SENATE BILL No. 278

February 27, 2007, Introduced by Senators GEORGE, PAPPAGEORGE, BIRKHOLZ, RICHARDVILLE, KUIPERS, KAHN, HARDIMAN, GARCIA, GLEASON, SANBORN, JACOBS, VAN WOERKOM, BROWN, THOMAS, SCOTT and BRATER and referred to the Committee on Health Policy.

A bill to promote the availability and affordability of health coverage in this state and to facilitate the purchase of that coverage; to create the Michigan helping ensure affordable and reliable treatment exchange and board; to provide for a determination of eligible health coverage plans; to provide for a determination of eligibility for assistance of certain enrollees; to prescribe certain powers and duties of certain officials and departments of this state; to provide for certain funds; to provide for the collection and disbursement of certain payments and surcharges; and to provide for certain reports.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. This act shall be known and may be cited as the "Michigan helping ensure affordable and reliable treatment (MI-

SENATE BILL No. 278

HEART) act".

Sec. 3. As used in this act:

(a) "Board" or "MI-HEART exchange board" means the board of the MI-HEART exchange created in section 5.

(b) "Carrier" means a health insurer, health maintenance organization, or health care corporation.

(c) "Commissioner" means the commissioner of the office of financial and insurance services.

(d) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all of the employer's employees and without regard to health status-related factors.

(e) "Eligible health coverage plan" or "plan" means any individual or group contract, policy, or certificate of health, accident, and sickness insurance or coverage issued by a carrier that meets the eligibility requirements established by the board under section 8 and is offered through the exchange. Eligible health coverage plan does not include a contract, policy, or certificate that provides coverage only for dental, vision, specified accident or accident-only coverage, credit, disability income, hospital indemnity, long-term care insurance, medicare supplement, coverage issued as a supplement to liability insurance, and specified disease insurance that is purchased as a supplement and not as a substitute for an eligible health coverage plan.

Eligible health coverage plan does not include coverage arising out of a worker's compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault, coverage under a plan through medicare, and coverage issued under 10 USC 1071 to 1110, and any coverage issued as a supplement to that coverage.

(f) "Eligible individual" means an individual who is a resident of the state who meets the eligibility requirements in section 11.

(g) "ERISA" means the employee retirement income security act of 1974, Public Law 93-406.

(h) "Exchange" or "MI-HEART exchange" means the MI-HEART exchange created in section 5.

(i) "Fund" means the MI-HEART exchange fund created in section 19.

(j) "Health care corporation" means a health care corporation operating pursuant to the nonprofit health care corporation reform act of 1980, 1980 PA 350, MCL 550.1101 to 550.1704.

(k) "Health insurer" means a health insurer with a certificate of authority under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(*l*) "Health maintenance organization" means a health maintenance organization with a license or certificate of authority under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(m) "Medicaid" means a program for medical assistance established under title XIX of the social security act, 42 USC 1396

to 1396v.

(n) "Medicare" means the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395hhh.

(o) "MI-HEART enrollee" or "enrollee" means an individual or his or her dependent who is enrolled in a plan.

(p) "MI-HEART program" means the program administered under section 9.

(q) "Premium assistance payment" means a payment of health coverage premiums made by the board to a plan on behalf of a MI-HEART enrollee who is an eligible individual.

(r) "Premium contribution payment" means a payment made by a MI-HEART enrollee or employer toward an eligible health coverage plan.

(s) "Resident" means a person living in the state, including a qualified alien, as defined by section 431 of the personal responsibility and work opportunity reconciliation act of 1996, Public Law 104-193, or a person who is not a citizen of the United States but who is otherwise permanently residing in the United States under color of law; provided, however, that the person has not moved into the state for the sole purpose of securing health coverage under this act.

(t) "Seal of approval" means the approval given by the board under section 8.

(u) "Small employer" means any person, firm, corporation, partnership, limited liability company, or association actively engaged in business who, on at least 50% of its working days during

the preceding and current calendar years, employed at least 2 but not more than 50 eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for state taxation purposes shall be considered 1 employer.

