SENATE BILL No. 595

September 7, 2011, Introduced by Senators KAHN, PAPPAGEORGE and RICHARDVILLE and referred to the Committee on Health Policy.

A bill to establish a basic health program; to create a basic health program trust fund; to provide for the powers and duties of certain state and local governmental officers and entities; to allow for the promulgation of rules; and to promote the availability and affordability of health coverage in this state.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. (1) This act shall be known and may be cited as the "Michigan basic health program act".

(2) As used in this act, the words and phrases defined in sections 3 to 7 have the meanings ascribed to them in those sections.

Sec. 3. (1) "Administrator" means the director of the department or his or her designee.

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(2) "Automatic assignment protocol" means the protocol for assigning individuals to standard health plans as currently used by the department of community health for medicaid managed care plans and as modified by the administrator to promote the availability and affordability of health coverage in this state consistent with section 1331 of the patient protection and affordable care act, 42 USC 18051.

(3) "Department" means the department of community health.

(4) "Eligible individual" means an individual who meets all of the following:

(a) Is a resident.

(b) Is not eligible to enroll in medicaid, medicare, or the state children's health insurance program authorized under title XIX of the social security act, 42 USC 1396 to 1396w-5, for benefits that at a minimum consist of the essential health benefits as described in section 1302(b) of the patient protection and affordable care act, 42 USC 18022.

(c) Has household income that exceeds 133% of the federal poverty line but does not exceed 200% of the federal poverty line for the size of the family involved.

(d) Is not eligible for minimum essential coverage, as defined in section 5000A(f) of the internal revenue code of 1986, 26 USC 5000A, or is eligible for an employer-sponsored plan that is not affordable coverage as determined under section 5000A(e)(2) of the internal revenue code of 1986, 26 USC 5000A.

(e) Has not attained age 65 as of the beginning of the plan year.

(5) "Exchange" means an American health benefit exchange established by this state pursuant to the patient protection and affordable care act.

(6) "Federal poverty line" means the poverty line published periodically in the federal register by the United States department of health and human services under its authority to revise the poverty line under 42 USC 9902.

(7) "Fund" means the basic health program trust fund created in section 9.

Sec. 5. (1) "Medicaid" means a program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5.

(2) "Medicare" means the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(3) "Patient protection and affordable care act" means the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, and includes regulations promulgated under those acts.

(4) "Program" means the basic health program established under this act.

Sec. 7. (1) "Resident" means an individual who voluntarily lives in this state with the intention of making his or her home in this state and not for a temporary purpose and who is not receiving public assistance from another state.

(2) "Service area" means the geographic area approved by the

administrator within which a standard health plan meets the requirements for the minimum provider network development as determined by the administrator under section 13.

(3) "Standard health plan" means a managed care health plan that this state contracts with as part of the program that meets all of the following requirements:

(a) Only enrolls eligible individuals.

(b) Provides at least the essential health benefits described in section 1302(b) of the patient protection and affordable care act, 42 USC 18022.

(c) Has and maintains a medical loss ratio of at least 85% as provided in section 1331(b)(3) of the patient protection and affordable care act, 42 USC 18051.

Sec. 9. (1) The basic health program trust fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source other than general fund state funds for deposit into the fund. The state treasurer shall direct the investment of the fund. The state treasurer shall credit to the fund interest and earnings from fund investments.

(3) Money in the fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

(4) The department is the administrator of the fund for auditing purposes.

(5) The administrator shall expend money from the fund without further appropriation for the purposes of reducing the premiums and cost-sharing of, or to provide additional benefits for, eligible

individuals enrolled in standard health plans in the program.

Sec. 11. The department shall establish, implement, and administer a basic health program in compliance with this act and section 1331 of the patient protection and affordable care act, 42 USC 18051.

Sec. 13. (1) In negotiating with a licensed health maintenance organization regarding its managed care health plans for participation in the program as a standard health plan, the administrator shall adopt a uniform procedure that includes a request for proposals that includes all of the following:

(a) Standards regarding the quality of services to be provided under the managed care health plan that are at least as rigid as those currently required of managed care health plans participating in the state medicaid program.

(b) Standards regarding the financial integrity of managed care health plans sponsored by responding health maintenance organizations.

(c) Standards regarding history and experience of responding health maintenance organizations in addressing the health care needs of, and providing quality health care services to, low-income residents.

(d) Standards for minimum provider network development to ensure that the managed care health plan's network for each service area within which it will participate has a sufficient number, mix, and geographic distribution to meet the target populations' needs and to ensure adequate service availability.

(2) Only managed care health plans that are provided by

licensed health maintenance organizations in this state and that have an active medicaid contract with the department at the time of the release of the request for proposals under subsection (1) are eligible to participate in the program. A managed care health plan that is not subject to the provisions of section 9010 of the patient protection and affordable care act is not eligible to participate in the program.

(3) The administrator shall select 3 standard health plans in each service area within this state that has mandatory participant populations of less than 100,000 and 4 standard health plans in each service area that has mandatory participant populations of 100,000 or more. The administrator may select a standard health plan for participation in more than 1 service area.

(4) In selecting standard health plans, the administrator shall give preference to licensed health maintenance organizations that are currently under a medicaid contract with the department and that have meaningful and proven chronic care, disease management, and preventive care programs.

Sec. 15. An individual who is a qualified individual under section 1312 of the patient protection and affordable care act, 42 USC 18032, and who is eligible for enrollment in a qualified health plan offered through the exchange is not an eligible individual under this act and shall not be enrolled in a standard health plan.

Sec. 17. (1) Upon enrollment, an eligible individual shall have 15 days during which to choose a standard health plan in his or her service area. The administration shall enroll an eligible individual who does not choose a standard health plan during the

15-day choice period in a standard health plan through the automatic assignment protocol.

(2) An eligible individual enrolled in a standard health plan under subsection (1) may request disenrollment at any time, without cause, during the first 90 days of enrollment.

(3) The administrator shall establish an annual, 30-day open enrollment period during which an eligible individual may disenroll from 1 standard health plan and enroll in another standard health plan participating in his or her service area.

Sec. 19. (1) The administrator shall do all of the following:

(a) Ensure that the participating standard health plans provide essential health benefits as described in section 1302(b) of the patient protection and affordable care act, 42 USC 18022.

(b) Evaluate performance measures as determined by the administrator.

(c) Contract with standard health plans as provided in this act.

(d) Seek approval from the secretary of the United States department of health and human services to do either of the following:

(*i*) Use a portion of the federal funds to be provided to the state under this program to fund administration of the program.

(*ii*) Use a portion of premiums paid by eligible individuals to fund administration of the program.

(e) Coordinate, to the extent possible, the medicaid managed care program, the basic health program, and the exchange.

(f) Any other activity necessary to fulfill his or her duties

under this act.

(2) The administrator may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, that he or she considers necessary to implement this act.