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BILL ANALYSIS

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Senate Bill 278 (Substitute S-2 as reported) *(as passed by the Senate)*
Senate Bill 280 (Substitute S-1 as reported) *(as passed by the Senate)*
Senate Bill 283 (Substitute S-1 as reported) *(as passed by the Senate)*
Sponsor: Senator Tom George (S.B. 278)
Senator Alan Sanborn (S.B. 280)
Senator Cameron S. Brown (S.B 283)
Committee: Health Policy

Date Completed: 5-8-07

RATIONALE

Reportedly, approximately 1.1 million Michigan residents do not have health insurance coverage. Due to the increasing cost of insurance, some employers are limiting the scope of the plans they offer to employees, or dropping coverage altogether. Individuals might not be able to afford private insurance, but exceed income limits to qualify for Medicaid or other assistance programs. As a result, the uninsured sometimes cannot afford routine, preventative care, or timely care when they are injured or become sick. As their conditions deteriorate, the extent and cost of necessary treatment increase. It has been suggested that measures should be taken to increase access to affordable health insurance for all Michigan residents, including the establishment of a State program through which individuals and groups could purchase coverage, and the extension of dependent child coverage to children up to age 26 who are no longer considered dependents.

CONTENT

Senate Bill 278 (S-2) would create the "Michigan Helping Ensure Affordable and Reliable Treatment (MI-HEART) Act" to do the following:

-- Create the MI-HEART Exchange to facilitate the availability, choice, and adoption of private eligible health coverage plans, as well as the purchase of health coverage products at an affordable price.

-- Prescribe the membership, powers, and duties of a board that would govern the Exchange.

-- Require the Exchange to offer eligible health coverage plans that had received its seal of approval.

-- Allow the Exchange, with the board's permission, to offer a health care plan that did not provide specific types of coverage otherwise required by law.

-- Allow all Michigan residents to apply to purchase health coverage through the Exchange.

-- Create the MI-HEART Program within the Exchange to provide subsidies to assist eligible individuals in purchasing health coverage.

-- Prescribe eligibility criteria for the Program.

-- Require the Exchange board to develop a plan for outreach and education designed to maximize enrollment of low-income uninsured residents in the Program.

-- Require the board to encourage the use of incentives to provide health promotion, chronic care management, and disease prevention.

-- Create the "MI-HEART Exchange Fund" and require premium contribution payments and surcharges to be deposited into the Fund.

-- Require the Exchange board to report annually to the Legislature and the

-- Auditor General on Exchange activities, receipts, and expenditures.
-- Require the board to conduct an annual study of the Exchange and its enrollees and submit to the Legislature a report based on the data collected.
-- Require the board, by January 1, 2011, to report to the Governor and the Legislature on progress in achieving universal health coverage in Michigan.

The proposed Act would not take effect unless Federal matching funds were secured for its implementation.

Senate Bills 280 (S-1) and 283 (S-1) would amend the Nonprofit Health Care Corporation Reform Act and the Insurance Code, respectively, to require a policy or certificate to permit the continuation of hospital or medical care coverage for a child until he or she reached age 26, even if the child were no longer considered a dependent, if he or she met certain criteria.

All of the bills are tie-barred to each other. They are described below in further detail.

Senate Bill 278 (S-2)

MI-HEART Exchange

The Exchange would be created in the Department of Community Health (DCH). The Exchange would be responsible for facilitating the availability, choice, and adoption of private eligible health coverage plans to individuals and groups and facilitating the purchase of health coverage products through the Exchange at an affordable price by individuals and groups. The Exchange would have to exercise its prescribed statutory duties, powers, and functions independently of the DCH Director.

The proposed Act would not take effect unless Federal matching funds were secured as necessary to implement the Act. The Exchange would have to begin offering eligible health coverage plans to individuals within 180 days, and to small businesses within 240 days, after Federal matching funds were procured.

"Eligible health coverage plan" or "plan" would mean any individual or group contract, policy, or certificate of health, accident, and sickness insurance or coverage issued by a carrier that met the eligibility requirements established by the Exchange board and that was offered through the Exchange. The term would not include a contract, policy, or certificate that provided coverage only for dental, vision, specified accident or accident-only coverage, credit, disability income, hospital indemnity, short-term or one-time limited duration policy or certificate of up to six months, long-term care insurance, Medicare supplement, coverage issued as a supplement to liability insurance, or specified disease insurance purchased as a supplement and not as a substitute for an eligible health coverage plan. "Carrier" would mean a health insurer, health maintenance organization (HMO), or Blue Cross and Blue Shield of Michigan (BCBSM).