(v) "Uninsured" means a resident who is not covered by a health insurance or coverage plan offered by a carrier, a self-funded health coverage plan, medicaid, medicare, or a medical assistance program.

Sec. 5. (1) The MI-HEART exchange is created within the department of community health and shall exercise its prescribed statutory duties, powers, and functions independently of the director of the department of community health. The exchange is responsible for facilitating the availability, choice, and adoption of private eligible health coverage plans to individuals and groups and facilitating the purchase of health coverage products through the exchange at an affordable price by individuals and groups.

(2) The MI-HEART exchange shall be governed by a board consisting of the following 15 members:

(a) The director of the department of community health or his or her designee.

(b) The director of the department of human services or his or her designee.

(c) The commissioner or his or her designee.

(d) The deputy director for medical services administration or his or her designee.

(e) Three members appointed by the governor with the advice

and consent of the senate, 1 of whom shall be a member in good standing of the American academy of actuaries, 1 of whom shall be a health economist, and 1 of whom shall represent a health care corporation.

(f) Four members appointed by the senate majority leader, 1 of whom shall be an employee health benefit specialist, 1 of whom shall represent health maintenance organizations, 1 of whom shall represent the general public, and 1 of whom shall represent medical providers.

(g) Four members appointed by the speaker of the house of representatives, 1 of whom shall represent small employers, 1 of whom shall represent health insurers, 1 of whom shall represent organized labor, and 1 of whom shall represent hospitals.

(3) The members first appointed to the board shall be appointed within 30 days after the effective date of this act. Appointed board members shall serve for terms of 4 years or until a successor is appointed, whichever is later, except that of the members first appointed 3 shall serve for 1 year, 4 shall serve for 2 years, 4 shall serve for 3 years, and 4 shall serve for 4 years.

(4) If a vacancy occurs on the board, the vacancy shall be filled for the unexpired term in the same manner as the original appointment. An appointed board member is eligible for reappointment.

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

(6) The first meeting of the board shall be called by the

director of the department of community health, who shall serve as chairperson. After the first meeting, the board shall meet at least monthly, or more frequently at the call of the chairperson or if requested by 8 or more members.

(7) Eight members of the board constitute a quorum for the transaction of business at a meeting of the board. An affirmative vote of 8 board members is necessary for official action of the board.

(8) The business that the board may perform shall be conducted at a public meeting of the board held in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

(9) A writing prepared, owned, used, in the possession of, or retained by the board in the performance of an official function is subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(10) Board members shall serve without compensation. However, board members may be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members.

(11) The chairperson shall hire an executive director to supervise the administrative affairs and general management and operations of the exchange and also serve as secretary of the exchange. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the exchange necessary to the functioning of the exchange. The executive director, with the approval of the board, shall do all of the following:

(a) Plan, direct, coordinate, and execute administrative functions in conformity with the policies and directives of the board and this act.

(b) Employ professional and clerical staff as necessary.

(c) Report to the board on all operations under his or her control and supervision.

(d) Prepare an annual budget and manage the administrative expenses of the exchange.

(e) Undertake any other activities necessary to implement the powers and duties under this act.

(12) The exchange shall begin offering eligible health coverage plans no later than 180 days after federal matching funds are procured under section 31.

Sec. 7. The board shall do all of the following:

(a) Develop a plan of operation for the exchange, which shall include, but is not limited to, all of the following:

(*i*) Establishes procedures for operations of the exchange.

(*ii*) Establishes procedures for communications with the executive director.

(*iii*) Establishes procedures for the selection of and the seal of approval for eligible health coverage plans as provided in section 8 to be offered through the exchange.

(*iv*) Establishes procedures for the enrollment of individuals and groups in plans.

(*v*) Establishes procedures for appeals of eligibility decisions as provided in section 13.

(*vi*) Establishes and manages a system of collecting and

depositing into the fund all premium payments made by, or on behalf of, individuals obtaining health coverage through the exchange, including any premium payments made by enrollees, employees, unions, or other organizations.

(*vii*) Establishes and manages a system for remitting premium assistance payments to carriers.

