HOUSE BILL No. 4741

May 11, 1993, Introduced by Reps. Bennane, Leland, Clack, Berman, Jondahl, Hollister, Wetters, Kilpatrick, Varga, Dobronski, Gire, Scott, Shepich, Wallace, Gubow, Olshove, Yokich, Freeman, Emerson, Ciaramitaro, Baade, Harder, DeMars, Harrison, Griffin, Brown, Porreca, Hood, Stallworth, Rivers, Mathieu, Byrum, Barns, Jacobetti, Gagliardi and Owen and referred to the Committee on Public Health.

A bill to establish a Michigan health access program; to require residents of this state to enroll in the program; to create a state health commission; to establish a standard health care benefit package; to provide for implementation of the standard health care benefit package; to create health insurance purchasing cooperatives; to create the Michigan health data subcommittee; to provide for the submission and collection of certain health care data; to provide for global budgeting; to create the Michigan health care catastrophic pool; to prescribe the powers and duties of certain state agencies and departments; to create a joint committee of the legislature; 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 access program 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 Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws.

(b) "Catastrophic health care pool" means the Michigan catastrophic health care pool created in section 41.

(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 or health care coverage, certified pursuant to section 25, and that provides the standard health care benefit package established in section 11 to residents in exchange for a prescribed premium or fee.

(d) "Commission" means the state health commission created in section 7.

(e) "HIPC" means a health insurance purchasing cooperative created in section 21.

(f) "Local health department" means that term as defined in section 1105 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.1105 of the Michigan Compiled Laws.

(g) "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.

(h) "Pool" means the Michigan health care catastrophic pool created in section 41.

(i) "Program" means the Michigan health access program created in section 5.

(j) "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.

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

(*l*) "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 health access program and who is less than 65 years of age.

(m) "Standard health care benefit package" means the standard health care benefit package created in section 11.

(n) "Subcommittee" means the Michigan health data subcommittee created in section 31.

(o) "Substance abuse treatment" means intermediate and outpatient care for substance abuse pursuant to the following:

(*i*) Charges, terms, and conditions for the services required to be provided under this subdivision shall not be less favorable than the maximum prescribed for any other comparable service.

(*ii*) The services required to be provided under this subdivision shall not be reduced by terms or conditions which

apply to other services in a contract, group or individual. This subparagraph shall not be construed to prohibit contracts that provide for deductibles and copayment provisions for services for intermediate and outpatient care for substance abuse.

(*iii*) The services required to be provided under this subdivision shall, at a minimum, provide for up to $1,656.00 in services for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(*iv*) As used in this subdivision, "intermediate care", "outpatient care", and "substance abuse" have those meanings ascribed to them in section 3425 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.3425 of the Michigan Compiled Laws.

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

(2) Each resident of this state who is not covered by medicare or a plan under section 27 that provides at least the standard health care benefit package 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 state health commission is created within the department of management and budget.

(2) The commission shall consist of 7 members, 3 of whom shall be appointed by the governor, 2 by the senate majority leader, and 2 by the speaker of the house of representatives.

(3) The members first appointed to the commission shall be appointed within 90 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, 1 shall serve for 2 years, 2 shall serve for 3 years, and 3 shall serve for 4 years.

(5) If a vacancy occurs on the commission, the appointing entity for the vacated position 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 appointing entity 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 120 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 package for all residents of this state pursuant to section 11.

(b) Establish the premium or fee pursuant to section 13 for each region that the commission will pay for the standard health care coverage benefit package.

(c) Provide health care planning for this state.

(d) Develop incentives to encourage a greater focus on primary care in graduate medical education facilities to increase the number of medical residents in primary care training.

(e) Approve regional and state report data from the subcommittee.

(f) Use the data collected by the subcommittee to implement quality, cost, and access requirements in certified plans, to establish health research projects, and to formulate practice guidelines for health care procedures.

(g) Determine a global budget for health care in each region based on data provided and recommendations made by the subcommittee.

(h) Select a generally accepted accounting system and require its use in each region and certified plan for all state health care expenditures.

(i) Provide for open enrollment schedules for each region, including permitting open enrollment at any time for new state residents, newborns, adoptions, foster child placements, and individuals who change regional residency, and provide for rules permitting a person to change health care plans outside an open enrollment period for good cause.

(j) Prepare a biennial report on quality, cost, access, and accountability in the state's health care delivery system based on data collected by the subcommittee and provide the report to the public through the public library system or any other means considered appropriate and to the senate and house of representatives standing committees on health and insurance issues.

