HOUSE BILL No. 4466

February 25, 2009, Introduced by Reps. Johnson, Durhal, Stanley, Bettie Scott and Cushingberry and referred to the Committee on Health Policy.

A bill to provide for a Michigan health insurance system; to provide for governance of the Michigan health insurance system; to establish health care regions; to establish various committees and boards; to create an office of consumer advocacy; to create an inspector general for the Michigan health insurance system; to provide for certain investigations, audits, and reviews; to create certain funds and accounts; to determine eligibility for and benefits of the Michigan health insurance system; to provide for certain reviews; to provide for certain reports; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; and to prescribe penalties and provide remedies.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

ARTICLE I GENERAL PROVISIONS

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

HOUSE BILL No. 4466

"Michigan health insurance system act".

Sec. 3. As used in this act:

(a) "Agency" means the Michigan health insurance agency.

(b) "Commissioner" means the health insurance commissioner.

(c) "Direct care provider" means any licensed health care professional that provides health care services through direct contact with the patient.

(d) "Essential community provider" means a health facility that has served as part of the state's health care safety net for low income and traditionally underserved populations in Michigan and that is 1 of the following:

(*i*) A "federally qualified health center" as defined under section 1395x(aa)(4) or 1396d(*l*)(2) of the social security act, 42 USC 1395x and 1396d(c)(1).

(*ii*) A "rural health clinic" as defined under section 1861(aa)(2) or 1905(*l*)(1) of the social security act, 42 USC 1395x(aa)(2) and 1396d.

(*iii*) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined under 25 USC 1603.

(e) "Health care professional" means a person licensed or registered under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838. Health care professional does not include a sanitarian or veterinarian.

(f) "Health care provider" means a health care professional, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(g) "Health facility" means a health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260, or any other organized entity where a health care professional provides health care to patients.

(h) "Health insurance fund" means the health insurance fund created in section 41.

(i) "Hospital" means a health facility that is licensed under part 215 of the public health code, 1978 PA 368, MCL 333.21501 to 333.21571.

(j) "Integrated health care delivery system" means a provider organization that meets all of the following criteria:

(*i*) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

(*ii*) Is compensated using capitation or facility budgets, except for copayments, for the provision of health care services.

(*iii*) Provides health care services primarily directly through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or 1 or more groups of physicians, organized on a group practice or individual practice basis.

(k) "Primary care provider" means a direct care provider that is a family physician, internist, general practitioner, pediatrician, an obstetrician/gynecologist, or a family certified nurse practitioner or physician's assistant practicing under

supervision as defined under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, or essential community providers who employ primary care providers.

(*l*) "System" or "health insurance system" means the Michigan health insurance system.

ARTICLE II MICHIGAN HEALTH INSURANCE SYSTEM AND GOVERNANCE

Sec. 5. (1) There is established the Michigan health insurance system, which shall be administered by the Michigan health insurance agency, an independent agency under the control of the commissioner and housed in the department of treasury.

(2) The Michigan health insurance agency is a separate entity in state government and its decisions are not subject to review by any other agency except as otherwise provided in this act.

(3) The Michigan health insurance agency shall be the single state agency with full power to supervise every phase of the administration of the Michigan health insurance system and to receive grants-in-aid made by the United States government or by the state in order to secure full compliance with the applicable provisions of state and federal law.

(4) The Michigan health insurance agency shall be comprised of the following entities:

(a) The health insurance policy board.

(b) The office of consumer advocacy.

(c) The office of health care planning.

(d) The office of health care quality.

(e) The health insurance fund.

Sec. 7. The Michigan health insurance system shall have all of

the following purposes:

(a) To provide universal and affordable health insurance coverage for all Michigan residents.

(b) To provide Michigan residents with an extensive benefit package.

(c) To control health care costs and the growth of health care spending.

(d) To achieve measurable improvement in health care outcomes.

(e) To prevent disease and disability and to maintain or improve health and functionality.

(f) To increase health care provider, consumer, employee, and employer satisfaction with the health care system.

(g) To implement policies that strengthen and improve culturally and linguistically sensitive care.

(h) To develop an integrated population-based health care database to support health care planning.

Sec. 11. (1) The commissioner shall be a citizen of this state, shall have his or her office at the seat of government, shall personally superintend the duties of the office, and shall not be a stockholder or directly or indirectly connected with the management of affairs of any insurer, pharmaceutical, or medical equipment company that sells products to the Michigan health insurance system for a period of 2 years prior to appointment as commissioner. The commissioner shall be appointed by the governor for a term of 4 years by and with the consent of the senate. The first commissioner shall be appointed by the governor not less than 75 days following the effective date of this act and shall be

subject to confirmation by the senate within 30 days of nomination. If the senate does not take up the nomination within 30 days, the nominee shall be considered to have been confirmed and may take office, except that, if the senate is not in session at the time the governor appoints the commissioner, the senate shall take up the confirmation of the nominee at the commencement of the next legislative session. Should the senate, by a vote, fail to confirm a nominee for the office of commissioner, the governor shall appoint a new nominee, subject to the confirmation of the senate.

(2) If a vacancy occurs in the office of commissioner by reason of death, removal, or otherwise, the governor shall fill that vacancy by appointment, by and with the advice and consent of the senate in the manner prescribed in subsection (1), for the balance of the unexpired term.

(3) The commissioner shall not be a state legislator or a member of the United States congress while holding the position of commissioner.

(4) The commissioner shall receive an annual salary as the legislature shall appropriate, payable as other state officers are paid under the accounting laws of the state. Within 15 days from the time of notice of his or her appointment, the commissioner shall take and subscribe the constitutional oath of office and file the oath in the office of the secretary of state, and shall also within the same period give to the people of the state of Michigan a bond in the penal sum of $50,000.00, with sureties to be approved by the state treasurer, conditioned for the faithful discharge of the duties of his or her office.

(5) For 2 years after completing service in the Michigan health insurance system, the commissioner shall not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, an insurer, pharmaceutical, or medical equipment company that sells products to the Michigan health insurance system.

Sec. 13. (1) The commissioner shall be the chief officer of the Michigan health insurance agency and shall administer all aspects of the agency.

(2) The commissioner shall be responsible for the performance of all duties, the exercise of all power and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the agency. The commissioner shall perform all duties imposed upon him or her by this act and other laws related to health care, and shall enforce the execution of those related to health care, and shall enforce the execution of those provisions and laws to promote their underlying aims and purposes. These broad powers shall include, but are not limited to, the power to establish the Michigan health insurance system budget and to set rates, to establish Michigan health insurance system goals, standards, and priorities, to hire and fire and fix the compensation of agency personnel, to make allocations to the health care regions, and to promulgate generally binding rules and regulations concerning any and all matters related to the implementation of this act and its purposes.

(3) The commissioner shall appoint the deputy health insurance commissioner, the director of the health insurance fund, the

consumer advocate, the chief medical officer, the chief enforcement officer, the director of planning, the director of the partnerships for health, the regional health planning directors, the chief enforcement counsel, and legal counsel in any action brought by or against the commissioner under or pursuant to any provision of any law under the commissioner's jurisdiction, or in which the commissioner joins or intervenes as to a matter within the commissioner's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the commissioner or before a person authorized by the commissioner.

(4) The personnel of the agency shall perform duties as assigned to them by the commissioner.

