members first appointed, 1 shall serve for 1 year, 2 shall serve for 2 years, 2 shall serve for 3 years, and 2 shall serve for 4 years.

(5) If a vacancy occurs on the commission, the governor shall make an appointment for the unexpired term in the same manner as the original appointment. A member shall not appoint a designee for his or her commission position.

(6) The governor may remove a member of the commission for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

(7) The first meeting of the commission shall be called not later than 60 days after the effective date of this act. At the first meeting, the commission shall elect from among its members a chairperson and other officers as it considers necessary or appropriate.

(8) A majority of the members of the commission constitute a quorum for the transaction of business at a meeting of the commission. A majority of the members present and serving are required for official action of the commission.

(9) The business that the commission may perform shall be conducted at a public meeting of the commission held in compliance with the open meetings act, Act No. 267 of the Public Acts

of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

(10) A writing prepared, owned, used, in possession of, or retained by the commission in the performance of an official function is subject to the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(11) A commission membership shall be a full-time paid unclassified position within the department of management and budget.

Sec. 9. The commission shall do all of the following:

(a) Establish a standard health care benefit plan for all residents of this state pursuant to section 11 by January 1, 1996.

(b) Provide health care planning for this state.

(c) Gather regional data an affordability and availability of certified plans and quality of health care delivered statewide.

(d) Use the data collected under subdivision (c) to implement quality, cost, and access requirements in certified plans.

(e) Provide for open enrollment schedules for each region.

(f) Prepare a biennial report on affordability and availability of certified plans and on quality of health care in the state's health care delivery system based on data collected under subdivision (c) and provide the report to the senate and house of representatives standing committees on health and insurance issues.

Sec. 11. The commission shall establish a standard health care benefit plan that provides the health care coverage recommended by the national health board. The standard health care benefit plan shall provide comprehensive medically necessary health care, including primary and preventive care, including all of the following if medically necessary or appropriate:

(a) Inpatient and outpatient hospital services.

(b) Emergency health services.

(c) Preventive health care including well-baby checkups and immunizations for children, periodic physical examinations, and routine laboratory work.

(d) Mental health and substance abuse services.

(e) Family planning.

(f) Pregnancy-related care.

(g) Hospice care.

(h) Home health and extended-care services following an acute illness.

(i) Ambulance services.

(j) Outpatient laboratory and diagnostic services.

(k) Prescription drugs and biologicals.

(*l*) Outpatient rehabilitation.

(m) Durable medical equipment.

(n) Vision and hearing care.

(o) Preventive dental services for children.

(p) Periodic medical checkups.

ARTICLE 2

Sec. 21. (1) A regional alliance is created within the department of management and budget for each of the following regions:

(a) Region A, which shall consist of Macomb, Monroe, Oakland, and Wayne counties.

(b) Region B, which shall consist of Clinton, Eaton, Genesee, Hillsdale, Huron, Ingham, Jackson, Lapeer, Lenawee, Livingston, Sanilac, St. Clair, Tuscola, and Washtenaw counties.

(c) Region C, which shall consist of Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw, and Shiawassee counties.

(d) Region D, which shall consist of Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties.

(e) Region E, which shall consist of Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Ionia, Iosco, Kalkaska, Kent, Lake, Leelanau, Manistee, Mason, Mecosta, Missaukee, Montcalm, Montmorency, Muskegon, Newaygo, Oceana, Osceola, Ogemaw, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, and Wexford counties.

(f) Region F, which shall consist of Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties.

(2) Each regional alliance shall be governed by a 6-member regional alliance board appointed by the governor, with the

advice and consent of the senate, 3 of whom shall be consumer representatives and 3 of whom shall be employer representatives. No member of the board shall be or have any financial interest in a health care provider, an insurer, health care corporation, health maintenance organization, or any other means of delivery of health care or health care coverage. Each board may appoint an advisory board of health care professionals and providers to assist the board.

(3) The members first appointed to each regional alliance board shall be appointed within 30 days after the effective date of this act.

(4) Members of each regional alliance board shall serve for terms of 3 years, or until a successor is appointed, whichever is later, except that of the members first appointed, 2 shall serve for 1 year, 2 shall serve for 2 years, and 2 shall serve for 3 years.

(5) The governor may remove a member of a regional alliance board for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

(6) The first meeting of each regional alliance board shall be called not later than 60 days after the effective date of this act. At the first meeting, each regional alliance board shall elect from among its members a chairperson and other officers as it considers necessary or appropriate.

(7) A majority of the members of a regional alliance board constitutes a quorum for the transaction of business at a meeting of the regional alliance board. A majority of the members

present and serving are required for official action of the board.

(8) The business that the regional alliance board may perform shall be conducted at a public meeting of the regional alliance board held in compliance with the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

(9) A writing prepared, owned, used, in possession of, or retained by the regional alliance board in the performance of an official function is subject to the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

Sec. 23. Each regional alliance board shall do all of the following for its region:

(a) Certify pursuant to section 25 those health care plans that meet the requirements of section 11 and that can deliver the standard health care benefit plan based on the authorized reimbursement level.