(k) Determine the appropriate utilization of local health departments for health care delivery in each region.

Sec. 11. (1) The commission shall establish a standard health care benefit package that provides coverage, without a lifetime limit. The standard health care benefit package for comprehensive medically necessary health care, including primary and preventive care, shall provide for all of the following:

(a) Inpatient and outpatient hospital services.

(b) Physician services.

(c) Preventive health care programs.

(d) Home health services.

(e) Emergency health services including ambulance services.

(f) Diagnostic laboratory and diagnostic and therapeutic radiological services.

(g) Mental health services.

(h) Health screenings.

(i) Substance abuse treatment.

(j) Long-term care including nursing home services.

(k) Vision care.

(l) Dental care.

(m) Prescription drugs.

(n) Rehabilitative services.

(2) In the biennial report prepared pursuant to section 9(j), the commission shall list what, if any, coverages provided for in subsection (1) should be expanded or added.

Sec. 13. (1) A certified plan wishing to provide the standard health care benefit package to residents in a region shall submit to the commission the cost for which it will provide the standard health care benefit package. The commission shall

examine the cost submitted by each certified plan in a region, shall examine the demographics and health status of individuals in the region, and shall determine the cost it will pay for the standard health care benefit package in each region. The commission shall establish a reimbursement mechanism that emphasizes primary care and the delivery of health care services in underserved areas. The cost of the standard health care benefit package in each region shall be limited by the global budget for the region as recommended by the subcommittee under section 33 and as determined by the commission. A plan may charge more than the state reimbursement amount but additional costs will be paid by the enrollee, the enrollee's employer, or any other available funding source.

(2) The commission shall provide and each HIPC shall reimburse each certified plan in its region the amount determined by the commission under subsection (1). A certified plan that charges more than the HIPC reimbursable amount shall collect the additional cost from the enrollee, the enrollee's employer, or any other available funding source.

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

(4) If 1 corporation or other entity that provides 1 or more certified plans in a region that has 2 or more certified plans operating in the region has a total enrollment of 70% of the

residents in the region, the commission shall prohibit any new enrollees in that plan pending a determination by the commission as to what changes are necessary in the region's allocated reimbursement level to allow more competition to exist in the region.

Sec. 15. The commission shall reimburse inpatient hospital capital-related costs pursuant to the standards required under medicare.

Sec. 17. The commission may hire an executive director. The executive director's position is unclassified. The executive director may hire employees and consultants as authorized by the commission and with the approval of the department of management and budget and may prescribe their duties. The attorney general shall provide legal services to the commission.

Sec. 19. The commission shall promulgate rules pursuant to the administrative procedures act of 1969 to implement its powers and duties under this act and to provide for an informal conference procedure. The informal conference procedure shall provide for a complaint and appeals process and shall afford a hearing to any resident who believes that the commission, an HIPC, or a certified plan has violated, is violating, or is threatening to violate any provision of this act or a rule promulgated under this act.

ARTICLE 2

Sec. 21. (1) A health insurance purchasing cooperative 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, Sanillac, 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, Barraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties.

(2) Each HIPC shall be governed by a 5-member board, 3 of whom shall be appointed by the governor, 1 appointed by the senate majority leader, and 1 appointed by the speaker of the house of representatives.

(3) The members first appointed to each HIPC shall be appointed within 120 days after the effective date of this act.

(4) Members of each HIPC 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, 1 shall serve for 2 years, 1 shall serve for 3 years, and 2 shall serve for 4 years.

(5) If a vacancy occurs on an HIPC, the appointing entity for the vacated position 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 HIPC position.

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

(7) The first meeting of each HIPC shall be called not later than 120 days after the effective date of this act. At the first meeting, each HIPC shall elect from among its members a chairperson and other officers as it considers necessary or appropriate.

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

(9) The business that the HIPC may perform shall be conducted at a public meeting of the HIPC 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 HIPC 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) An HIPC membership shall be a full-time paid unclassified position within the department of management and budget.

Sec. 23. Each HIPC 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 package based on the commission authorized reimbursement level.

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

(c) Provide monthly payments for standard health care benefit packages to certified plans and to plans under section 27.

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

(e) Establish criteria under which managed competition may occur.

(f) Monitor and collect data for the subcommittee on quality, cost, access, and accountability of health care in the region.

(g) Provide information to consumers in the region through the public library system and through other means considered appropriate by the HIPC on the availability of certified plans.

(h) Provide for a toll-free telephone number that residents of the region can access during normal business hours to obtain information on health care.

(i) Research health care outcomes and health care practice guidelines.

