HOUSE BILL No. 4740

May 11, 1993, Introduced by Reps. Hollister, Rivers, DeMars, Leland, Emerson, Schroer, Pitoniak, Jondahl, Bennane, Scott, Gubow, Freeman, Kilpatrick, Harrison, Wallace and Dobronski and referred to the Committee on Public Health.

A bill to provide for a health plan with universal access; to provide for certain powers and duties; to provide for certain powers and duties of certain state offices and agencies; and to provide for an appropriation.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. This act shall be known and may be cited as "Michicare".

Sec. 3. As used in this act:

(a) "Board" means the board of directors created in section 4.

(b) "Department" means the department of public health.

(c) "Global budget" means an annual budget that includes all expenses other than capital expenditures.

(d) "Health care facility" means a hospital, nursing home, county medical care facility, hospice, health maintenance

organization, freestanding surgical outpatient facility, clinical laboratory, community health center, migrant health center, ambulance operation, advanced mobile emergency care service, or limited advanced mobile emergency care service.

(e) "Health care provider" means a health care facility or a person who is licensed or otherwise authorized under article 15 of Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws, to provide health care to individuals.

(f) "Health maintenance organization" means an entity that delivers health services that are medically indicated to enrollees under the terms of a health maintenance contract, directly or through contracts with affiliated providers, without regard to the frequency, extent, or kind of health services, and that is responsible for the availability, accessibility, and quality of the health services provided.

(g) "Hospice" means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(h) "Hospital" means a facility offering inpatient, overnight care, and services for observation, diagnosis, and treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. The term includes a sanatorium falling within the definition of "hospital" in title XVIII.

(i) "Nurse specialist" means a registered nurse who has received a specialty certification as a nurse midwife, nurse anesthetist, or nurse practitioner.

(j) "Participating provider" means a health care provider who signs a participation agreement developed pursuant to section 7(2) authorizing him or her to receive payment from the plan by means of a global budget, capitation amounts, or fee for service, for furnishing covered services to plan members.

(k) "Physician" means an individual licensed in this state to engage in the practice of medicine or osteopathic medicine and surgery.

(*l*) "Plan" means the health plan established by this act.

(m) "Resident" means a person domiciled in this state and who has been domiciled in this state for not less than 30 days, except that a newborn domiciled in this state is a resident from the moment of birth.

(n) "Title XVIII" means 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, 1395w-4 to 1395ccc.

(o) "Title XIX" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, and 1396i to 1396u.

Sec. 4. (1) A board of directors is created within the department. The board shall consist of the directors of the departments of public health, social services, and mental health, the commissioner of insurance, and the director of the office of

services to the aging, who shall all be ex officio, nonvoting members of the board and the following 17 voting members appointed by the director of the department:

(a) Five representatives of health care consumer advocacy organizations that have a statewide constituency and who have been involved in activities related to health care consumer advocacy including issues of interest to low and moderate income individuals.

(b) Three representatives of labor organizations.

(c) Three representatives of business and industry.

(d) One representative of hospitals.

(e) One representative of nursing homes.

(f) Two representatives of physicians.

(g) Two representatives of licensed health care professionals who are not physicians.

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

(3) Members of the board shall serve for 5-year terms, or until a successor is appointed, whichever is later, except that of the members first appointed, 3 shall serve for 1 year, 3 shall serve for 2 years, 3 shall serve for 3 years, 4 shall serve for 4 years, and 4 shall serve for 5 years.

(4) If a vacancy occurs on the board, the director of the department shall make an appointment for the unexpired term in the same manner as the original appointment.

(5) The director of the department may remove a board member 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 held within 45 days after the effective date of this act. At the first meeting, the board shall elect from among its members a chairperson and other officers as it considers necessary or appropriate. After the first meeting, the board shall meet at least quarterly or more often upon the call of the chair or as provided by the board.

(7) Nine board members constitute a quorum for the transaction of business at a board meeting. Nine board members are necessary for official board action.

(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, 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 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.

(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.

Sec. 5. (1) There is created within the department a health plan to provide comprehensive health care coverage including long-term care and mental health and substance abuse services to all residents of this state, using a unified, publicly funded, financing mechanism.

(2) Every resident of this state is a member of the plan. A nonresident of this state who is employed in this state may choose to become a member by paying the requisite tax under section 25.

(3) Membership in the plan does not impinge upon a member's right to consent to or to refuse treatment or other services offered under the plan.

(4) A member in the plan shall have free choice of health care providers.