(*viii*) Establishes and manages a system for remitting premium contribution payments to carriers.

(*ix*) Establishes a plan for publicizing the existence of the exchange and the exchange's eligibility requirements and enrollment procedures.

(*x*) Develops criteria for determining that certain health coverage plans shall no longer be made available through the exchange, and develops a plan to remove the seal of approval from certain health coverage plans.

(*xi*) Develops a standard application form for individuals and groups, seeking to purchase health coverage through the exchange, and for eligible individuals who are seeking a premium assistance payment that includes information necessary to determine an applicant's eligibility under section 11, previous and current health coverage, and payment method.

(b) Determine each applicant's eligibility for purchasing health coverage offered by the exchange, including eligibility for premium assistance payments.

(c) Seek and receive any funding from the federal government, departments or agencies of the state, private foundations, and other entities.

(d) Contract with professional service firms as may be necessary and fix their compensation.

(e) Contract with companies that provide third-party administrative and billing services for health coverage products.

(f) Adopt bylaws for the regulation of its affairs and the conduct of its business.

(g) Adopt an official seal and alter the same.

(h) Maintain an office at such place or places as it may designate.

(i) Sue and be sued in its own name.

(j) Approve the use of its trademarks, brand names, seals, logos, and similar instruments by participating carriers, employers, or organizations.

(k) Enter into interdepartmental agreements.

(*l*) Create and publish each year the MI-HEART consumer price schedule.

(m) Create and publish each year a premium schedule.

(n) Subject to this act, review annually the publication of the income levels for the federal poverty guidelines and devise a schedule of a percentage of income for each 50% increment of the federal poverty level at which an individual could be expected to contribute said percentage of income toward the purchase of health coverage and examine any contribution schedules, such as those set for government benefits programs. The report shall be published annually. Prior to publication, the schedule shall be reported to the house of representatives and senate standing committees on appropriations, health, and insurance issues.

Sec. 8. (1) The exchange shall only offer eligible health coverage plans that have received the exchange seal of approval to individuals and groups.

(2) Each eligible health coverage plan offered through the exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits.

(3) No health coverage plan shall be offered through the exchange that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

(4) The exchange shall offer a variety of health coverage plans, at least 1 of which shall provide for a high deductible with only catastrophic coverage. Eligible health coverage plans receiving the exchange seal of approval shall meet all requirements of health coverage plans required under state law, rule, and regulation except that, in order to satisfy the goal of universal health care coverage in this state, the board may permit a health care plan to be offered through the exchange that does not provide for the coverages or offerings required under section 3406a, 3406b, 3406c, 3406d, 3406e, 3406m, 3406n, 3406p, 3406q, 3406r, 3425, 3609a, 3613, 3614, 3615, 3616, or 3616a of the insurance code of 1956, 1956 PA 218, MCL 500.3406a, 500.3406b, 500.3406c, 500.3406d, 500.3406e, 500.3406m, 5003406n, 500.3406p, 500.3406q, 500.3604r, 500.3425, 500.3609a, 500.3613, 500.3614, 500.3615, 500.3616, and 500.3616a, or section 401b, 401f, 401g, 414a, 415, 416, 416a, 416b,

416c, 416d, or 417 of the nonprofit health care corporation reform act of 1980, 1980 PA 350, MCL 550.1401b, 550.1401f, 550.1401g, 550.1414a, 550.1415, 550.1416, 550.1416a, 550.1416b, 550.1416c, 550.1416d, and 550.1417. In making the determination of which provisions of section 3406a, 3406b, 3406c, 3406d, 3406e, 3406m, 3406n, 3406p, 3406q, 3406r, 3425, 3609a, 3613, 3614, 3615, 3616, or 3616a of the insurance code of 1956, 1956 PA 218, MCL 500.3406a, 500.3406b, 500.3406c, 500.3406d, 500.3406e, 500.3406m, 500.3406n, 500.3406p, 500.3406q, 500.3604r, 500.3425, 500.3609a, 500.3613, 500.3614, 500.3615, 500.3616, and 500.3616a, or section 401b, 401f, 401g, 414a, 415, 416, 416a, 416b, 416c, 416d, or 417 of the nonprofit health care corporation reform act of 1980, 1980 PA 350, MCL 550.1401b, 550.1401f, 550.1401g, 550.1414a, 550.1415, 550.1416, 550.1416a, 550.1416b, 550.1416c, 550.1416d, and 550.1417, are not required to be provided in a health coverage plan offered through the exchange, the board shall determine whether real cost savings will be achieved so that the variety of health coverage plans available through the exchange and the affordability of these plans are maximized.