(j) Investigate complaints on the delivery of health care for residents of the region and refer complaints that cannot be satisfied to the complaint and appeals process developed pursuant to section 19.

(k) Provide a review and penalty system for health care plans that are certified but that are having problems with quality, cost, access, or accountability. Penalties would include prohibiting new enrollees, decreasing state payments, permitting enrollees to switch plans at any time, and, if there is a threat to public health or safety, revoking the plan's certification.

(l) Provide consumers with information on open enrollment periods and the right to cancel or change certified plans.

(m) Recommend that the commission sanction voluntary agreements between providers in the region that will improve quality, access, or affordability of health care but might constitute a violation of antitrust laws if undertaken without government direction.

(n) Make recommendations to the commission regarding major capital expenditures or the introduction of expensive new

technologies and medical practices that are being proposed or considered by providers in the region.

(o) Undertake voluntary activities to educate consumers, providers, and purchasers or to promote voluntary, cooperative community cost containment, access, or quality of care projects.

(p) Make recommendations to the commission regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(q) Make recommendations under this subsection to the commission in the form of an annual regional plan beginning June 30, 1996.

Sec. 25. Each HIPC shall only certify a health care plan that meets all of the following:

(a) Is able to deliver the standard health care benefit package 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 health status and without individual medical underwriting, preexisting condition exclusions, or waiting periods.

(d) Agrees to use community rating.

(e) Agrees to provide coverage for standard health care benefits as defined in section 11 of up to $100,000.00 in a calendar year for each enrollee.

Sec. 27. A health plan regulated pursuant to the employee retirement income security act of 1974, Public Law 93-406, 88

Stat. 829 that provides the standard health care benefit package to its members shall receive reimbursement for the standard health care benefit package pursuant to section 13.

Sec. 29. Upon request of an HIPC, 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. (1) The Michigan health data subcommittee is created within the department of management and budget.

(2) The subcommittee shall consist of 15 members appointed to ensure gender balance and to ensure that geographic areas of the state are represented in proportion to their population. The subcommittee shall be appointed as follows:

(a) Two members representing certified plans who shall be appointed by the governor.

(b) Six members representing health care providers who shall be appointed by the governor, including 1 member representing hospitals, 1 member representing physicians practicing in urban areas, 1 member representing physicians practicing in rural areas, 1 member representing registered professional nurses, and 2 members representing providers other than hospitals, physicians, and nurses.

(c) Two members representing employers who shall be appointed by the governor, including 1 member who represents employers with fewer than 100 employees and 1 member who represents other employers.

(d) Three consumer members, 1 of whom shall be appointed by the governor, 1 of whom shall be appointed by the senate majority leader, and 1 of whom shall be appointed by the speaker of the house of representatives.

(e) Two members representing labor unions who shall be appointed by the governor.

(3) The subcommittee includes the director of public health or his or her designee, the director of commerce or his or her designee, and the director of the department of labor or his or her designee.

(4) A member representing employers, consumers, or employee unions shall not have any personal financial interest in the health care system, except as an individual consumer of health care services. An employee who participates in the management of a health care payment or benefits plan may serve as a member representing employers or labor unions.

(5) A member shall not participate or vote in subcommittee proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the subcommittee's proceedings other than as an individual consumer of health care services.

(6) Pursuant to section 7 of Act No. 170 of the Public Acts of 1964, being section 691.1407 of the Michigan Compiled Laws, a member of the subcommittee is not civilly liable for an act or omission by that person if the act or omission was within the scope of the member's responsibilities under this act.

(7) The members first appointed to the subcommittee shall be appointed within 90 days after the effective date of this act.

(8) Appointed members of the subcommittee 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.

(9) If a vacancy occurs on the subcommittee, the appointing entity for the vacated position shall make an appointment for the unexpired term in the same manner as the original appointment.

(10) The appointing entity may remove a member of the subcommittee for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

(11) The first meeting of the subcommittee shall be called not later than 120 days after the effective date of this act. At the first meeting, the subcommittee shall elect from among its members a chairperson and other officers as it considers necessary or appropriate.

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

(13) The business that the subcommittee may perform shall be conducted at a public meeting of the subcommittee 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.

(14) A writing prepared, owned, used, in possession of, or retained by the subcommittee 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.

(15) A member of the subcommittee is not entitled to compensation for serving as a member, but the director may reimburse a member for expenses incurred while carrying out his or her duties under this act, pursuant to the standardized travel regulations of the department of management and budget.