Exchange Board; Executive Director

The Exchange would be governed by a board consisting of the following 17 members:

-- The DCH Director or his or her designee.
-- The Director of the Department of Human Services or his or her designee, who would serve as an ex officio nonvoting member.
-- The Commissioner of the Office of Financial and Insurance Services (OFIS) or his or her designee.
-- The Deputy Director for Medical Services Administration or his or her designee, who would serve as an ex officio nonvoting member.
-- Three members appointed by the Governor with the advice and consent of the Senate, including one who was a member in good standing of the American Academy of Actuaries, one health economist, and one who represented BCBSM.
-- Five members appointed by the Senate Majority Leader, including one employee health benefit specialist, one who represented small employers (defined below) with fewer than 10 employees, one who represented HMOs but not an HMO owned by BCBSM, one who represented low-income health care advocacy organizations, and one who represented medical providers.
-- Five members appointed by the Speaker of the House of Representatives, including one who represented the

general public, one who represented small employers with at least 10 employees, one who represented health insurers, one who represented organized labor, and one who represented hospitals.

The members first appointed to the board would have to be appointed within 30 days after the bill took effect. Appointed members would serve for terms of four years or until a successor was appointed, whichever was later; of the members first appointed, however, three would serve for one year, four for two years, four for three years, and four for four years.

If a vacancy occurred, it would have to be filled for the unexpired term in the same manner as the original appointment. An appointed member would be eligible for reappointment. The Governor could remove a member for incompetence, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

The first board meeting would have to be called by the DCH Director, who would serve as the chairperson. After the first meeting, the board would have to meet at least monthly, or more frequently at the call of the chairperson or if requested by eight or more members.

Eight members would constitute a quorum for the transaction of business at a board meeting. An affirmative vote of eight members would be necessary for official board action. The board would be subject to the Open Meetings Act and the Freedom of Information Act.

Board members would serve without compensation, but could be reimbursed for their actual and necessary expenses incurred in the performance of their official duties as board members.

The chairperson would have to hire an executive director to supervise the administrative affairs and general management and operations of the Exchange and serve as its secretary. The executive director would have to receive a salary commensurate with the duties of the office. He or she could appoint other officers and employees of the Exchange necessary to its functioning. With the board's approval, the executive director would have to do all of the following:

-- Plan, direct, coordinate, and execute administrative functions in conformity with the policies and directives of the board and the proposed Act.
-- Employ professional and clerical staff as necessary.
-- Report to the board on all operations under his or her control and supervision.
-- Prepare an annual budget and manage the administrative expenses of the Exchange.
-- Undertake any other activities necessary to implement the powers and duties under the proposed Act.

Plan of Operation

The board would have to develop a plan of operation for the Exchange. The plan would have to establish procedures for the Exchange's operation, for communication with the executive director, for the enrollment of individuals and groups in plans, and for appeals of eligibility decisions. The plan also would have to establish and manage the following:

-- A system of collecting and depositing into the MI-HEART Fund all premium payments made by, or on behalf of, individuals obtaining health coverage through the Exchange, including any payments made by enrollees, employees, unions, or other organizations.
-- A system for remitting premium assistance payments to carriers.
-- A system for remitting premium contribution payments to carriers.

The plan of operation would have to establish a plan for publicizing the existence of the Exchange and its eligibility requirements and enrollment procedures; develop criteria for determining that certain health coverage plans would no longer be made available through the Exchange; and develop a plan to remove the seal of approval from certain health coverage plans.

In addition, the plan of operation would have to develop a standard application form for individuals and groups seeking to purchase health coverage through the Exchange, and for eligible individuals seeking a premium assistance payment, that included information necessary to determine

an applicant's eligibility under the proposed Act, previous and current health coverage, and payment method.

("Eligible individual" would mean an individual who was a Michigan resident who met prescribed eligibility requirements. "Resident" would mean a person living in the State, including a qualified alien under the Federal Personal Responsibility and Work Opportunity Reconciliation Act, and a person who was not a U.S. citizen but was otherwise permanently residing in the U.S. under color of law, provided that the person did not move into the State for the sole purpose of securing health coverage under the MI-HEART Act.