(5) The commissioner shall adopt a seal bearing the inscription: "Commissioner, Michigan Health Insurance Agency, State of Michigan." The seal shall be affixed to or imprinted on all orders and certificates issued by him or her and other instruments as he or she directs. All courts shall take notice of this seal.

(6) The administration of the agency shall be supported from the health insurance fund.

(7) The commissioner, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the agency, unless the commissioner finds that this availability or publication is contrary to law. This act does not authorize the commissioner; any of the commissioner's assistants, clerks, or deputies; or any other agency personnel to disclose any information withheld from public inspection except among themselves

or when necessary or appropriate in a proceeding or investigation under this act or to other federal or state regulatory agencies. This act does not create or derogate from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the commissioner; any of his or her assistants, clerks, and deputies; or any other agency personnel.

(8) It is unlawful for the commissioner; any of his or her assistants, clerks, or deputies; or any other agency personnel to use for personal benefit any information that is filed with or obtained by the commissioner and that is not then generally available to the public.

(9) The commissioner shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities include, but are not limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate; contribution of more than $500.00 to any 1 candidate in a calendar year or a contribution in excess of an aggregate of $1,000.00 in a calendar year for all political parties or organizations; and attempting to avoid compliance with this prohibition by making contributions through a spouse or other family member.

(10) The commissioner shall not participate in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she or a family member or a business partner or colleague has a financial interest.

(11) The commissioner, in pursuit of his or her duties, shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(12) The attorney general shall render to the commissioner opinions upon all questions of law, relating to the construction or interpretation of any law under the commissioner's jurisdiction or arising in the administration thereof, that may be submitted to the attorney general by the commissioner and upon the commissioner's request shall act as the attorney for the commissioner in actions and proceedings brought by or against the commissioner or under or pursuant to any provision of any law under the commissioner's jurisdiction.

Sec. 15. The commissioner shall do all of the following:

(a) Oversee the establishment as part of the administration of the agency of all of the following:

(*i*) The health insurance policy board, pursuant to section 17.

(*ii*) The office of consumer advocacy, pursuant to section 21.

(*iii*) The office of health care planning, pursuant to section 111.

(*iv*) The office of health care quality, pursuant to section 115.

(*v*) The health insurance fund, pursuant to section 41.

(*vi*) The payments board, pursuant to section 53.

(*vii*) The public advisory committee, pursuant to section 19.

(b) Determine Michigan health insurance system goals, standards, guidelines, and priorities.

(c) Establish health care regions, pursuant to section 31.

(d) Ensure the delivery of, and equal access to, high-quality health care for Michigan residents.

(e) Establish evidence-based standards to guide delivery of health care and ensure a smooth transition to delivery of health care under statewide standards.

(f) Develop methods to measure and monitor the quality of health care provided to Michigan residents and to make needed improvements.

(g) Develop methods to measure and monitor the performance of health care providers and to make needed improvements.

(h) Establish a capital management plan for the Michigan health insurance system, including, but not limited to, a standardized process and format for the development and submission of regional operating and regional capital budget requests.

(i) Ensure the establishment of policies that support the public health.

(j) Establish and maintain appropriate statewide and regional health care databases.

(k) Establish a means to identify areas of medical practice where standards of care do not exist and establish priorities and a timetable for their development.

(*l*) Establish standards for mandatory reporting by health care providers and remedies and penalties for failure to report.

(m) Establish a comprehensive budget that ensures adequate funding to meet the health care needs of Michigan residents and the compensation for providers for health care provided pursuant to this act.

(n) Establish standards and criteria for allocation of operating and capital funds from the health insurance fund.

(o) Establish standards and criteria for development and submission of provider operating budget requests.

(p) Determine the level of funding to be allocated to each health care region.

(q) Annually assess projected revenues and expenditures pursuant to this act to assure financial solvency of the system.

(r) Institute necessary cost controls pursuant to this act to assure financial solvency of the system.

(s) Develop separate formulae for budget allocations and review the formulae annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees, and prices.

(t) Meet regularly with the chief medical officer, the consumer advocate, the director of planning, the director of the payments board, the director of the partnerships for health, regional planning directors, and regional medical officers to review the impact of the agency and its policies on the health of Michigan residents and on satisfaction with the Michigan health insurance system.

(u) Negotiate for or set rates, fees, and prices involving any aspect of the Michigan health insurance system and establish procedures thereto.

(v) Establish a capital management framework for the Michigan health insurance system pursuant to this act to ensure that the needs for capital health care infrastructure are met, pursuant to

the goals of the system.

(w) Ensure a smooth transition to Michigan health insurance system oversight of capital health care planning.

(x) Establish an evidence-based formulary for all prescription drugs and durable and nondurable medical equipment for use by the Michigan health insurance system.

(y) Utilize the purchasing power of the state to negotiate price discounts for prescription drugs and durable and nondurable medical equipment for use by the Michigan health insurance system.

(z) Ensure that use of state purchasing power achieves the lowest possible prices for the Michigan health insurance system.

(aa) Create incentives and guidelines for research needed to meet the goals of the system and disincentives for research that does not achieve Michigan health insurance system goals.

(bb) Implement eligibility standards for the system.

(cc) Provide support during the transition for training and job placement for persons who are displaced from employment as a result of the initiation of the new Michigan health insurance system.

(dd) Establish an enrollment system that ensures all eligible Michigan residents, including those who travel frequently; those who have disabilities that limit their mobility, hearing, or vision; those who cannot read; and those who do not speak or write English, are aware of their right to health care and are formally enrolled.

(ee) Oversee the establishment of a system for resolution of grievances pursuant to this act.

(ff) Establish an electronic claims and payments system for the Michigan health insurance system, to which all claims shall be filed and from which all payments shall be made, and implement, to the extent permitted by federal law, standardized claims and reporting methods.

(gg) Establish a system of secure electronic medical records that comply with state and federal privacy laws and that are compatible across the system.

(hh) Establish an electronic referral system that is accessible to providers and to patients.

(ii) Establish guidelines for mandatory reporting by health care providers.

(jj) Establish a technology advisory committee to evaluate the cost and effectiveness of new medical technology and make recommendations for the inclusion of those technologies in the benefit package.

(kk) Ensure that consumers of health care have access to information needed to support choice of health care professionals.

(*ll*) Collaborate with the boards that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely fashion and that consumers and health care professionals have access to information needed to support choice of health facility.

(mm) Establish a health insurance system internet website that provides information to the public about the Michigan health insurance system that includes, but is not limited to, information that supports choice of health care providers and informs the

public about state and regional health insurance policy board meetings and activities of the partnerships for health.

(nn) Procure funds, including loans, to lease or purchase insurance for the system and its employees and agents.

(oo) Establish a process for the system to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of the system.

(pp) Annually report to the legislature and the governor, on or before October of each year and at other times pursuant to this act, on the performance of the Michigan health insurance system, its fiscal condition and need for rate adjustments, consumer copayments or consumer deductible payments, recommendations for statutory changes, receipt of payments from the federal government, whether current year goals and priorities are met, future goals, and priorities, and major new technology or prescription drugs or other circumstances that may affect the cost of health care.

Sec. 17. (1) The commissioner shall establish a health insurance policy board and shall serve as the president of the board.

(2) The board shall do all of the following:

(a) Establish health insurance system goals and priorities, including research and capital investment priorities.

(b) Establish the scope of services to be provided to Michigan residents.