(5) The plan shall pay for covered services provided to a plan member in the amounts and subject to the conditions as are prescribed by rules promulgated under this act. Hospitals, nursing homes, health maintenance organizations, community health centers, and migrant health centers shall receive global budgets. Other participating providers shall be directly reimbursed on a fee-for-service basis.

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

(a) Establish policies and procedures for the operation of the plan.

(b) Develop a budget for the plan, with separate line items for prevention, services, training, capital expenditures, and administrative costs.

(c) Recommend and pursuant to public hearings implement cost containment strategies consistent with the studies called for in subdivision (u) that will provide controls on the total plan budget.

(d) Develop a schedule of covered services, which shall include those services listed in section 21. The board shall hold public hearings as part of this process.

(e) Establish a review process for assessing and modifying covered services and renegotiating the reimbursement schedule based upon research on the effectiveness of particular health tests and procedures required under subdivision (u).

(f) Assure that prevention and primary health care services are available to all members and encourage all members to select a primary health care provider to manage their care.

(g) Negotiate an annual, global budget with each participating hospital, nursing home, health maintenance organization, community health center, and migrant health center.

(h) After consultation and negotiation with health care providers, develop a reimbursement schedule for covered services.

(i) Decide which types of health care providers are eligible to be participating providers.

(j) Create a plan fund, under department management, to receive earmarked tax revenues and federal funds, and to pay for

covered services, capital expenditures, administrative costs, and other costs allowable under this act.

(k) Establish procedures for the handling and accounting of plan assets and money.

(*l*) Develop a system to handle claims in an expeditious manner to avoid undue delay in participating providers receiving payment.

(m) Develop and implement a program to publicize the plan's existence, the services covered, and how and where to obtain these services. All printed material shall be in language and in languages that plan members can understand.

(n) Develop a participation agreement for providers that includes, but is not limited to, all of the following:

(*i*) Agreement not to discriminate against plan members on the basis of race, sex, age, ethnicity, handicap, or income.

(*ii*) Agreement to honor plan members' rights.

(*iii*) Agreement to establish a means for plan members to gain access to their own medical records.

(o) Establish procedures under which members and providers may appeal decisions to an impartial body on issues of eligibility, medical necessity, and reimbursement amount.

(p) Provide an effective system of quality assurance and develop agreements with medical providers to establish protocols on peer review and medical provider discipline and provide technical assistance to providers to improve quality of care and establish a graduated system of disciplinary action to assist providers in improving quality of care.

(q) Provide a system to ensure the confidentiality of member identified records.

(r) With the department's assistance, file an annual report with the governor, the secretary of the senate, and the clerk of the house of representatives. The report shall summarize the activities of the plan in the preceding calendar year, including a financial report of money received, benefits paid, expenses of administration and other payments, and data on complaints received about the plan. The annual report shall be available to the public.

(s) Arrange for an independent, annual audit of plan operations.

(t) Conduct studies, as necessary, on remaining problems of access and steps necessary to address those problems; the efficacy of cost containment measures in the plan; the effectiveness of particular health tests or procedures; provider performance; plan member satisfaction; the general health of plan members; the effect of the plan on the need for nursing home care; whether the plan has affected employment opportunities of plan members; and on any other health plan related issue. All studies upon their completion shall be available to the public.

(u) Issue recommendations, as necessary, to the legislature for changes to this act and other state law, and to congress for changes in federal law, to improve access to health care, ensure health care quality, and control health care costs.

Sec. 8. The department shall do all of the following:

(a) Administer the plan. The department's goal in administering the plan shall be to provide comprehensive health care coverage for all plan members within the limits of dedicated revenues available, to ensure access to covered services for all members, and to ensure the quality of those services.

(b) Seek necessary waivers, execute agreements, and comply with requirements to enable all payments available under title XVIII, title XIX, and other federal health programs to be credited to the plan.

(c) Develop interdepartmental agreements with the departments of social services, mental health, transportation, education, including Michigan rehabilitation service and disability determination service, and with other appropriate departments and offices including the office of services to the aging to facilitate access to services under the plan.

(d) Promulgate rules pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, as necessary to implement this act.

Sec. 9. (1) The department is authorized to pay for all of the following out of plan funds:

(a) Member health care claims.

(b) Administrative expenses acquired under the plan.

(c) Capital expenditures of hospitals, nursing homes, community health centers, and migrant health centers, that may include construction, renovation, and equipment costs.

(d) Education aimed at health promotion and the prevention of illness or injury.

(e) Part or all of the education and training expenses of medical and nursing students and graduates in return for a commitment to practice in medically underserved areas in this state.

(f) Part or all of the malpractice premiums of participating providers upon conditions set by the plan.