"Premium contribution payment" would mean a payment made by a MI-HEART enrollee or employer toward an eligible health coverage plan. "Premium assistance payment" would mean a payment of health coverage premiums made by the board to a plan on behalf of a MI-HEART enrollee who was an eligible individual.)

Exchange Board Duties

The board would have to determine each applicant's eligibility for purchasing health coverage offered by the Exchange, including eligibility for premium assistance payments. The board also would have to review annually the publication of the income levels for the Federal poverty guidelines and devise a schedule of a percentage of income for each 50% increment of the Federal poverty level at which an individual could be expected to contribute that percentage of income toward the purchase of health coverage, and examine any contribution schedules, such as those set for government benefits programs. The report would have to be published annually. Before publication, the schedule would have to be reported to the House and Senate standing committees on appropriations, health, and insurance issues.

Additionally, the board would have to do all of the following:

-- Seek and receive any funding from the Federal government, State departments or agencies, private foundations, and other entities.
-- Publish each year the premiums for plans with the MI-HEART seal of approval.
-- Enter into interdepartmental agreements.
-- Contract with professional service firms as necessary and fix their compensation.
-- Contract with companies that provide third-party administrative and billing services for health coverage products.
-- Adopt bylaws for the regulation of its affairs and the conduct of its business.
-- Adopt and alter an official seal.
-- Maintain an office at a place or places the board designated.
-- Sue and be sued in its own name.
-- Approve the use of its trademarks, brand names, seals, logos, and similar instruments by participating carriers, employers, or organizations.

Eligible Health Coverage Plans

The Exchange could offer to individuals and groups only eligible health coverage plans that had received the Exchange seal of approval. Each eligible health coverage plan offered through the Exchange would have to contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits. A health coverage plan could not be offered through the Exchange if the plan excluded an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

The Exchange would have to offer a variety of health plans, including at least one that provided for a high deductible with only catastrophic coverage. Eligible health coverage plans receiving the seal of approval would have to meet all requirements of health coverage plans required under State law, rule, and regulation. In order to satisfy the goal of universal health care coverage in this State, however, the board could permit the Exchange to offer a health care plan that did not provide for the following specified coverage or offerings required under certain sections of the Insurance Code and the Nonprofit Health Care Corporation Reform Act:

-- Prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy or the removal of a body part due to illness or injury.

-- Mental health services provided by the DCH or a county community mental health board when appropriate services cannot be delivered otherwise, or if the provider is designated by a court order.
-- Hospice care.
-- Breast cancer diagnostic, outpatient treatment, and rehabilitative services, and breast cancer screening mammography coverage.
-- Drugs used in antineoplastic therapy.
-- Routine obstetrical and gynecologic services.
-- Pediatric services for a dependent minor.
-- Programs to prevent the onset of clinical diabetes; related equipment, supplies, and educational training; and related pharmaceuticals.
-- Off-label drug use.
-- Obstetrical and gynecologic services performed by a physician or a nurse midwife.
-- Inpatient, outpatient, and intermediate substance abuse treatment.

In determining the coverage or offerings that did not have to be provided in a health coverage plan offered through the Exchange, the board would have to determine whether real cost savings would be achieved so that the variety of health coverage plans available through the Exchange and their affordability were maximized.

The Exchange seal of approval would have to be assigned to an eligible health coverage plan that the board determined satisfied the provisions of the proposed Act, provided good value to residents, and provided quality medical benefits and administrative services.

The board could withdraw an eligible health coverage plan from the Exchange only after notice to the carrier.

The Exchange could apply a surcharge to all eligible health coverage plans. A surcharge could be used only to pay actual administrative and operational expenses of the Exchange and so long as the surcharge was applied uniformly to all eligible health coverage plans offered through the Exchange. A surcharge could not be used to pay any premium assistance payments.

Each carrier participating in the Exchange would have to furnish reasonable reports the board determined necessary to enable the executive director to carry out his or her duties under the proposed Act, including detailed loss-ratio and experience reports that identified administrative cost and medical charge trends.

All Michigan residents could apply to purchase health coverage through the Exchange. An applicant would have the right to receive a written determination of eligibility and, if eligibility were denied, a written denial detailing the reasons for the denial and the right to appeal any eligibility decision, provided the appeal was conducted pursuant to the process established by the board.