(c) Determine when an increase in health insurance premiums or when a change in the health insurance premium structure is needed.

(d) Establish guidelines for evaluating the performance of the

health insurance system, health care regions, and health care providers.

(e) Establish guidelines for ensuring public input on health insurance system policy, standards, and goals.

(3) The board shall consist of the following members:

(a) The commissioner.

(b) The deputy health insurance commissioner.

(c) The director of the health insurance fund.

(d) The consumer advocate.

(e) The chief medical officer.

(f) The director of health care planning.

(g) The director of the partnerships for health.

(h) The director of the payments board.

(i) Two representatives from health care regional planning boards. A regional representative shall serve a term of 1 year, and terms shall be rotated in order to allow every region to be represented within a 5-year period. A regional planning director shall appoint the regional representative to serve on the board.

(4) It is unlawful for the board members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the board and that is not then generally available to the public.

Sec. 19. (1) The commissioner shall establish a public advisory committee to advise the health insurance policy board on all matters of health insurance system policy.

(2) Members of the public advisory committee shall include all of the following:

(a) Four physicians, all of whom shall be board certified in their field. The senate majority leader and the governor shall each appoint 1 member. The speaker of the house of representatives shall appoint 2 of these members, both of whom shall be primary care providers.

(b) One registered nurse, to be appointed by the governor.

(c) One licensed vocational nurse, to be appointed by the senate majority leader.

(d) One licensed health practitioner, to be appointed by the speaker of the house of representatives.

(e) One mental health care provider, to be appointed by the senate majority leader.

(f) One dentist, to be appointed by the governor.

(g) One representative of private hospitals, to be appointed by the senate majority leader.

(h) One representative of public hospitals, to be appointed by the governor.

(i) Four consumers of health care. The governor shall appoint 2 of these members, one of whom shall be a member of the disability community. The senate majority leader shall appoint a member who is 65 years of age or older. The speaker of the house of representatives shall appoint the fourth member.

(j) One representative of organized labor, to be appointed by the speaker of the house of representatives.

(k) One representative of essential community providers, to be appointed by the senate majority leader.

(*l*) One union member, to be appointed by the senate majority

leader.

(m) One representative of small business, to be appointed by the governor.

(n) One representative of large business, to be appointed by the speaker of the house of representatives.

(o) One pharmacist, to be appointed by the speaker of the house of representatives.

(3) In making appointments pursuant to this section, the governor, the senate majority leader, and the speaker of the house of representatives shall make good faith efforts to assure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(4) Any member appointed by the governor, the senate majority leader, or the speaker of the house of representatives shall serve for a 4-year term. These members may be reappointed for succeeding 4-year terms.

(5) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy and shall be filled in the same manner in which the vacating member was selected or appointed. The commissioner shall notify the appropriate appointing authority of any actual or expected vacancies on the board.

(6) Members of the advisory committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

(7) The advisory committee shall meet at least 6 times a year in a place convenient to the public. All meetings of the board shall be open to the public, pursuant to the open meetings act,

1976 PA 267, MCL 15.261 to 15.275.

(8) Appointed committee members shall have worked in the field they represent on the committee for a period of at least 2 years prior to being appointed to the committee.

(9) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the committee and that is not generally available to the public.

Sec. 21. (1) There is within the agency an office of consumer advocacy to represent the interests of the consumers of health care. The goal of the office is to help Michigan residents secure the health care services and benefits to which they are entitled under the laws administered by the agency and to advocate on behalf of and represent the interests of consumers in governance bodies created by this act and in other forums.

(2) The office shall be headed by a consumer advocate appointed by the commissioner.

(3) The consumer advocate shall establish an office in Lansing and other offices throughout the state that shall provide convenient access to Michigan residents.

(4) The consumer advocate shall do all the following:

(a) Administer all aspects of the office of the consumer advocate.

(b) Assure that services of the consumer advocate are available to all Michigan residents.

(c) Serve on the health insurance policy board and participate in the regional partnership for health.

(d) Oversee the establishment and maintenance of a grievance process and independent medical review system pursuant to this act.

(e) Participate in the grievance process and independent medical review system on behalf of consumers pursuant to this act.

(f) Receive, evaluate, and respond to consumer complaints about the health insurance system.

(g) Provide a means to receive recommendations from the public about ways to improve the health insurance system and hold public hearings at least once annually to receive recommendations from the public.

(h) Develop educational and informational guides for consumers describing their rights and responsibilities and informing them about effective ways to exercise their rights to secure health care services and to participate in the health insurance system. The guides shall be easy to read and understand, available in English and other languages, including Braille and formats suitable for those with hearing limitations, and shall be made available to the public by the agency, including access on the agency's internet website and through public outreach and educational programs and displayed in health care provider offices or facilities.

(i) Establish a toll-free telephone number to receive complaints regarding the agency and its services. The agency internet website shall have complaint forms and instructions on their use.

(j) Report annually to the public, the commissioner, and the legislature about the consumer perspective on the performance of the health insurance system, including recommendations for needed

improvements.

(5) Nothing in this act prohibits a consumer or class of consumers or the consumer advocate from seeking relief through the judicial system.

(6) The consumer advocate in pursuit of his or her duties shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(7) It is unlawful for the consumer advocate or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the agency and that is not then generally available to the public.

Sec. 23. (1) There is within the office of the attorney general an office of the inspector general for the Michigan health insurance system. The inspector general shall be appointed by the governor with the advice and consent of the senate.

(2) The inspector general shall have broad powers to investigate, audit, and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the system, the costs of which are reimbursed by the system.

(3) The inspector general shall investigate allegations of misconduct on the part of an employee or appointee of the agency and on the part of any health care provider of services that are reimbursed by the system and shall report any findings of misconduct to the attorney general.

(4) The inspector general shall investigate patterns of medical practice that may indicate fraud and abuse related to

overutilization or underutilization or other inappropriate utilization of medical products and services. The inspector general shall arrange for the collection and analysis of data needed to investigate the inappropriate utilization of these products and services.

(5) The inspector general shall conduct additional reviews or investigations of financial and business records when requested by the governor or by any member of the legislature and shall report findings of the review or investigation to the governor and the legislature.

(6) The inspector general shall establish a telephone hotline for anonymous reporting of allegations of failure to make health insurance premium payments established by this act. The inspector general shall investigate information provided to the hotline and shall report any findings of misconduct to the attorney general.

(7) The inspector general shall annually report recommendations for improvements to the system or the agency to the governor and the legislature.

Sec. 27. (1) The health insurance system shall be operational no later than 2 years after the effective date of this act and shall be funded from a loan from the general fund and from private sources identified by the commissioner.

(2) The commissioner shall assess health plans and insurers for care provided by the system in those cases in which a person's health care coverage extends into the time period in which the new system is operative.

(3) The commissioner shall implement means to assist persons

who are displaced from employment as a result of the initiation of the new health insurance system, including the period of time during which assistance shall be provided and possible sources of funds to support retraining and job placement. That support shall be provided for a period beginning on the effective date of this act and ending 5 years after the effective date of this act.

Sec. 29. (1) The commissioner shall appoint a transition advisory group to assist with the transition to the system. The transition advisory group shall include, but is not limited to, the following members:

(a) The commissioner.

(b) The consumer advocate.

(c) The chief medical officer.

(d) The director of health care planning.

(e) The director of the health insurance fund.

(f) Experts in health care financing and health care administration.