Sec. 33. (1) The subcommittee shall recommend to the commission an annual limit on the rate of growth of public spending on health care services for residents of this state. The subcommittee shall recommend a limit on annual growth that does not exceed the gross domestic product. The subcommittee shall recommend a limit at a rate that is achievable through good faith and the cooperative efforts of health care consumers, purchasers, and providers.

(2) For purposes of setting limits under this section, the subcommittee shall collect from each provider in the state data on revenue received from patients during a time period specified by the subcommittee. Each provider doing business in the state shall provide the data requested by the subcommittee at the times and in the form specified by the subcommittee. The department of commerce and the department of public health shall cooperate fully with the subcommittee in achieving compliance with the reporting requirements of this section. As provided in sections

16221 and 20165 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16221 and 333.20165 of the Michigan Compiled Laws, intentional failure to provide reports requested under this section is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider.

(3) If a provider refuses to provide a report or information required under this section, the subcommittee may obtain a court order requiring the provider to produce documents and allowing the subcommittee to inspect the records of the provider for purposes of obtaining the information required under this section.

(4) The data received by the subcommittee under this section is confidential, is not public information, and is not 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. The commission shall promulgate rules that require data provided to the subcommittee to be in a form that does not identify individual patients, employers, purchasers, or other persons, except with the written permission of the affected person.

Sec. 35. The subcommittee shall do all of the following:

(a) Establish recommended statewide and regional limits on growth in total health care spending under this act, monitor regional and statewide compliance with the limits, and take action to achieve compliance to the extent authorized by this act.

(b) Provide technical assistance to each regional HIPC.

(c) Monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure an appropriate level of quality.

(d) Monitor and promote the development and implementation of practice parameters.

(e) Assist regions, providers, certified plans, employers, employees, and consumers in improving the affordability, quality, and accessibility of health care.

Sec. 37. (1) By January 15, 1995, the subcommittee shall submit to the commission for approval a plan, with as much detail as possible, for slowing the growth in health care spending to the growth rate recommended by the subcommittee for the 1992-93 fiscal year. The goal of the plan shall be to reduce the growth rate of health care spending, adjusted for population changes, so that it does not exceed the gross domestic product.

(2) In developing the plan required under subsection (1), the subcommittee shall consider the advisability and feasibility of all of the following options, but is not required to incorporate them into the plan:

(a) Data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or actuarially adjusted average per capita rates that reflect the demographics of the state or of a region.

(b) Methods of adjusting spending limits to account for patients who are not state residents, to reflect care provided to

a person outside the person's region, and to adjust for demographic changes over time.

(c) Methods that could be used to monitor compliance with the spending limits.

(d) Criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits.

(e) Methods that could be used to help providers, certified plans, consumers, and communities control spending growth.

(f) Methods of identifying activities of consumers, providers, or certified plans that contribute to excessive growth in spending.

(g) Methods of encouraging voluntary activities that will help keep spending within the limits.

(h) Methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements.

(i) Methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the subcommittee.

(j) Methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments.

(k) Methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable

provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services.

(*l*) Methods of imposing mandatory requirements relating to the delivery of health care, such as practice parameters, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers.

(m) Methods of preventing unfair health care practices that give a provider or certified plan an unfair advantage or financial benefit or that significantly circumvent, subvert, or obstruct the goals of this act.

(n) Methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care.

ARTICLE 4

Sec. 41. (1) The Michigan health care catastrophic pool is created within the department of treasury.

(2) Health care expenditures for a resident that exceed $100,000.00 in a calendar year shall be paid by the HIPC in the region where the resident resides from the pool.

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

ARTICLE 5

Sec. 51. (1) The joint legislative committee on health care access is created and, except as otherwise provided in this subsection, consists of 5 members of the senate and 5 members of the house of representatives appointed in the same manner as standing

committees are appointed for terms of 2 years. The joint legislative committee on health care access shall include 3 members of the majority party and 2 members of the minority party from each house. If the political parties are evenly split in either house of the legislature, the joint legislative committee on health care access consists of 6 members of the senate and 6 members of the house of representatives appointed in the same manner as standing committees are appointed for terms of 2 years. The house in which the political parties are not evenly split shall include 4 members from the majority party and 2 members from the minority party. The house in which the political parties are evenly split shall include 3 members from each party.

(2) The joint legislative committee on health care access may review the activities of the commission, each HIPC, the subcommittee, and all other state agencies involved in the implementation and administration of this act, including efforts to obtain federal approval through waivers and other means.

Sec. 53. The commission, each HIPC, and the subcommittee shall report on their activities under this act annually and at other times at the request of the joint legislative committee on health care access.