MI-HEART Program; Premium Subsidies

For the purpose of reducing the number of uninsured individuals in Michigan, the MI-HEART Program would be created within the Exchange. The board would have to administer the Program in consultation with the DCH and the Department of Human Services.

The Program would have to provide subsidies to assist eligible individuals in purchasing health coverage. Subsidies could be paid only on behalf of an eligible individual who was enrolled in an eligible health coverage plan, and would have to be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by the board. Eligibility for premium assistance payments would have to be determined as provided in the proposed Act. After consultation with representatives of any carrier eligible to receive premium subsidy payments, representatives of eligible small employers, representatives of hospitals that served a high number of uninsured individuals, and representatives of low-income health care advocacy organizations, the board would have to develop a plan for outreach and education that was designed to reach low-income uninsured residents and maximize their enrollment in the MI-HEART Program.

("Uninsured" would mean a resident who was not covered by a health insurance or coverage plan offered by a carrier, a self-funded health coverage plan, Medicaid, Medicare, or a medical assistance program.)

The board would have to procure eligible health coverage plans for the Program that included all of the following:

-- Wellness services.
-- Inpatient services.
-- Outpatient services and preventive care.
-- Prescription drugs.
-- Medically necessary inpatient and outpatient mental health services and substance abuse services.
-- Emergency care services.

Premium assistance payments would have to be made as provided in the proposed Act and under a schedule set annually by the board in consultation with the DCH. The schedule would have to be published annually. If the executive director determined that the amount in the Fund was insufficient to meet the projected costs of enrolling new eligible individuals, he or she would have to impose a cap on enrollment in the Program and notify the board, the Governor, and the House and Senate standing committees on appropriations, health, and insurance issues.

The Program would have to provide that an enrollee with a household income that did not exceed 100% of the Federal poverty level was responsible only for a copayment toward the purchase of each pharmaceutical product and for use of emergency room services in acute care hospitals for nonemergency conditions equal to that required of enrollees in the Medicaid program. The board could waive copayments upon a finding of substantial financial or medical hardship. No other premium, deductible, or other cost sharing could apply to an enrollee described in these provisions under the Program.

The Program would have to provide that an enrollee with a household income that exceeded 100% but did not exceed 200% of the Federal poverty level was not responsible for a premium contribution payment that exceeded 5% of his or her gross household income, and that copayments, deductibles, and other cost-sharing measures were reasonably established so as to encourage and promote maximum enrollment.

An uninsured individual would be eligible to participate in the MI-HEART Program if all of the following conditions were met:

-- The individual's household income did not exceed 200% of the Federal poverty level.
-- The individual had been a Michigan resident for the previous six months.
-- The individual was not eligible for any government program, Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP).
-- The individual had not accepted a financial incentive from his or her employer to decline the employer's subsidized health coverage plan.
-- In the last six months the individual's or family member's employer had not provided health coverage for which the individual was eligible.

The last condition would not apply if health coverage were not provided due to the individual's or family member's loss of employment, loss of eligibility for coverage due to loss of employment hours, or loss of dependency status.

An individual who was an employee of a small employer would be eligible to participate in the Program if all of the following conditions were met:

-- At least 75% of the employer's eligible employees seeking health care coverage through the employer were covered under an eligible health coverage plan.
-- The employer paid at least 33% of the premium contribution payment.
-- The employer agreed to participate in a payroll deduction program to facilitate premium contribution payments by employees who would benefit from deductibility of gross income under Federal regulations.
-- The employer agreed to make available in a timely manner for confidential review by the executive director any of the employer's information, documents, or records that the Exchange reasonably determined were necessary to determine compliance with the proposed Act.
-- The individual's household income did not exceed 200% of the Federal poverty level.
-- The individual had been a Michigan resident for the previous six months.
-- The individual was not eligible for any government program, Medicaid, Medicare, or SCHIP.

("Small employer" would mean any person, firm, corporation, partnership, limited liability company, or association actively engaged in business that, on at least 50% of its working days during the preceding and current calendar years, employed at least two but not more than 50 eligible employees. In determining the number of eligible employees, companies that were affiliated companies or that were eligible to file a combined tax return for State taxation purposes would be considered one employer. "Eligible employee" would mean an employee who worked on a full-time basis with a normal workweek of at least 30 hours. The term would include an employee who worked on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chose and if this eligibility criterion were applied uniformly among all of the employer's employees and without regard to health status-related factors.)