(g) Direct care providers.

(h) Representatives of retirement boards.

(i) Employer and employee representatives.

(j) Hospital, essential community provider, and long-term care facility representatives.

(k) Representatives from state departments and regulatory bodies that shall or may relinquish some or all parts of their delivery of health service to the system.

(*l*) Representatives of counties.

(m) Consumers of health care.

(2) The transition advisory group shall advise the commissioner on all aspects of the implementation of this act.

(3) The transition advisory group shall make recommendations to the commissioner, the governor, and the legislature on how to integrate health care delivery services and responsibilities relating to the delivery of the services of the following departments and agencies into the system:

(a) The department of community health.

(b) The department of human services.

(c) The office of services to the aging.

(d) The mental health and substance abuse administration.

(e) The office of financial and insurance services.

(4) The transition advisory group shall report its findings to the commissioner, the governor, and the legislature. The transition to the system shall not adversely affect publicly funded programs currently providing health care services.

ARTICLE III REGIONALIZATION

Sec. 31. (1) The purpose of regionalization is to support local planning and decision making.

(2) The commissioner shall establish up to 10 health insurance system regions composed of geographically contiguous counties grouped on the basis of the following considerations:

(a) Patterns of utilization.

(b) Health care resources, including workforce resources.

(c) Health needs of the Michigan residents, including public health needs.

(d) Geography.

(e) Population and demographic characteristics.

(3) The commissioner shall appoint a director for each region. Regional planning directors shall serve at the will of the commissioner and may serve up to 2 8-year terms to coincide with the terms of the commissioner.

(4) Each regional planning director shall appoint a regional medical officer.

Sec. 33. (1) Regional planning directors shall administer the health insurance region and perform regional health care planning pursuant to this act. The regional planning director shall be responsible for all duties, the exercise of all powers and jurisdiction, and the assumptions and discharge of all responsibilities vested by law in the regional agency. The regional planning director shall perform all duties imposed upon him or her by this act and by other laws related to health care and shall enforce execution of those provisions and laws to promote their underlying aims and purposes.

(2) The regional planning director shall reside in the region in which he or she serves.

(3) The regional planning director shall do all of the following:

(a) Establish and administer a regional office of the state agency. Each regional office shall include, at minimum, an office of each of the following: consumer advocacy, health care quality, health care planning, and partnerships for health.

(b) Establish regional goals and priorities pursuant to standards, goals, priorities, and guidelines established by the

commissioner.

(c) Assure that regional administrative costs meet standards established by this act.

(d) Seek innovative means to lower the costs of administration in the region.

(e) Plan for the delivery of, and equal access to, high quality and culturally and linguistically sensitive health care that meets the needs of all regional residents pursuant to standards established by the commissioner.

(f) Seek innovative means to improve health care quality.

(g) Appoint regional planning board members and serve as president of the board.

(h) Implement policies established by the commissioner to provide support to persons displaced from employment as a result of the initiation of the new system.

(i) Make needed revenue sharing arrangements so that regionalization in no way limits a patient's choice of health care provider.

(j) Implement procedures established by the commissioner for the resolution of grievances.

(k) Implement processes established by the commissioner to permit the public to share concerns and provide ideas, opinions, and recommendations regarding all aspects of the system policy.

(*l*) Report regularly to the public and, at intervals determined by the commissioner, and pursuant to this act, to the commissioner, on the status of the regional health insurance system, including evaluating access to health care, quality of health care delivered,

and health care provider performance and recommending needed improvements.

(m) Identify and prioritize regional health care needs and goals, in collaboration with the regional medical officer, regional health care providers, the regional planning board, and the regional director of partnerships for health.

(n) Identify and maintain an inventory of regional health care assets.

(o) Establish and maintain regional health care databases.

(p) Convene meetings of regional health care providers to facilitate coordinated regional health care planning.

(q) Establish and implement a regional capital management plan pursuant to the capital management plan established by the commissioner for the system.

(r) Implement standards and formats established by the commissioner for the development and submission of operating budget requests.

(s) Support regional health care providers in developing operating and capital budget requests.

(t) Receive, evaluate, and prioritize health care provider operating and capital budget requests pursuant to standards and criteria established by the commissioner.

(u) Prepare a 3-year regional budget request that meets the health care needs of the region pursuant to this act, for submission to the commissioner.

(v) Establish a comprehensive 3-year regional health insurance budget using funds allocated to the region by the commissioner.

(w) Regularly assess projected revenues and expenditures to ensure fiscal solvency of the regional health insurance system.

Sec. 35. (1) The regional medical officers shall do all of the following:

(a) Administer all aspects of the regional office of health care quality.

(b) Serve as a member of the regional health insurance board.

(c) Support the delivery of high-quality health care to all residents of the region pursuant to this act.

(d) Ensure a smooth transition to health care delivery by regional health care providers under evidence-based standards that guide clinical decision making.

(e) Support the development and distribution of user-friendly software for use by health care providers in order to support the delivery of high-quality health care.

(f) In collaboration with the chief medical officer, evaluate evidence-based standards of health care in use at the time the Michigan health insurance system becomes operative.

(g) Assure the implementation of improvements needed so that all standards of health care are used to guide clinical decision making in the system.

(h) Assure the delivery of uniformly high standards of health care to all Michigan residents.

(i) In collaboration with the regional planning director, oversee a regional effort to assure the establishment of community-based networks of solo providers, small group practices, essential community providers, and providers of auxiliary Michigan health

insurance system services that support health care providers in, and assure the delivery of, comprehensive, coordinated health care to Michigan residents.

(j) Assure the evaluation and measurement of the quality of health care delivered in the region, including assessment of the performance of individual health care providers, pursuant to standards and methods established by the chief medical officer.

(k) Provide feedback to and support and supervision of health care providers needed to improve the quality of health care they deliver.

(*l*) Assure the provision of information to assist consumers in evaluating the performance of health care providers.

(m) Identify areas of medical practice where standards have not been established, and collaborate with the chief medical officer to establish priorities in developing needed standards.

(n) Collaborate with regional public health officers to establish regional health policies that support the public health.

(o) Establish a regional program to monitor and decrease medical errors and their causes pursuant to standards and methods established by the chief medical officer.

(p) Support the development and implementation of innovative means to provide high-quality health care and assist providers in securing funds for innovative demonstration projects that seek to improve health care quality.

(q) Establish means to assess the impact of health insurance system policies intended to assure the delivery of high-quality health care and evidence-based standards.

(r) Collaborate with the chief medical officer and the director of planning in the development and maintenance of regional health care databases.

(s) Ensure the enforcement of health insurance system reporting requirements.

(t) Support health care providers in developing regional budget requests.

(u) Collaborate with the regional planning director of the partnerships for health to develop patient education on appropriate utilization of health care services.

(v) Annually report to the public, the regional planning board, and the chief medical officer on the status of regional health care programs, needed improvements, and plans to implement and evaluate delivery of health care improvements.

Sec. 37. (1) Each region shall have a regional health insurance board consisting of 13 members who shall be appointed by the regional planning director. Members shall serve 8-year terms that coincide with the term of the regional planning director and may be reappointed for a second term.

(2) Regional planning board members shall have resided for a minimum of 2 years in the region in which they serve prior to appointment to the board.

(3) Regional planning board members shall reside in the region they serve while on the board.