(5) The exchange seal of approval shall be assigned to an eligible health coverage plan that the board determines satisfies this section, provides good value to residents, and provides quality medical benefits and administrative services.

(6) The board may withdraw an eligible health coverage plan from the exchange only after notice to the carrier.

(7) The board shall procure eligible health coverage plans for the MI-HEART program that include, but are not limited to, all of

the following:

(a) Wellness services.

(b) Inpatient services.

(c) Outpatient services and preventive care.

(d) Prescription drugs.

(e) Medically necessary inpatient and outpatient mental health services and substance abuse services.

(f) Emergency care services.

Sec. 9. (1) For the purpose of reducing the number of uninsured individuals in the state, there shall be a MI-HEART program within the exchange. The MI-HEART program shall be administered by the board in consultation with the department of community health and the department of human services. The MI-HEART program shall provide subsidies to assist eligible individuals in purchasing health coverage, provided that subsidies shall only be paid on behalf of an eligible individual who is enrolled in an eligible health coverage plan, and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by the board. Eligibility for premium assistance payments under this section shall be determined as provided in this act. After consultation with representatives of any carrier eligible to receive premium subsidy payments under this act, representatives of small employers eligible under section 11(2), representatives of hospitals that serve a high number of uninsured individuals, and representatives of low-income health care advocacy organizations, the board shall develop a plan for outreach and education that is designed to reach low-income uninsured residents

and maximize their enrollment in the MI-HEART program.

(2) Premium assistance payments under the MI-HEART program shall be made as provided in this act and under a schedule set annually by the board in consultation with the department of community health. The schedule shall be published annually. If the executive director determines that amounts in the fund are insufficient to meet the projected costs of enrolling new eligible individuals, the executive director shall impose a cap on enrollment in the MI-HEART program and shall notify the board, the governor, and the house of representatives and senate standing committees on appropriations, health, and insurance issues.

(3) The MI-HEART program shall provide that an enrollee with a household income that does not exceed 100% of the federal poverty level is only responsible for a copayment toward the purchase of each pharmaceutical product and for use of emergency room services in acute care hospitals for nonemergency conditions equal to that required of enrollees in the medicaid program. The board may waive copayments upon a finding of substantial financial or medical hardship. No other premium, deductible, or other cost sharing shall apply to an enrollee described in this subsection under the MI-HEART program.

(4) The MI-HEART program shall provide that an enrollee with a household income that exceeds 100% of the federal poverty level but does not exceed 200% of the federal poverty level is not responsible for a premium contribution payment that exceeds 5% of his or her gross family income.

Sec. 11. (1) An uninsured individual is eligible to

participate in the MI-HEART program if all of the following are met:

(a) An individual's or family's household income does not exceed 200% of the federal poverty level.

(b) The individual has been a resident of the state for the previous 6 months.

(c) The individual is not eligible for any government program, medicaid, medicare, or the state children's health insurance program authorized under title XXI of the social security act, 42 USC 1397aa to 1397jj.

(d) The individual's or family member's employer has not provided health coverage in the last 6 months for which the individual is eligible.

(e) The individual has not accepted a financial incentive from his or her employer to decline his or her employer's subsidized health coverage plan.

(2) An individual who is an employee of a small employer is eligible to participate in the MI-HEART program if all of the following are met:

(a) Not less than 75% of the small employer's eligible employees seeking health care coverage through the small employer are covered under an eligible health coverage plan.

(b) The small employer pays at least 33% of the premium contribution payment.