(2) The plan may provide funds to county health departments to effect any plan goal.

Sec. 11. The department may do all of the following:

(a) Hire and supervise staff to work for the plan.

(b) Enter into contracts necessary or proper to carry out the provisions and purposes of this act.

(c) Contract for any of the tasks in section 8, or with the board's approval section 7, if such action is cost effective.

(d) Enter into contracts with plans in other states for coverage of emergency or urgent care of members while present in other states, and for coverage of residents of other states while present in this state.

(e) Pay for covered services received by a member in emergency or urgent situations while in another state.

(f) Pay for covered services received by a nonmember in emergency or urgent situations and seek reimbursement directly from the nonmember and through subrogation from a third party payer.

(g) Make loans to providers for start-up costs of an individual or group practice in medically underserved areas in this state.

(h) Invest plan funds as permitted by law.

Sec. 12. (1) The board shall establish in each local department of public health a community health planning committee.

(2) The community health planning committee shall be composed of 9 members providing proportionate representation from business, labor, health care providers, and consumers and consumer organizations in the community. Members shall be appointed by the bodies that appoint the director of the local department of public health and shall serve 3-year terms. A member shall not serve for more than 2 terms.

(3) The health planning committee shall assist the board in carrying out its functions under section 7. The health planning committee shall hold at least 2 public hearings each year to receive testimony from experts and the public on the status of health care, access to health care, and health care costs in the community.

(4) The health care planning committee shall present an annual report to the board and to the public summarizing the findings of its hearings and its meetings, detailing actions it has taken concerning health care access, quality, and costs in the community, and listing any recommendations it proposes for the coming year.

Sec. 13. (1) A physician, nurse specialist, or other eligible health care provider may become a participating provider by signing a participation agreement. A participating provider shall be eligible for reimbursement for covered services provided to a plan member that are within the scope of authorized practice of the individual or institution providing the services.

(2) The plan shall revoke the right of participation of any health care provider who loses his or her license as a health care provider or who is convicted of health care fraud.

Sec. 15. Each participating hospital, long-term care facility, community health center, and migrant health center shall negotiate with the plan for an annual budget based on past performance and projected changes in the number or scope of services. Requests for payment of capital costs shall be submitted separately through the certificate of need process.

Sec. 17. A participating provider that is not paid on a capitation basis or by global budget shall submit his or her accounts for payment of covered services performed for plan members directly to the plan for payment and shall look solely to the plan for payment of services rendered under the plan. Payment by the plan shall constitute payment in full for the service. A participating provider shall not collect from a plan member any money for a covered service rendered under the plan.

Sec. 19. The department shall design and maintain a system of processing claims to ensure that providers receive timely payment in the correct amount for allowable claims with a minimum of paperwork.

Sec. 21. Covered services shall include at least the following services if medically necessary and approved by a physician or appropriate professional:

(a) Professional services for health maintenance, prevention, diagnosis and treatment of injuries, illnesses, and conditions. Treatment shall include services for acute care, rehabilitation, and health maintenance.

(b) Ongoing community based support services, including personal assistance services and respite care.

(c) Rehabilitative services, including physical, occupational, and speech therapy to enable a member to recover and maintain health.

(d) Hospital services, including in-patient hospitalization for the treatment of mental and emotional disorders.

(e) Outpatient mental health services.

(f) Nursing home services.

(g) Services of a licensed hospice.

(h) Services of a home health agency.

(i) Services by a licensed ambulance or emergency medical treatment team.

(j) Dental services, including artificial teeth.

(k) Prenatal care, well child care, and immunizations.

(l) Diagnostic tests, including hearing and vision examinations.

(m) Prescription drugs.

(n) Blood and blood products, anesthetics, and oxygen.

(o) Orthoses and protheses.

(p) Eyeglasses, hearing aids, and rental or purchase of durable medical equipment.

(q) Diagnostic X-rays and laboratory tests.

Sec. 23. An insurance policy, certificate, or contract that provides reimbursement on an expense-incurred or indemnity basis for any service or services covered under the plan shall not be sold to a plan member.

Sec. 25. The plan shall be funded through an employee health care contribution, the health portions of worker's compensation and no-fault automobile insurance, a sales tax on services, and federal funds from existing mental health programs, public health programs, substance abuse programs, medicaid, and medicare.

Sec. 27. Each year the legislature shall appropriate to the plan the amount of all earmarked taxes, the amount of all federal funds for health care anticipated to be received, and additional funds the legislature shall consider appropriate. The earmarked taxes and federal funds shall not be appropriated by the state for other purposes.

Sec. 29. The plan shall begin operation on January 1, 1995.