SENATE BILL No. 814

January 17, 1996, Introduced by Senator A. SMITH and referred to the Committee on Health Policy and Senior Citizens.

A bill to establish a health benefit plan; to establish a universal health care insurance fund; to provide for employer, employee, and state contributions to the fund; to establish an advisory board; to prescribe the powers and duties of certain state agencies, departments, and persons; to provide standards, requirements, and certification for certain insurers; and to prescribe penalties.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

ARTICLE 1

Sec. 1. This act shall be known and may be cited as the "universal health care insurance and safety net act".

Sec. 2. 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) "Advisory board" means the board created in section 21.

(c) "Child" means an individual less than 18 years of age or if a full-time student, less than 23 years of age.

(d) "Commissioner" means the commissioner of insurance.

(e) "Director" means the director of the department of public health.

(f) "Employee" means an individual employed by an employer for 17-1/2 or more hours per week who is not a temporary employee.

(g) "Employee's family" means the spouse and children of an employee.

(h) "Employer" means a person who employs in 1996 through 2001, an average of 10 or more individuals; in 2002 through 2007, 7 or more individuals; and in 2008 and thereafter, 4 or more individuals for 17-1/2 or more hours per week and who is required to pay the individuals it employs the minimum wage prescribed by section 6 of the fair labor standards act of 1938, chapter 676, 52 Stat. 1062, 29 U.S.C. 206, or would be required to pay the minimum wage but for section 3(s) or section 13(a) of the fair labor standards act of 1938, chapter 676, 52 Stat. 1060 and 1067, 29 U.S.C. 203 and 213.

(i) "Health benefit plan" means a plan as described in article 2 that provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

(j) "Health insurance zone" means the county or counties participating in a universal health care insurance fund under article 3.

(k) "Indemnity plan" means a health benefit plan that makes payment with respect to items and services furnished by a provider with a certificate of authority in this state to provide the items and services if the provider is a type of provider covered under the plan, the provider is not excluded from receiving payment under the plan on the basis of fraud, abuse, or incompetence, and the plan does not differentiate in payment to providers under the plan based on a contractual arrangement or lack of a contractual arrangement between the plan and the provider, and under which an individual incurs an obligation or makes payment for a covered item or service and the plan reimburses the individual or the provider of the services for the amounts payable for the item or service under the plan.

(*l*) "Managed-care plan" means a health maintenance organization, preferred provider, or other health benefit plan under which items or services must generally be furnished either by providers having a contractual relationship with the plan or providers included on a list specified by the plan.

(m) "Medicaid recipient" means an individual eligible to receive medical services under the medical assistance program administered under the social welfare act, Act No. 280 of the Public Acts of 1939, being sections 400.1 to 400.119b of the Michigan Compiled Laws.

(n) "Monthly actuarial rate" means, with respect to a health benefit plan in a plan year, the average monthly per enrollee amount that the employer providing the plan estimates, for enrollees under the plan during the year, would be necessary to pay for the total benefits required under the plan during the year, including administrative costs for the provision of the benefits and an appropriate amount for a contingency margin.

(o) "Person" means an individual, corporation, partnership, firm, organization, or association.

(p) "Taxable income" means that term as defined in section 28 of the income tax act of 1967, Act No. 281 of the Public Acts of 1967, being section 206.28 of the Michigan Compiled Laws.

(q) "Temporary employee" means an individual employed by a temporary help services firm who is assigned to perform duties for a person and who is not assigned to perform and complete 300 hours or more of service for a temporary help services firm on behalf of 1 or more persons in a period of 6 consecutive months.

(r) "Temporary help services firm" means a person engaged in the business of furnishing temporary employees for another person.

(s) "Universal health care insurance fund" means a fund established under section 40.

Sec. 3. (1) An employer's employee and the employee's family shall be provided with a health benefit plan pursuant to this act.

(2) Subsection (1) does not apply to an employer who provides its employees with a health benefit plan that is actuarially equivalent as determined by the commissioner to the health benefit plan provided for in article 2.

Sec. 4. (1) An employer who does not provide a health benefit plan that is actuarially equivalent to the health benefit plan provided for in this act shall do all of the following:

(a) Contribute to the universal health care insurance fund collected as part of the withholdings of employees for payroll taxes in the insurance zone where the employee is employed an amount equal to 3% of each of its employee's taxable incomes.

(b) Contribute to the universal health care insurance fund in the insurance zone where the employee is employed by withholding from each employee who is not a participant in a health benefit plan an amount equal to 3% of the employee's taxable income.