(c) The small employer agrees to participate in a payroll deduction program to facilitate premium contribution payments by employees who will benefit from deductibility of gross income under

26 USC 104, 105, 106, and 125.

(d) The small employer agrees to make available in a timely manner for confidential review by the executive director any of the employer's documents, records, or information that the exchange reasonably determines is necessary to determine compliance with this act.

(e) The individual's or family's household income does not exceed 200% of the federal poverty level.

(f) The individual has been a resident of the state for the previous 6 months.

(g) The individual is not eligible for any government program, medicaid, medicare, or the state children's health insurance program authorized under title XXI of the social security act, 42 USC 1397aa to 1397jj.

Sec. 13. All residents of the state may apply to purchase health coverage through the exchange. A resident who has applied to the MI-HEART program has the right to receive a written determination of eligibility and, if eligibility is denied, a written denial detailing the reasons for the denial and the right to appeal any eligibility decision, provided the appeal is conducted pursuant to the process established by the board.

Sec. 15. The exchange shall enter into interagency agreements with the department of treasury to verify income data for participants in the MI-HEART program. Such written agreements shall include provisions permitting the exchange to provide a list of individuals participating in or applying for the MI-HEART program, including any applicable members of the households of such

individuals, who would be counted in determining eligibility, and to furnish relevant information, including, but not limited to, name, social security number, if available, and other data required to assure positive identification. The department of treasury shall furnish the exchange with information on the cases of persons so identified, including, but not limited to, name, social security number, and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources.

Sec. 17. (1) The exchange may apply a surcharge to all eligible health coverage plans, which shall be used only to pay actual administrative and operational expenses of the exchange and so long as the surcharge is applied uniformly to all eligible health coverage plans offered through the exchange. A surcharge shall not be used to pay any premium assistance payments.

(2) Each carrier participating in the exchange shall furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his or her duties under this act.

Sec. 19. (1) The MI-HEART exchange fund is created within the state treasury.

(2) Premium contribution payments and surcharges collected by the exchange shall be deposited into the fund. The state treasurer may receive money or other assets from any source 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) Money in the fund shall be expended only as provided in this act.

Sec. 21. The board shall keep an accurate account of all exchange activities and of all its receipts and expenditures and shall annually make a report thereof at the end of its fiscal year to the governor, to the house of representatives and senate standing committees on appropriations, health, and insurance issues, and to the auditor general. The auditor general may investigate the affairs of the exchange, may severally examine the properties and records of the exchange, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the exchange. The exchange is subject to annual audit by the auditor general.

Sec. 23. No later than 2 years after the exchange begins operation and every year thereafter, the board shall conduct a study of the exchange and the persons enrolled in the exchange and shall submit a written report to the governor and the house of representatives and senate standing committees on appropriations, health, and insurance issues on the status and activities of the exchange based on data collected in the study. The report shall also be available to the general public upon request. The study shall review all of the following for the immediately preceding year:

(a) The operation, administration, and costs of the exchange.

(b) What health coverage plans are available to individuals

and groups through the exchange and the experience of those plans. The experience of the plans shall include data on number of enrollees in the plans, plans' expenses, claims statistics, and complaints data. Health information obtained under this act is subject to the federal health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(c) The number of MI-HEART enrollees in the MI-HEART program and the total amount of premium assistance payments made.

(d) How the exchange met its goals.

(e) Other information considered pertinent by the board.

Sec. 25. The board shall report to the governor and to the house of representatives and senate standing committees on appropriations, health, and insurance issues by January 1, 2011 on progress in achieving universal health coverage in this state. The report shall examine any trends in the number of uninsured individuals in this state since the effective date of this act and types and costs of health coverage available and shall make recommendations on methods to achieve universal health coverage in this state, including, but not limited to, whether health coverage should be mandated, how a mandate would be implemented, and how a mandate would be enforced.

Sec. 31. This act shall not take effect unless federal matching funds are secured as necessary to implement this act.

Enacting section 1. This act does not take effect unless all of the following bills of the 94th Legislature are enacted into law:

(a) Senate Bill No. 283.

(b) Senate Bill No. 280.