(4) The board shall consist of the following members:

(a) The regional planning director, the regional medical officer, the regional director of the partnerships for health, and

a public health officer from 1 of the regional counties. When there is more than 1 county in a region, the public health officer board position shall rotate among the public health county officers on a timetable to be established by each regional planning board.

(b) A representative from the office of consumer advocacy.

(c) One expert in health care financing.

(d) One expert in health care planning.

(e) Two members who are direct patient care providers in the region.

(f) One member who represents ancillary health care workers in the region.

(g) One member representing hospitals in the region.

(h) One member representing essential community providers in the region.

(i) One member representing the public.

(5) The regional planning director shall serve as chair of the board.

(6) The purpose of the regional planning boards is to advise and make recommendations to the regional planning director on all aspects of regional health policy.

(7) Meetings of the board shall be open to the public pursuant to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

ARTICLE IV FUNDING

Sec. 41. (1) There is established in the department of treasury the health insurance fund. The fund shall be administered by a director appointed by the commissioner.

(2) All money collected, received, and transferred pursuant to

this act, including money collected as a remedy or penalty for violations of this act, shall be transmitted to the department of treasury to be deposited to the credit of the health insurance fund for the purpose of financing the Michigan health insurance system. All money in the fund at the close of the fiscal year shall remain in the fund, shall not lapse, and shall be carried forward to the following year.

(3) All claims for health care services rendered shall be made to the health insurance fund through an electronic claims and payments system; however, alternative provisions shall be made for providers without electronic systems.

(4) All payments made for health care services shall be disbursed from the health insurance fund through an electronic claims and payments system; however, alternative provisions shall be made for providers without electronic systems.

(5) The director of the fund shall serve on the health insurance policy board.

Sec. 43. (1) The director of the health insurance fund shall establish the following accounts within the health insurance fund:

(a) A system account to provide for all annual state expenditures for health care.

(b) A reserve account.

(2) During the first 5 years of operation of the system, the director shall maintain a reserve account.

Sec. 45. (1) The director of the health insurance fund shall immediately notify the commissioner when regional or statewide revenue and expenditure trends indicate that expenditures appear to

exceed revenues.

(2) If the commissioner determines that statewide revenue trends indicate the need for statewide cost control measures, the commissioner shall convene the health insurance policy board to discuss the need for cost control measures and shall immediately report to the public regarding the possible need for cost control measures.

(3) Cost control measures include any or all of the following:

(a) Changes in the health insurance system or health facility administration that improve efficiency.

(b) Changes in the delivery of health care services that improve efficiency and care quality.

(c) Postponement of introduction of new benefits or benefit improvements.

(d) Postponement of planned capital expenditures.

(e) Limitations on the reimbursement of Michigan health insurance system managers and upper level managers.

(f) Limitations on health care provider reimbursement above a specified amount of aggregate billing for employers other than the Michigan health insurance system administration, whose compensation is determined by the payment board and who are not subject to state civil service statutes.

(g) Limitations on aggregate reimbursements to manufacturers of pharmaceutical and durable and nondurable medical equipment.

(h) Deferred funding of the reserve account.

(i) Imposition of copayments or deductible payments. Any copayment or deductible payments imposed shall be subject to all of

the following requirements:

(*i*) No copayment or deductible may be established when prohibited by federal law.

(*ii*) All copayments and deductibles shall meet federal guidelines for copayments and deductible payments that may lawfully be imposed on persons with low income.

(*iii*) The commissioner shall establish standards and procedures for waiving copayments or deductible payments and a waiver card which shall be issued to a patient or to a family to indicate the waiver. Copayment and deductible waivers shall be reviewed annually by the regional planning director.

(*iv*) Waivers shall not affect the reimbursement of health care providers.

(*v*) Any copayments or deductible payments established pursuant to this section shall be transmitted to the department of treasury to be deposited to the credit of the health insurance fund.

(*vi*) No copayments shall be established for preventive care as determined by a patient's primary provider.

(j) Imposition of an eligibility waiting period if the commissioner determines that large numbers of people are emigrating to the state for the purpose of obtaining health care through the Michigan health insurance system.

(4) Nothing in this act shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(5) Nothing in this act shall preclude employees from receiving benefits available to them under a collective bargaining

agreement or other employee-employer agreement that are superior to benefits under this act.

(6) Cost control measures implemented by the commissioner and the health insurance policy board shall remain in place in the state until the commissioner and the health insurance policy board determine that the cause of a revenue shortfall has been corrected.

(7) If the health insurance policy board determines that cost control measures described in subsection (3) will not be sufficient to meet a revenue shortfall, the commissioner shall report to the legislature and to the public on the causes of the shortfall and the reasons for the failure of cost controls and shall recommend measures to correct the shortfall, including an increase in health insurance system premium payments.

Sec. 47. (1) If the commissioner or a regional planning director determines that regional revenue and expenditure trends indicate a need for regional cost control measures, the regional planning director shall convene the regional planning board to discuss the possible need for cost control measures and to make a recommendation about appropriate measures to control costs. These may include any of the following:

(a) Changes in health insurance system or health facility administration that improve efficiency.

(b) Changes in the delivery of health services that improve efficiency or care quality.

(c) Postponement of planned regional capital expenditures.

(d) Limitation on reimbursement of health care providers, upper level managers, or pharmaceutical or medical equipment

manufacturers above a specified amount of aggregate billing.

(2) If a regional planning board is convened to implement cost control measures, the commissioner shall participate in the regional planning board meeting.

(3) The regional planning director, in consultation with the commissioner, shall determine if cost control measures are warranted and those measures that shall be implemented.

(4) Imposition of copayments or deductibles, postponement of new benefits or benefit improvements, deferred funding of the reserve account, establishment of eligibility waiting periods, and increases in health insurance premium payments may occur on a statewide basis only and with the concurrence of the commissioner and the health insurance policy board.

(5) If a regional planning director and regional planning board are considering imposition of cost control measures, the regional planning director shall immediately report to the residents of the region regarding the possible need for cost control measures.

(6) Cost control measures shall remain in place in a region until the regional planning director and the commissioner determine that the cause of a revenue shortfall has been corrected.

Sec. 49. (1) The commissioner annually shall prepare a health insurance system budget that includes all expenditures, specifies a limit on total annual state expenditures, and establishes allocations for each health care region that shall cover a 3-year period and that shall be disbursed on a quarterly basis.

(2) The commissioner shall limit the growth of spending on a

statewide and on a regional basis, by reference to average growth in state domestic product across multiple years; population growth, actuarial demographics, and other demographic indicators; differences in regional costs of living; advances in technology and their anticipated adoption into the benefit plan; improvements in efficiency of administration and care delivery; and improvements in the quality of care, and by reference to projected future state domestic product growth rates.

(3) The commissioner shall project health insurance system revenues and expenditures for 3, 6, 9, and 12 years pursuant to this act.

(4) The commissioner shall annually convene a health insurance system revenue and expenditure conference to discuss revenue and expenditure projections and future health insurance system policy directions and initiatives, including means to lower the cost of administration. Participants shall include regional health directors and medical officers, directors of the health insurance fund and payments board, the consumer advocate, state and regional directors of the partnerships for health, and representatives of the health insurance system facility upper level managers.

(5) The Michigan health insurance system budget shall include all of the following:

(a) Providers and managers budget.

(b) Capitated budgets.

(c) Noncapitated operating budgets.

(d) Capital investment budget.

(e) Purchasing budget.