The Exchange would have to enter into interagency agreements with the Department of Treasury to verify income data for participants in the Program. The written agreements would have to permit the Exchange to provide a list of individuals participating in or applying for the Program, including any applicable members of their households, who would be counted in determining eligibility, and to furnish relevant information, including name, Social Security number, if available, and other data required to assure positive identification. The Department of Treasury would have to give the Exchange information on the cases of identified people, including name, Social Security number, and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources.

Incentives

The Exchange board would have to encourage the use of incentives to provide health promotion, chronic care management, and disease prevention. Incentives could include rewards, premium discounts, or rebates, or otherwise waive or modify copayments, deductibles, or other cost-sharing measures. Incentives would have to be available to all similarly situated individuals and be designed to prevent disease. Incentives could not be used to impose higher costs on an individual based on a health factor.

MI-HEART Exchange Fund

The bill would create the MI-HEART Exchange Fund within the State Treasury. Premium contribution payments and surcharges collected by the Exchange would have to be deposited into the Fund. The State Treasurer could receive money or other assets from any source for deposit into the Fund, and would have to direct its investment. The Treasurer would have to credit to the Fund interest and earnings from Fund investments. Money in the Fund at the close of the fiscal year would remain in the Fund and would not lapse to the General Fund. Fund money could be spent only as provided in the proposed Act.

Board Reports & Studies

The Board would have to keep an accurate account of all Exchange activities and all of its receipts and expenditures, and would have to report annually at the end of the fiscal year to the Governor, the House and Senate standing committees on appropriations, health, and insurance issues, and the Auditor General. The Auditor General could investigate the Exchange's affairs, severally examine the Exchange's properties and records, and prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the Exchange. The Exchange would be subject to annual audit by the Auditor General.

Within two years after the Exchange began operation and every year after that, the board would have to conduct a study of the Exchange and the people enrolled in it and submit to the Governor and the House and Senate standing committees on appropriations, health, and insurance issues a written report on the Exchange's status and activities based on data collected in the study. The report would have to be available to the general public upon request. The study would have to review all of the following for the immediately preceding year:

-- The operation, administration, and costs of the Exchange.

-- The number of MI-HEART enrollees in the MI-HEART Program and the total amount of premium assistance payments made.
-- How the Exchange met its goals.
-- The amount and reasonableness of a surcharge and its impact on premiums.
-- What health coverage plans were available to individuals and groups through the Exchange and the experience of those plans, including any adverse selection trends.

The experience of the plans would have to include data on the number of enrollees in the plans, plans' expenses, claims statistics, and complaints data. Health information obtained under the proposed Act would be subject to the Federal Health Insurance Portability and Accountability Act or regulations promulgated under it.

By January 1, 2011, the board would have to report to the Governor and to the House and Senate standing committees on appropriations, health, and insurance issues on progress in achieving universal health coverage in this State. The report would have to examine any trends in the number of uninsured individuals in Michigan since the proposed Act took effect, trends in adverse selection, and types and costs of health coverage available. The report also would have to make recommendations on methods to achieve universal health coverage in Michigan, including whether health coverage should be mandated and how a mandate would be implemented and enforced.

Senate Bills 280 (S-1) and 283 (S-1)

The bills would require a policy or certificate that provided for hospital or medical coverage for dependent children to permit the continuation of that coverage for a child until he or she reached age 26, even if the child were no longer considered a dependent, if the child met all of the following criteria:

-- Was unmarried.
-- Had no dependents of his or her own.
-- Was a resident of this State or resided somewhere else temporarily.
-- Was not eligible for a group health benefits or coverage plan from his or her employer.
-- Was not provided coverage under any other group or individual health benefits or coverage plan.
-- Had not accepted a financial incentive from his or her employer or other source to decline any other group or individual health benefits or coverage plan.
-- Was continuously covered before the application for continuous coverage under one or more individual or group health benefits or coverage plans with no break in coverage that exceeded 62 days.

Senate Bill 280 (S-1) would apply to a BCBSM certificate delivered, issued for delivery, or renewed in Michigan that provided for hospital or medical care coverage for dependent children. Senate Bill 283 (S-1) would apply to a policy, certificate, or contract delivered, issued for delivery, or renewed in Michigan that provided for hospital or medical care coverage or reimbursement for hospital or medical care for dependent children.