(2) The amounts paid by the employer and withheld on behalf of an employee under this section shall accrue on the last day of the month in which they are withheld and shall be returned and paid to the universal health care insurance fund by the employer within 15 days after the end of the month in the same manner as other payroll taxes.

(3) An employer required by this section to pay an amount and withhold an amount holds the amount withheld as a trustee for the universal health care insurance fund and is liable for the payment thereof to the universal health care insurance fund and is not liable to any individual for the amount of the payment.

Sec. 5. For each employee whose employer pays an amount and withholds an amount under section 4, the state shall pay to the universal health care insurance fund in the insurance zone where the employee is employed an amount equal to 3% of the employee's taxable income.

Sec. 6. For each medicaid recipient who resides in an insurance zone, the state shall pay to the universal health care insurance fund located in that insurance zone an amount equal to 9% of the average taxable income paid for an employee in the county whose employer pays an amount and withholds an amount under section 4.

Sec. 7. (1) An employer who violates this act by not contributing or by failing to withhold under section 4 is subject to a civil fine of not more than 10% of the total amount of the employer's expenditures for wages for employees in that year, in addition to an assessment to cover all back contributions of the employee, employer, and the state without a right to contribution.

(2) A civil fine under this section shall be assessed by the director. The director shall not assess a civil fine on an employer until the employer has been given notice and an opportunity to present its views.

(3) In determining the amount of the civil fine, the director shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of noncompliance by the director.

(4) An employer that knowingly does not comply with section 3 or section 4 shall be liable for damages including health care costs incurred to the employee or the employee's family resulting from the failure to comply.

(5) An individual injured or adversely affected or aggrieved by a violation of the requirements of this act may bring an action to enjoin the violation or to compel compliance. In a judicial proceeding under this subsection, the court, in its discretion, may allow the party bringing the action a reasonable attorney's fee as part of costs if the party substantially prevails. At least 15 days before the date a party brings an action under this subsection, the party shall give notice by registered mail to the director and the attorney general. The notice shall state the nature of the alleged violation and the court in which the action will be brought.

Sec. 8. (1) Except as otherwise provided, an employee may not waive his or her enrollment in a health benefit plan or his or her family's enrollment in a health benefit plan under this act.

(2) An employee may waive enrollment in a health benefit plan for his or her spouse or child under this act if the spouse or child is covered under a health benefit plan due to the employment of the spouse or the child's other parent.

(3) A child employee may waive enrollment in a health benefit plan under this act if the child is covered under a health benefit plan due to the employment of the child's parent.

(4) An employee who works 17-1/2 hours or more of service per week for 2 employers may waive enrollment in a health benefit plan of 1 of the employers.

(5) An employer may not fail or refuse to hire, discharge, or otherwise discriminate against any individual who has a spouse or child because the employer is required to comply with this act.

ARTICLE 2

Sec. 20. (1) A health benefit plan shall do all of the following:

(a) Provide benefits for items and services pursuant to section 22.

(b) Provide coverage of employees and employees' families enrolled in the plan pursuant to section 24.

(c) Provide for premiums, deductibles, copayments, and coinsurance pursuant to section 27.

(2) A health benefit plan meets the requirements of this article notwithstanding that it does not meet 1 or more requirements of section 22 if the actuarial benefits under the plan are not less than the actuarial benefits that would have applied if the plan met the requirements described in subsection (1).

(3) Notwithstanding any other provision of law, a health benefit plan may meet the requirements of section 22(1)(e) by including payment for any combination of benefits specified in section 22(1)(e) if the plan includes payment for benefits that are actuarially equivalent to the benefits for which payment is

required and if the plan provides both types of benefits described in section 22(1)(e).

Sec. 21. (1) The commissioner shall establish an advisory board to advise the director on the development of actuarial equivalency standards and other matters relating to the administration of this act.

(2) The board shall consist of 10 members appointed by the commissioner as follows:

(a) Four members representing employers, who shall be experienced in the administration of and knowledgeable about health insurance and shall be actively engaged in the management or design of health insurance programs.

(b) Two members representing labor organizations, who shall be experienced in the administration of and knowledgeable about health insurance and shall be actively engaged in the management or design of health insurance programs.

(c) Two members representing the insurance industry, at least 1 of whom shall be knowledgeable about small group policies.

(d) Two members who are actuaries, experienced in the administration of and knowledgeable about health insurance programs.

(3) Members of the board shall serve for a term of 4 years, except that members first appointed shall serve for staggered terms, as designated by the commissioner. A member may serve on the board after the expiration of the term of the member until a successor has taken office as a member of the board.

