SUBSTITUTE FOR

SENATE BILL NO. 422

A bill to create a low-income health plan; to create a low-income health plan 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; to promote the availability and affordability of health coverage in this state; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. (1) This act shall be known and may be cited as the "Michigan low-income health plan 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) "Covered primary care benefits" means the health

care treatment and services that are covered under the plan as established by the director under section 11.

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

(3) "Director" means the director of the department.

(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.

(c) Has household income that does not exceed 100% of the federal poverty line, for the size of the family involved. For the purpose of determining household income under this subdivision, the director shall use the modified adjusted gross income-equivalent standards for this state that are approved under section 1902(e)(14)(E) of the social security act, 42 USC 1396a.

(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.

(f) Is not eligible for benefits through the United States department of veterans affairs.

(5) "Exchange" means an American health benefit exchange operating in this state pursuant to the federal act.

Sec. 5. (1) "Federal 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.

(2) "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.

(3) "Fund" means the Michigan low-income plan trust fund created in section 9.

(4) "Health plan" or "plan" means the Michigan low-income health plan created under section 11.

Sec. 7. (1) "Medicaid" or "medical assistance program" means the program of medical assistance provided under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, and title XIX of the social security act, 42 USC 1396 to 1396w-5.

(2) "Medicaid contracted health plan" means that term as defined in section 106 of the social welfare act, 1939 PA 280, MCL 400.106.

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

(4) "Member" means an eligible individual who is enrolled in the health plan and who fulfills all conditions of participation in the plan as provided in this act or established by the department under this act.

(5) "Resident" means an individual who is a citizen of the United States or is legally present in the United States, who

voluntarily lives in this state with the intention of making his or her home in this state and not for a temporary purpose, who has lived in this state for 6 months or more, and who is not receiving public assistance from another state.

Sec. 9. (1) The Michigan low-income plan trust fund is created within the state treasury.

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

(5) The director shall expend money from the fund to administer this act and, if money is available, to provide additional benefits for members, including, but not limited to, increasing the limit on inpatient hospitalization coverage under section 11(3)(e)(*ii*).

Sec. 11. (1) The Michigan low-income health plan is created in the department. The director shall implement and administer the health plan so that it is in compliance with this act and is operational by January 1, 2014. The department may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, that it considers necessary or appropriate under this act.

(2) The director shall do all of the following under this act:

(a) Implement the plan so that eligible individuals enroll in the plan through an exchange.

(b) Implement the plan so that eligible individuals are enrolled in the plan with a medicaid contracted health plan. The director shall ensure that health care professionals who participate with a medicaid contracted health plan will accept as patients an eligible individual who enrolls in that medicaid contracted health plan under this section.

(c) Establish or provide for the establishment of an enrollment process that identifies whether an individual who is attempting to enroll in the health plan is eligible for enrollment in any other public or private health benefit coverage plan and that directs that individual to enroll in that other health benefit coverage plan.

(d) Implement a financial participation requirement so that members pay a monthly household premium based on household income for the size of the family involved as follows:

(*i*) For a household with income that is 25% or less of the federal poverty line, a monthly household premium of $5.00.

(*ii*) For a household with income that is more than 25% and 50% or less of the federal poverty line, a monthly household premium of $10.00.

(*iii*) For a household with income that is more than 50% and 79% or less of the federal poverty line, a monthly household premium of $15.00.

(*iv*) For a household with income that is more than 79% and 100% or less of the federal poverty line, a monthly household premium of

$20.00.

(e) Implement the plan so that payments to federally qualified health centers for a covered primary care benefit are no more than the medical assistance program paid for the covered primary care benefit at the levels provided for in the 2011-2012 state fiscal year.

(f) Implement the plan in a manner that ensures that the plan is the payor of last resort.

(g) Implement the plan so that any cost-sharing requirements are equal to those required under the medical assistance program. As used in this subdivision, cost-share requirement includes a copayment, coinsurance, or deductible.

(3) The director shall establish or modify the health care treatment and services that will be covered primary care benefits, subject to all of the following:

(a) Except as otherwise specifically provided in this act, include at a minimum essential health benefits as described in section 1302(b) of the federal act.

(b) Provide for the coverage of primary care and preventive services in the same manner as provided for under medicaid diagnosis related group codes and at the levels provided for in the 2011-2012 state fiscal year.

(c) Except as otherwise provided in this subdivision, provide for the coverage of prescription drugs and require the use of generic prescription drugs if a generic alternative exists for a brand name product, as recommended by the member's prescribing provider and as is consistent with section 109h of the social

welfare act, 1939 PA 280, MCL 400.109h, and part 97 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709.

(d) Provide for the coverage of certain specified outpatient hospital procedures.

(e) Provide for the coverage of inpatient hospitalization with coverage limited as follows:

(*i*) Except as otherwise provided in subparagraph (*ii*), to an amount not to exceed the amount that would have been payable for that coverage under the medical assistance program at the levels provided for in the 2011-2012 state fiscal year.

(*ii*) To an amount not to exceed $35,000.00 a year, or a higher limit if increased under section 9(5), for each covered individual.

(f) Provide coverage for substance use disorder treatment services, which services must be bid out based on performance objectives established by the department.

(g) Provide coverage for mental health services that are obtained through a specialty prepaid health plan under the medical assistance program or that are bid out based on performance objectives established by the department.

Sec. 12. The department shall transmit all money received under this act, including all financial participation payments from members required under section 11, to the state treasurer for deposit into the fund.

Sec. 13. A medicaid contracted health plan shall comply with this act to enroll eligible individuals as members of the plan. A medicaid contracted health plan shall comply with performance objectives established by the department under this act. The

department shall establish clear performance objectives in order to ensure success of the plan in this state.

Sec. 15. Upon enrollment, a member shall comply with all conditions of participation in the plan, including any financial participation requirements established under this act. A member who violates this section may be removed from enrollment in the plan. An individual who is removed from enrollment in the plan is not eligible for covered primary care benefits under the plan for a period of at least 3 months. An individual who has been removed from enrollment in the plan under this section may reapply for enrollment in the plan after the 3-month penalty period has expired if the individual has paid any previously unsatisfied financial participation requirements.

Sec. 17. (1) Beginning April 1, 2015, the department shall submit an annual report of its activities under this act to the senate majority leader, the speaker of the house of representatives, the chair of the house and senate appropriations committees, the chair of the house and senate appropriations subcommittees on community health, and the chair of the house and senate appropriations subcommittees on human services. The chair of the house or senate appropriations committee may request that specific information regarding the department's activities under this act be included in an annual report required under this subsection. The department shall include information requested by a committee chair in its next annual report required under this subsection.

(2) In addition to information provided in an annual report

under subsection (1), the chair of the house or senate appropriations committee may request information regarding the department's activities under this act from the department at any time. The department shall respond in a timely manner to a request for information under this subsection.

<<Sec. 18. The department shall request a determination from the appropriate federal agency as to whether an employer that has 50 or more employees and that is subject to a penalty under the federal act may, in lieu of paying the penalty, purchase a catastrophic-only health benefit plan for an employee who attempts to purchase a health benefit plan offered through an exchange. If the federal agency approves the proposal described in this section, the department shall implement and administer a program to facilitate the purchase of a catastrophic-only health benefit plan by an employer described in this section.>>

Sec. 19. This act is repealed effective January 1, 2017.