(b) Establish the premium or fee pursuant to section 27 for each region that the alliance will pay for the standard health care benefit plan.

(c) Be the central purchasing agent for the standard health care benefit plan for all residents in the region.

(d) Provide that residents in the region are offered a choice of all of the following plans:

(*i*) An integrated health plan that uses network providers. Under this plan consumers pay $10.00 copayments for outpatient

and professional services and do not make additional copayments for inpatient services, preventive services, or home health care following an acute illness. To obtain care from providers outside the network, this plan may offer a point-of-service option that allows patients to visit any health care provider, including those who may not belong to the patient's plan.

(*ii*) A fee-for-service plan that permits the consumer to see any health care provider. Under this plan consumers pay $200.00 annual deductibles and families pay $400.00 annual deductibles before coverage begins. Thereafter, a 20% coinsurance requirement must be met. An individual shall not pay more than $1,500.00 per year and a family not more than $3,000.00 per year. No deductible or coinsurance requirement applies for preventive services.

(*iii*) A preferred provider plan that uses network providers with $10.00 copayments for using these providers and 20% coinsurance for using nonnetwork providers. No copayment or coinsurance requirement applies for preventive services.

(e) Provide monthly payments for standard health care benefit plans to certified plans.

(f) Provide direct health care options for populations and rural areas that the regional alliance determines are underserved by 1 or more providers.

(g) Monitor and collect data for the commission on affordability, accessibility, and quality of health care in the region.

(h) Conduct annual surveys of consumer satisfaction with the health care and certified plans in the region.

(i) Establish standards to ensure quality of health care to residents in the region under standard health care benefit plans.

(j) Provide consumers with information on open enrollment periods, quality and cost of certified plans, and the right to cancel or change certified plans.

Sec. 25. Each regional alliance board shall only certify a health care plan that does all of the following:

(a) Establishes that it is capable of delivering the standard health care benefit plan without lifetime limits and in accordance with defined criteria for quality and accountability.

(b) Meets the solvency standards of its enabling legislation.

(c) Agrees to accept all residents in the region regardless of age and health, employment, or financial status and without individual medical underwriting, preexisting condition exclusions, or waiting periods.

(d) Agrees to use community rating and agrees to not set or adjust premiums based on age, gender, or other factors relating to projected or actual use of health services under the plan or based on the geographic location of the region.

Sec. 27. (1) A proponent of a certified plan wishing to provide the standard health care benefit plan to residents in a region shall submit to the regional alliance board the premium or fee for which it will provide the certified standard health care

benefit plan. The regional alliance board shall examine the cost submitted by each certified plan in the region and the demographics and health status of individuals in the region, and shall determine the cost it will pay for the standard health care benefit plan in each region. The regional alliance board shall establish a reimbursement mechanism that emphasizes primary care and the delivery of health care services in underserved areas.

(2) Each regional alliance shall reimburse each certified plan in its region the amount determined by the regional alliance board under subsection (1).

(3) If a region has only 1 certified plan providing the standard health care benefit plan to residents in the region, the regional alliance board shall promulgate rules pursuant to the administrative procedures act of 1969 to assure that quality health care is delivered in that region.

Sec. 29. Upon request of a regional alliance, the commissioner of insurance shall investigate a certified plan to determine if it is in violation of this act or any other act to which it is subject.

ARTICLE 3

Sec. 31. The department of public health shall establish a work group on health care fraud and abuse. The work group shall include representatives from the departments of attorney general, social services, mental health, and state police, the office of auditor general, the insurance bureau, insurers, and the United States department of justice.

Sec. 33. The work group on health care fraud and abuse shall prepare a report on health care fraud and abuse and shall submit the report to the governor and the senate and house of representatives standing committees on health and insurance issues by December 31, 1995. The report on health care fraud and abuse shall include, but not be limited to, all of the following:

(a) The identification of the major forms of health care fraud and abuse including an evaluation of present reimbursement procedures that provide opportunities for fraudulent and abusive practices.

(b) An assessment of current laws, rules, and regulations to determine if they are adequate to control fraudulent activities, and if not, recommendations for legislation to strengthen current laws, rules, and regulations.

(c) Recommendations as to civil financial penalties against health care providers who submit false claims.

(d) Recommendations on restrictions to eliminate referral "kickbacks" in the private sector and on new standards that prohibit health care providers from sending their patients for services at institutions in which they have financial interests.

(e) Recommendations on accountability standards that make health care provider misconduct and other misconduct automatic grounds for exclusion from all certified plans.

(f) The identification of key private and public agencies and organizations involved in the detection or prosecution of fraud and a determination as to how these agencies and

organizations can best coordinate their efforts to provide a more effective approach to controlling fraud and abuse.

(g) An assessment of the feasibility of permitting insurers to share information regarding provider billing and an examination of methods to permit insurers to collaborate in the investigation of providers suspected of fraud.

(h) An evaluation of the potential impact of allowing persons who report fraud to receive a portion of the fine levied against a provider who is successfully prosecuted.