(4) The members of the board shall receive per diem expenses and compensation as established by the legislature and shall be entitled to receive actual and necessary travel expenses.

(5) The board shall develop and transmit to the director all of the following:

(a) At least 3 model health plans that are actuarially equivalent to the minimum health benefit plan required under this act.

(b) A table of actuarial equivalency describing permitted variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under an optional, enhanced health benefit plan as a percentage increase or decrease in the minimum plan, with the table describing as many variations as possible in order to facilitate compliance with this act.

(c) Recommendations for procedures to facilitate the process by which an employer may certify actuarial equivalency for plan variations not provided in the model health benefit plans or the table of actuarial equivalency and for certification of multiple plans offered by the same employer.

(6) The board shall review proposed changes and options to the health benefit package required in the minimum plan and options such as vision, dental, and prescriptions and transmit a cost benefit analysis of the changes or options, along with recommendations, to the director and to the legislature.

(7) The director shall publish a table that describes variations in covered services, copayments, deductibles, limits

on out-of-pocket expenses, and an employer's share of the premium or premiums under an optional, enhanced health benefit plan as a percentage increase or decrease in the minimum plan. The table shall describe as many variations as feasible. In developing the table, the director shall consider the recommendations of the board.

(8) If a health benefit plan provides variations not expressly provided for in the table or if the 1 or more elements of covered services, copayments, deductibles, and limits on out-of-pocket services are given a different relative value by a health benefit plan administrator than is provided by the table, the plan shall not be considered out of compliance with this act if the plan has established actuarial equivalency by a good faith process and has been certified as actuarially equivalent by an actuary meeting credentials established by the American academy of actuaries or by the director.

(9) A health benefit plan shall be considered out of compliance with this act if the director has found the plan not to be in compliance. If the plan is found not to be in compliance, a penalty shall not be levied against the plan for the prior period of noncompliance if the plan complies with subsection (8).

(10) The director shall establish rules pursuant to the administrative procedures act of 1969 that provide for a streamlined procedure for an employer that has multiple health plans, at least 1 of which has been certified as at least actuarially equivalent, for the approval of an additional health plan that is at least actuarially equivalent to the certified plan.

(11) For purposes of this section, "actuarial benefits" means the amount by which the total of the amounts payable as benefits under a health benefit plan exceed the amount of the premiums, deductibles, copayments, and coinsurance payable by the employee under the plan, as determined on an actuarial basis per enrollee for a plan year.

Sec. 22. (1) A health benefit plan shall include payment for all of the following:

(a) Inpatient and outpatient hospital care.

(b) Inpatient and outpatient physician services.

(c) Diagnostic and screening tests.

(d) Prenatal care and well-baby care provided to children who are 1-year old or younger.

(e) Optional mental health care if elected as follows:

(*i*) Inpatient hospital care for a mental disorder for not less than 45 days per year except that days of inpatient care may be substituted for days of partial hospitalization according to a ratio established by the director.

(*ii*) Outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a physician, a licensed or certified clinical psychologist, a certified social worker, or other licensed or certified mental health professional or licensed or certified clinic or center providing mental health services.

(2) A health benefit plan is not required to provide payment for items and services that are not medically necessary or that are experimental services and procedures.

Sec. 23. The director shall prescribe and annually revise a schedule specifying the amount, duration, and scope of well-baby care required under section 22(1)(d).

Sec. 24. Coverage for an employee and the employee's family enrolled under a health benefit plan provided by an employer under this act shall begin not later than the latest of the following:

(a) Thirty days after the day on which the employee first performs an hour of service as an employee of that employer.

(b) The first day on which the employer is required to meet the requirements of this act.

Sec. 25. A health benefit plan under this act may not exclude or otherwise limit an individual from coverage under the plan on the basis that the individual has, or at any time has had, any disease, disorder, or condition.

Sec. 26. A temporary employee shall become eligible for coverage under a health benefit plan of a temporary services firm on the first day of the first calendar month following the completion of 320 hours of service during a period of 6 consecutive months if employed by the employer on the eligibility date and shall be eligible for continued coverage under this act in each calendar month following the month of initial coverage, if the employee has completed at least 70 hours of service in the immediately preceding calendar month and has not been terminated before the first day of the calendar month.

Sec. 27. (1) A health benefit plan may require an employee enrollee to pay for premiums, deductibles, and coinsurance

amounts for coverage under the plan, but only if the premiums, deductibles, copayments, and coinsurance do not exceed the limitations imposed under this section.