(f) Research and innovation budget.

(g) Workforce training and development budget.

(h) Reserve account.

(i) System administration system.

(j) Regional budgets.

(6) In establishing budgets, the commissioner shall make adjustments based on all of the following:

(a) Costs of transition to the new system.

(b) Projections regarding the health services anticipated to be used by Michigan residents.

(c) Differences in cost of living between the regions, including the overhead costs of maintaining medical practices.

(d) Health risk of enrollees.

(e) Scope of services provided.

(f) Innovative programs that improve care quality, administrative efficiency, and workplace safety.

(g) Unrecovered cost of providing health care to persons who are not members of the Michigan health insurance system. The commissioner shall seek to recover the costs of health care provided to persons who are not members of the system.

(h) Costs of workforce training and development.

(i) Costs of correcting health outcome disparities and the unmet needs of previously uninsured and underinsured enrollees.

(j) Relative usage of different health care providers.

(k) Needed improvements in access to health care.

(*l*) Projected savings in administrative costs.

(m) Projected savings due to provision of primary and

preventive health care to Michigan residents, including savings from decreases in preventable emergency room visits and hospitalizations.

(n) Projected savings from improvements in health care quality.

(o) Projected savings from decreases in medical errors.

(p) Projected savings from systemwide management of capital expenditures.

(q) Cost of incentives and bonuses to support the delivery of high-quality health care, including incentives and bonuses needed to recruit and retain an adequate supply of needed health care providers and managers and to attract health care providers to medically underserved areas.

(r) Costs of treating complex illnesses, including disease management programs.

(s) Cost of implementing standards of health care, health care coordination, electronic medical records, and other electronic initiatives.

(t) Costs of new technology.

(u) Technology research and development costs and costs related to health insurance system use of new technologies.

Sec. 51. The commissioner shall annually establish the total funds to be allocated for provider and manager compensation pursuant to this section. In establishing the provider and manager budgets, the commissioner shall allot sufficient funds to assure that Michigan can attract and retain those providers and managers needed to meet the health needs of Michigan residents.

Sec. 53. (1) The commissioner shall establish the payments board and shall appoint a director and members of the board.

(2) The payments board shall be composed of experts in health care finance and insurance systems, a designated representative of the commissioner, a designated representative of the health insurance fund, and a representative of the regional planning directors who shall serve a 2-year term. The position of regional representative shall rotate among the directors of the regional planning boards.

(3) The purpose of the board is to establish and maintain a plan for the compensation of all of the following pursuant to the manager and provider budget established by the commissioner:

(a) Upper level managers in private health care facilities, including hospitals, integrated health care delivery systems, group medical practices, and essential community facilities.

(b) Elected and appointed Michigan health insurance system managers and officers who are exempt from statutes governing civil service employment.

(c) Health care professionals including physicians, osteopathic physicians, dentists, podiatrists, nurse practitioners, physician assistants, chiropractors, acupuncturists, psychologists, social workers, marriage, family, and child counselors, and other health care professionals who are required by law to be licensed to practice in Michigan and who provide services pursuant to this act.

(d) Health care providers licensed and accredited to provide services in Michigan may choose to be compensated for their services either by the Michigan health insurance system or by a

person to whom they provide services.

(e) Nothing in this act is intended to interfere with, change, or affect the terms of compensation established under contracts between unions and the health insurance system during negotiations for the labor cost component of the health insurance system operating budget.

(f) Health care providers electing to be compensated by the Michigan health insurance system shall enter into a contract with the health insurance system pursuant to provisions of this section.

(g) Health care providers electing to be compensated by persons to whom they provide services, instead of by the Michigan health insurance system, may establish charges for their services.

(4) Only the Michigan health insurance plan as provided under this act shall be sold in Michigan for services provided by the Michigan health insurance plan.

(5) Health care providers licensed or accredited to provide services in Michigan, who choose to be compensated by the health insurance system instead of by patients to whom they provide services, may choose how they wish to be compensated under this act, as fee-for-service providers or as salaried providers in health care systems that provide comprehensive, coordinated services.

(6) The compensation plan shall include all of the following:

(a) Actuarially sound payments for health care providers in the fee-for-service sector and for health care providers working in health systems where comprehensive and coordinated services are provided, including the actuarial basis for them.

(b) Payment schedules which shall be in effect for 3 years.

(c) Bonus and incentive payments, including, but not limited to, all the following:

(*i*) Bonus payments for providers and upper level managers who, in providing services and managing facilities, practices, and integrated health care delivery systems, pursuant to this act, meet performance standards and outcome goals established by the Michigan health insurance system.

(*ii*) Incentive payments for providers and upper level managers who provide services to the Michigan health insurance system in areas identified by the office of health care planning as medically underserved.

(*iii*) Incentive payments required to achieve the ratio of generalist to specialist providers needed in order to meet the standards of health care and service needs of the population.

(*iv*) Incentive payments required to recruit and retain nurse practitioners and physician assistants in order to provide primary and preventive health care to Michigan residents.

(*v*) No bonus or incentive payment may be made in excess of the total allocation for provider and manager incentive and bonus reimbursement established by the commissioner in the health insurance system budget.

(*vi*) No incentive may adversely affect the health care a patient receives or the care a health care provider recommends.

(7) Health care providers shall be paid for all services provided pursuant to this act, including health care provided to persons who are subsequently determined to be ineligible for the

Michigan health insurance system.

(8) Licensed health care providers who deliver services not covered under the Michigan health insurance system may establish rates for and charge patients for those services.

(9) Reimbursement to providers and managers shall not exceed the amount allocated by the commissioner to provider and manager annual budgets.

Sec. 55. (1) Fee-for-service health care providers shall choose representatives to negotiate reimbursement rates with the payments board on their behalf.

(2) The payments board shall establish a uniform system of payments for all services provided pursuant to this act.

(3) Payment schedules shall be available to health care providers in printed and in electronic documents.

(4) Payment schedules shall be in effect for 3 years, at which time payment schedules may be renegotiated. Payment adjustments may be made at the discretion of the payments board to meet the goals of the health insurance system.

(5) In establishing a uniform system of payments, the payments board shall collaborate with regional health directors and shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled health care providers in the region.

(6) Fee-for-service health care providers shall submit claims electronically to the health insurance fund and shall be paid promptly for claims filed in compliance with procedures established by the health insurance fund. If a properly filed claim for

eligible services is not paid promptly, the provider shall be paid interest on the claim at a rate of 12%, compounded annually.

Sec. 57. Compensation for health care providers and upper level managers employed by integrated health care delivery systems, group medical practices, and essential community providers that provide comprehensive, coordinated services shall be determined according to the following guidelines:

(a) Providers and upper level managers employed by systems that provide comprehensive, coordinated health care services shall be represented by their respective employers for the purposes of negotiating reimbursement with the payments board.

(b) In negotiating reimbursement with systems providing comprehensive, coordinated services, the payments board shall take into consideration the need for comprehensive systems to have flexibility in establishing provider and upper level manager reimbursement.

(c) Payment schedules shall be in effect for 3 years. However, payment adjustments may be made at the discretion of the payments board to meet the goals of the health insurance system.

(d) The payments board shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers and upper level managers to the regions.

(e) The payments board shall establish a timetable for reimbursement negotiations. If an agreement on reimbursement is not reached according to the timetable established by the payments board, the payments board shall establish reimbursement rates, which shall be binding.