Under Senate Bill 280 (S-1), if a BCBSM certificate provided continuation coverage and the child for which the coverage was provided attained age 27 during the certificate year, coverage for him or her would have to continue through the end of the certificate year.

Under both bills, a covered person's policy or certificate could require payment of a premium by the covered person or child, subject to the OFIS Commissioner's approval, for any period of continuation coverage. The premium could not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage before the termination of coverage at the age specified in the policy or certificate. The applicable portion of the premium would have to be determined pursuant to rules adopted by the Commissioner based upon the difference between the policy's or certificate's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier that the Commissioner considered appropriate and that provided a substantially similar result.

The bills specify that they would not prohibit an employer from requiring an employee to pay all or part of the cost of continuous coverage provided for that employee's child.

If the MI-HEART Exchange board determined that certain sections of the Insurance Code and the Nonprofit Health Care Corporation Reform Act should be waived as provided in the proposed MI-HEART Act, then those sections identified by the board would not have to be provided or offered in an eligible health coverage plan. ("Eligible health coverage plan" would mean that term as defined in the proposed Act.)

The Insurance Code requires all HMO contracts to include, at a minimum, basic health services. Under Senate Bill 283 (S-1), this requirement would not apply to HMO contracts that were eligible health coverage plans offered through the Exchange under the proposed MI-HEART Act.

Proposed MCL 550.1409b & 550.1409c (S.B. 280)
MCL 500.3519 et al. (S.B. 283)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument
Senate Bill 278 (S-2) would help increase access to affordable health insurance among the State's currently uninsured population, particularly those individuals with an income of less than 200% of the Federal poverty level. The proposed Exchange would have to offer insurance plans with varying levels of coverage, enabling individuals to choose plans that fit their needs at a price they could afford. The plans offered through the Exchange also would provide small business owners, for whom increasing insurance costs are a significant concern, with more coverage options for their employees. Increased access to health insurance, combined with the use of incentives for health promotion, chronic care management, and disease prevention (which the Exchange board would have to encourage), should help to improve the health of Michigan residents and contain the growth of health care costs.

Response: The composition of the Exchange board would be weighted in favor of the Legislature. While the Governor would appoint three voting members, the Speaker and the Senate Majority Leader would appoint a total of 10. Additionally, the Governor's appointees would require the advice and consent of the Senate, and two of the four additional executive branch members would not have a vote. It would be appropriate for the executive branch to have a more prominent role in the Exchange's administration.

Supporting Argument
According to a July 2006 report by the DCH, "Characteristics of the Uninsured and Select Health Insurance Coverage in Michigan", adults ages 21-24 and 25-29 are more likely than any other age group to be uninsured. Young adults just entering the workforce often work in occupations that are unlikely to offer employer-based coverage. Additionally, single people are less likely to be insured than are married people, who frequently can be covered under a spouse's policy. Senate Bills 280 (S-1) and 283 (S-1) would allow an unmarried person with no children to be covered under his or her parents' insurance policy until age 26. Since people in this age group reportedly carry a low actuarial risk, the cost of extending coverage to them should not be burdensome.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

Senate Bill 278 (S-2)

Implementation of the bill would be contingent upon Federal approval of the proposed Michigan First Healthcare Plan. Negotiations on the structure and financing of this program are currently in progress and it is not certain how much State or local financial effort would be necessary to operate the MI-HEART Exchange. Financial resources would need to be devoted to the operation of the Exchange for a number of administrative functions outlined in the bill. The fiscal impact associated with operating the Exchange would be determined by the scale of the Michigan First program and the amount of Federal money available for administrative functions.

Increasing the number of residents of the State with health coverage would likely reduce the amount of uncompensated care provided by publicly operated health facilities. Reducing the amount of uncompensated care provided in the State would likely lead to a marginal reduction in the cost of health benefit rates, including

those offered by State and local governments.

Senate Bills 280 (S-1) and 283 (S-1)

Increasing the number of young adults eligible for inclusion on their parent's health insurance would likely lead to an indeterminate increase in health benefit cost for employers, including State and local governments that provide health coverage, although a covered person could be required to pay a premium for continuation coverage.

To the extent that the bills reduced the number of uninsured in the State, Michigan could see a small indeterminate decrease in Medicaid expenditure.

Fiscal Analyst: David Fosdick