(2) A health benefit plan may not require an employee to pay a premium for coverage for a period of longer than 1 month or to pay a premium the amount of which on a monthly basis exceeds 3% of the employee's hourly wage.

Sec. 28. A health benefit plan may provide for the optional premiums to be applied and the monthly actuarial rate to be computed separately for employees without a family and for employees with a family, and with respect to employees with a family, to be computed separately for employees who have a spouse and children, for employees who have a spouse but no children, and for employees who do not have a spouse but have children. However, the basic insurance program shall be extended to every child of an employee, and no employer shall discriminate against any individual who has dependents from participating in the program or employment.

Sec. 29. (1) Except as permitted under subsection (3), a health benefit plan may not provide, for benefits provided in any plan year, for a deductible amount that exceeds the following:

(a) For benefits payable for items and services furnished to an employee with no family member enrolled under the plan, for a plan year beginning in the first calendar year that begins more than 1 year after the date of the enactment of this act, $150.00, or for a subsequent calendar year, the limitation of deductions specified in this subdivision for the previous calendar year

increased by the percentage increase in the Detroit consumer price index for the 12-month period ending on September 30 of the preceding calendar year.

(b) For benefits payable for items and services furnished to an employee with a family member enrolled under the plan, for a plan year beginning in the first calendar year that begins more than 1 year after the date of the enactment of this act, $250.00, or for a subsequent calendar year, the limitation of deductions specified in this subdivision for the previous calendar year increased by the percentage increase in the Detroit consumer price index for the 12-month period ending on September 30 of the preceding calendar year.

(2) A health benefit plan may not provide, for benefits provided in any plan year, for a deductible amount for prenatal care or well-baby care described in section 22(1)(d).

(3) A health benefit plan may provide for another deductible amount instead of the limitations under subsection (1)(a) if the amount does not exceed, on an annualized basis, 1% of the total wages paid to the employee in the plan year, or for another deductible amount instead of the limitations under subsection (1)(b) if the amount does not exceed, on an annualized basis, 2% of the total wages paid to the employee in the plan year.

Sec. 30. (1) Except as otherwise provided in this section, a health benefit plan shall not require payment of any copayment or coinsurance for an item or service for which coverage is required by this act in an amount that exceeds 10% of the cost of the item or service, require payment of any copayment or

coinsurance for prenatal care or well-baby care described in section 22(1)(d), or require payment of any copayment or coinsurance for items and services required under section 22 furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit.

(2) If a health benefit plan establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under subsection (1) for items and services furnished by nonparticipating providers.

(3) A health benefit plan may provide for copayment or coinsurance in excess of the amount permitted under subsection (1) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

(4) For care provided under section 22(1)(e)(*ii*), a health benefit plan may not require payment of any copayment or coinsurance for an item or service for which coverage is required by this act in an amount that exceeds 50% of the cost of the item or service.

(5) A health benefit plan under this act may provide for an out-of-pocket limit other than that defined in subsection (6)(b) if, for a plan year with respect to an employee and the employee's family, the limit does not exceed, on an annualized

basis, 10% of the total wages paid to the employee in the plan year.

(6) As used in this section:

(a) "Out-of-pocket expenses" means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and the employee's family covered under the plan.

(b) "Out-of-pocket limit" means for a plan year beginning in the first calendar year that begins more than 1 year after the effective date of this act, $1,000.00, or for a subsequent calendar year, the out-of-pocket limit of $1,000.00 for the previous calendar year increased by the percentage increase in the Detroit consumer price index for the 12-month period ending on September 30 of the preceding calendar year.

ARTICLE 3

Sec. 40. There is created within each health insurance zone a universal health care insurance fund. The universal health care insurance fund shall receive the amounts described in section 4(1) and sections 5 and 6 and may accept other grants, gifts, and funds.

Sec. 41. The universal health care insurance fund shall be operated by a board of directors in each insurance zone composed of the following 9 members:

(a) Three members elected by employers contributing to the fund under section 4(1)(a).

(b) Three members elected by employees contributing to the fund under section 4(1)(b) and by the medicaid recipients benefited by the universal health care insurance fund in the insurance zone.

(c) Two members appointed by the county board of commissioners, or if a charter county, by the county executive in the county or counties in the health insurance zone.

(d) One member who shall serve as chair of the board of directors selected by the director of the department of public health, and appointed by the governor with the advice and consent of the senate.