Sec. 59. (1) The payments board shall annually report to the commissioner on the status of health care provider and upper level manager reimbursement, including satisfaction with reimbursement levels and the sufficiency of funds allocated by the commissioner for provider and upper level manager reimbursement. The payments board shall recommend needed adjustments in the allocation for provider payments.

(2) The office of health care quality shall annually report to the commissioner on the impact of the bonus payments in improving quality of health care, health outcomes, and management effectiveness. The payments board shall recommend needed adjustments in bonus allocations.

(3) The office of health care planning shall annually report to the commissioner on the impact of the incentive payments in recruiting health care providers and upper level managers to underserved areas, in establishing the needed ratio of generalist to specialist providers, and in attracting and retaining nurse practitioners and physician assistants to the state, and shall recommend needed adjustments.

Sec. 61. (1) The commissioner shall establish an allocation for each region to fund regional operating budgets for a period of 3 years. Allocations shall be disbursed to the regions on a quarterly basis.

(2) Integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated operating budget or a system operating

budget that covers all costs of providing health care services.

(3) Health care providers choosing to function on the basis of a capitated or system operating budget shall submit 3-year operating budget requests to the regional planning director, pursuant to standards and guidelines established by the commissioner.

(4) Health care providers may include in their operating budget requests reimbursement for ancillary health care or social services that were previously funded by money now received and disbursed by the health insurance fund.

(5) No payment may be made from an operating or a capitated budget for a capital expense except as stipulated in section 69.

(6) Regional planning directors shall negotiate operating budgets with regional health care entities, which shall cover a period of 3 years.

(7) Operating and capitated budgets shall include health care workforce labor costs. Where unions represent employees working in systems functioning under operating or capitated budgets, unions shall represent those employees in negotiations with the regional planning director for the purpose of establishing their reimbursement.

Sec. 63. (1) Health systems and medical practices functioning under operating and capitated budgets shall immediately report any projected operating deficit to the regional planning director. The regional planning director shall determine whether projected deficits reflect appropriate increases in utilization, in which case the director shall make an adjustment to the operating budget.

If the director determines that deficits are not justifiable, no adjustment shall be made.

(2) If a regional planning director determines that adjustments to operating budgets will cause a regional revenue shortfall and that cost control measures may be required, the regional planning director shall report the possible revenue shortfall to the commissioner and take actions required pursuant to section 45.

Sec. 65. (1) No payment may be made from a health system operating budget or from a capitated budget to provide a shareholder dividend.

(2) The inspector general shall monitor operating budgets to determine whether an unlawful payment has been made pursuant to this section.

(3) The commissioner shall establish and enforce remedies and penalties for violations of this section.

(4) Money collected for violations of this section shall be remitted to the health insurance fund for use in the Michigan health insurance system.

Sec. 67. (1) Margins generated by a facility operating under a health system capitated budget or from an operating budget may be retained and used to meet the health care needs of the population.

(2) No margin may be retained if that margin was generated through inappropriate limitations on access to health care or compromises in the quality of health care or in any way that adversely affected or is likely to adversely affect the health of the persons receiving services from a health facility, integrated

health care delivery system, group medical practice, or essential community provider functioning under an operating or capitated budget.

(3) The chief medical officer shall evaluate the source of margin generation and report violations of this section to the commissioner.

(4) The commissioner shall establish and enforce remedies and penalties for violations of this section.

(5) Money collected pursuant to violations of this section shall be remitted to the health insurance fund for use in the Michigan health insurance system.

(6) Health facilities operating under health system capitated and operating budgets may raise and expend funds from sources other than the Michigan health insurance system, including, but not limited to, private or foundation donors and other non-Michigan health insurance system sources for purposes related to the goals of this act and in accordance with provisions of this act.

Sec. 69. (1) During the transition, the commissioner shall develop a capital management plan which shall govern all capital investments and acquisitions undertaken in the Michigan health insurance system. The plan shall include a framework, standards, and guidelines for all of the following:

(a) Standards whereby the office of health care planning shall oversee, assist in the implementation of, and ensure that the provisions of the capital management plan are enforced.

(b) Assessment and prioritization of short- and long-term Michigan health insurance system capital needs on statewide and

regional bases.

(c) Assessment of capital assets and capital health care shortages on a regional and statewide basis.

(d) Development by the commissioner of a health insurance system capital budget that supports health insurance system goals, priorities, and performance standards and meets the health needs of Michigan residents.

(e) Development, as part of the Michigan health insurance system capital budget, of regional capital allocations that shall cover a period of 3 years.

(f) Exploration and evaluation of, and support for, noninvestment means to meet health care needs, including, but not limited to, improvements in administrative efficiency, health care quality, and innovative service delivery, use, adaptation, or refurbishment of existing land and property and identification of publicly owned land or property that may be available to the Michigan health insurance system and that may meet a capital need.

(g) Development of capital inventories on a regional basis, including the condition, utilization capacity, maintenance plan and costs, deferred maintenance of existing capital inventory, and excess capital capacity.

(h) A process whereby those intending to make capital investments or acquisitions shall prepare a business case for making the investment or acquisition, including the full life-cycle costs of the project or acquisition, an environmental impact report that meets existing state standards, and a demonstration of how the investment or acquisition meets the health needs of Michigan

residents it is intended to serve. Acquisitions include the acquisition of land, operational property, or administrative office space.

(i) Standards and a process whereby the regional planning directors shall evaluate, accept, reject, or modify a business plan for a capital investment or acquisition. Decisions of a regional planning director may be appealed through a grievance resolution process established by the commissioner.

(j) Standards for binding project contracts between the health insurance system and the party developing a capital project or making a capital acquisition that shall govern all terms and conditions of capital investments and acquisitions, including terms and conditions for health insurance system grants, loans, lines of credit, and lease purchase arrangements.

(k) A process and standards whereby the health insurance fund shall negotiate terms and conditions of the Michigan health insurance system loans, grants, lines of credit, and lease purchase arrangements for capital investments and acquisitions. Terms and conditions negotiated by the health insurance fund shall be included in project contracts.

(*l*) A plan for the commissioner and for the regional planning directors to issue requests for proposals and to oversee a process of competitive bidding for the development of capital projects that meet the needs of the Michigan health insurance system.

(m) Responses to requests for proposals and competitive bids shall include a description of how a project meets the service needs of the region and addresses the environmental impact report

and shall include the full life-cycle costs of a capital asset.

(n) Requests for proposals shall address how intellectual property will be handled and shall include conflict-of-interest guidelines.

(o) A process and standards for periodic revisions in the capital management plan, including annual meetings in each region to discuss the plan and make recommendations for improvements in the plan.

(p) Standards for determining when a violation of these provisions shall be referred to the attorney general for investigation and possible prosecution of the violation.

(q) Development of performance standards and a process to monitor and measure performance of those making capital health care investments and acquisitions, including those making capital investments pursuant to a state competitive bidding process.

(r) A process for earned autonomy from state capital investment oversight for those who demonstrate the ability to manage capital investment and capital assets effectively in accordance with Michigan health insurance system standards, and standards for loss of earned autonomy when capital management is ineffective.

(2) Terms and conditions of capital project oversight by the Michigan health insurance system shall be based on the performance history of the project developer. Health care providers may earn autonomy from oversight if they demonstrate effective capital planning and project management, pursuant to the goals and guidelines established by the commissioner. Health care providers

who do not demonstrate such proficiency shall remain subject to oversight by the regional planning director or shall lose autonomy from oversight.