Sec. 43. A county with a population of less than 500,000 residents may agree to form a universal health care insurance fund in an insurance zone with another county or counties. A universal health care insurance fund in an insurance zone that consists of more than 1 county shall be operated by a board of directors composed of the members listed in section 41, except that if 2 counties participate, each county shall have a total of 6 members with 2 members elected under section 41(a), 2 members elected under section 41(b), and 2 members appointed under section 41(c), and if 3 or more counties participate, each county shall have a total of 3 members with 1 member elected under section 41(a), 1 member elected under section 41(b), and 1 member appointed under section 41(c).

Sec. 44. The board of directors of the universal health care insurance fund shall do all of the following:

(a) Select, monitor, and oversee the insurance providers participating in providing service for the universal health care insurance fund in the insurance zone.

(b) Designate hospitals, clinics, and providers eligible to participate in providing services for the universal health care insurance fund in the insurance zone.

(c) Evaluate and make recommendations concerning coverage and programs being offered by the universal health care insurance fund in the insurance zone.

Sec. 45. The commissioner shall establish procedures for the periodic certification of participating insurers in a universal health care insurance fund. To be certified as an insurer under this article, the applicant shall do all of the following:

(a) Meet standards of financial stability established by the commissioner.

(b) Meet standards for quality and type of services established by the commissioner.

(c) Meet the requirements of section 47.

(d) Agree to enroll any group in the state applying for enrollment that is eligible to enroll with a participating insurer.

(e) Agree to offer only plans and plan options approved by the commissioner to organizations required to enroll with a participating insurer.

(f) Agree that if it offers a managed care program to an organization within the state, it will also make that managed

care program, with benefits packages meeting the requirements of section 47, available in its capacity as participating insurer.

(g) Agree to allow its offerings to be listed in material distributed by the commissioner, described in a form as the commissioner may prescribe, and to enroll persons who wish to enroll by mail by accepting a completed form to be contained in the material.

Sec. 46. (1) To be certified as a participating insurer in a universal health care insurance fund, the insurer shall submit to the commissioner an application for certification. The application shall include the following:

(a) Specific descriptions of each of the health benefit plans the insurer proposes to offer under section 47 as a participating insurer.

(b) Information as is needed for the commissioner to consider the items described in subsection (2).

(2) In reviewing applications for certification as participating insurers, the commissioner shall consider all of the following:

(a) The price of health benefit plans proposed to be offered by the applicant.

(b) The quality and types of services to be provided under the plans.

(c) The experience of the applicant in providing and managing health benefit plans.

(d) The financial stability of the applicant.

(3) Not later than 1 year after the effective date of this act, the commissioner shall certify participating insurers for each universal health care insurance fund. The commissioner shall publish in the Michigan register a list of the participating insurers certified under this section.

(4) The commissioner shall periodically evaluate the performance of participating insurers under this act. If the commissioner finds that a participating insurer is not substantially meeting this act's requirements, the commissioner, after notice and opportunity for a hearing, may terminate the certification of the insurer.

Sec. 47. (1) A participating insurer shall offer to employers located in its health insurance zone either of the following:

(a) Two indemnity plans, 1 of which provides only the minimum benefits required of a health benefit plan under this act and the other which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the health insurance zone.

(b) Two managed-care plans, 1 of which provides only the minimum benefits required of a health benefit plan under this act and the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the health insurance zone.

(2) For a plan described in subsection (1)(a) or (b), a participating insurer shall provide optional, additional benefits for an additional premium. The options shall include variations

in copayments, deductibles, and the catastrophic cap, and additional services and categories of providers including dental, vision, and hearing. The benefits shall be subject to approval by the commissioner and, to the maximum extent feasible, shall be standard across carriers within a zone of the state.

Sec. 48. Each participating insurer shall fix optional premiums for the plans required under section 47 under a community rating system for all employers. An insurer may not set or adjust these premiums based on the age or gender of employees or employees' families, on other factors relating to the projected or actual use of health services under the plan, or on geographical location within the health insurance zone.

Sec. 49. (1) Each participating insurer in a universal health care insurance fund may enter into subcontracts with other entities in carrying out this act. The commissioner shall encourage participating insurers to enter into appropriate arrangements with entities representing business groups for the provision of administrative services with respect to businesses enrolled in plans offered by the insurers. Each such insurer shall reduce the premiums otherwise charged for the health benefit plans to such businesses by an amount that reflects the value of the administrative services.

(2) The commissioner shall provide technical assistance and enrollment forms to employers required under this act to provide health benefit plans. In carrying out this subsection, the commissioner shall, to the maximum extent feasible, enter into contracts with business service bureaus, chambers of commerce,

and other entities with experience in providing health insurance services to businesses.

Sec. 50. This act shall take effect January 1, 1996.