(3) In general, no capital investment may be made from an operating budget. However, guidelines shall be established for the types and levels of small capital investments that may be undertaken from an operating budget without the approval of the regional planning director.

Sec. 71. (1) Regional planning directors shall develop a regional capital development plan pursuant to the Michigan health insurance system capital management plan established by the commissioner. In developing the regional capital development plan, the regional planning director shall do all of the following:

(a) Implement the standards and requirements of the capital management plan established by the commissioner.

(b) Develop and annually update a regional budget request that covers a period of 3 years.

(c) Assist regional health care providers to develop capital budget requests pursuant to the Michigan health insurance system capital management plan established by the commissioner.

(d) Receive and evaluate capital budget requests from regional health care providers.

(e) Establish ranking criteria to assess competing demands for capital.

(f) Conduct ongoing project evaluation to assure that terms and conditions of project funding are met.

(2) Services provided as a result of capital investments or

acquisitions that do not meet the terms of the regional capital development plan and the capital management plan developed by the commissioner shall not be reimbursed by the Michigan health insurance system.

Sec. 73. (1) Assets financed by state grants, loans, and lines of credit and lease purchase arrangements shall be owned, operated, and maintained by the recipient of the grant, loan, line of credit, or lease purchase arrangements, according to terms established at the time of issuance of the grant, loan, or line of credit, or lease purchase arrangement.

(2) Assets financed under long-term leases with the Michigan health insurance system shall be transferred to public ownership at the end of the lease.

(3) Assets financed by private capital or donations are owned, operated, and maintained by the borrower or donor recipient.

Sec. 75. The health regions shall make financial information available to the public when the Michigan health insurance system contribution to a capital project is greater than $50,000,000.00. Information shall include the purpose of the project or acquisition, its relation to Michigan health insurance system goals, the project budget, the timetable for completion, and performance standards and benchmarks.

Sec. 77. (1) The commissioner shall establish a budget for the purchase of prescription drugs and durable and nondurable medical equipment for the health insurance system.

(2) The commissioner shall use the purchasing power of the state to obtain the lowest possible prices for prescription drugs

and durable and nondurable medical equipment.

(3) The commissioner shall make discounted prices available to all Michigan residents, health care providers, and prescription drug and medical equipment wholesalers and retailers of products approved for use in and included in the benefit package of the Michigan health insurance system.

Sec. 79. (1) The commissioner shall establish a budget to support research and innovation that has been recommended by the chief medical officer, the director of planning, the consumer advocates, the partnerships for health, and others as required by the commissioner.

(2) The research and innovation budget shall support the goals and standards of the Michigan health insurance system.

Sec. 81. (1) The commissioner shall establish a budget to support the training, development, and continuing education of health care providers and the health care workforce needed to meet the health care needs of Michigan residents and the goals and standards of the health insurance system.

(2) The commissioner shall establish guidelines for giving special consideration for employment to persons who have been displaced as a result of the transition to the new health insurance system.

Sec. 83. (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation so that all current federal payments to the state for health care be paid directly to the Michigan health insurance system, which shall then assume responsibility for all benefits and services previously paid for by

the federal government with those funds.

(2) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution for health care services in Michigan that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

(3) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation so that all current state payments for health care shall be paid directly to the system, which shall then assume responsibility for all benefits and services previously paid for by state government with those funds.

(4) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the legislature a contribution for health care services that shall not decrease in relation to state government expenditures for health care services in the year that this act was enacted, except that it may be corrected for change in state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

(5) The commissioner shall establish formulae for equitable contributions to the Michigan health insurance system from all Michigan counties and other local government agencies.

(6) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation so that all county or other local government agency payments shall be paid directly to the Michigan health insurance system.

(7) The system's responsibility for providing care shall be

secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for these programs is not transferred to the health insurance fund or that the transfer is delayed beyond the date on which initial benefits are provided under the system.

(8) In order to minimize the administrative burden of maintaining eligibility records for programs transferred to the system, the commissioner shall strive to reach an agreement with federal, state, and local governments in which their contributions to the health insurance fund shall be fixed to the rate of change of the state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

Sec. 85. (1) The commissioner shall pursue all reasonable means to secure a repeal or a waiver of any provision of federal law that preempts any provision of this act. If a repeal or a waiver of law or regulations cannot be secured, the commissioner shall exercise his or her powers to promulgate rules and regulations, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this act.

(2) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan that, under federal law, preempts provisions of this act shall first seek benefits under that contract or plan before receiving benefits from the system under this act.

(3) No benefits shall be denied under the system created by this act unless the employee has failed to take reasonable steps to

secure like benefits from the contract or plan, if those benefits are available.

(4) Nothing in this section shall preclude a person from receiving benefits from the system under this act that are superior to benefits available to the person under an existing contract or plan.

(5) Nothing in this act is intended, nor shall this act be construed, to discourage recourse to contracts or plans that are protected by federal law.

(6) To the extent permitted by federal law, a health care provider shall first seek payment from the contract or plan before submitting bills to the Michigan health insurance system.

Sec. 87. (1) It is the intent of this act to establish a single public payer for all health care in Michigan. However, until such time as the role of all other payers for health care has been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(2) As used in this act, collateral source includes all of the following:

(a) Insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance.

(b) Health care service plans and pension plans.

(c) Employers.

(d) Employee benefit contracts.

(e) Government benefit programs.

(f) A judgment for damages for personal injury.

(g) Any third party who is or may be liable to an individual for health care services or costs.

(3) "Collateral source" does not include either of the following:

(a) A contract or plan that is subject to federal preemption.

(b) Any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in subsection (2) is not excluded from the obligations imposed by this act by virtue of a contract or relationship with a governmental unit, agency, or service.

(4) The commissioner shall attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in Michigan into the Michigan health insurance system.

(5) Whenever an individual receives health care services under the system and he or she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care provider shall forward this information to the commissioner. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide

additional information as requested by the commissioner.

(6) The Michigan health insurance system shall seek reimbursement from the collateral source for services provided to the individual and may institute appropriate action, including suit, to recover the reimbursement. Upon demand, the collateral source shall pay to the health insurance fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the system.

Sec. 89. (1) If a collateral source is exempt from subrogation or the obligation to reimburse the system as provided in this act, the commissioner may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the system.

(2) To the extent permitted by federal law, contractual retiree health benefits provided by employers shall be subject to the same subrogation as other contracts, allowing the Michigan health insurance system to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenues of the benefits directly to the Michigan health insurance system.

ARTICLE V ELIGIBILITY AND BENEFITS

Sec. 91. (1) All Michigan residents are eligible for the Michigan health insurance system. Residency shall be based upon physical presence in the state with the intent to reside. The commissioner shall establish standards and a simplified procedure to demonstrate proof of residency.

(2) The commissioner shall establish a procedure to enroll

eligible residents and provide each eligible individual with identification that can be used by health care providers to determine eligibility for services.

Sec. 93. (1) The Michigan health insurance system shall provide health care coverage to Michigan residents who are temporarily out of the state. The commissioner shall determine eligibility standards for residents temporarily out of state for longer than 90 days who intend to return and reside in Michigan and for nonresidents temporarily employed in Michigan.

(2) Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions established by the commissioner. The commissioner may require that a resident be transported back to Michigan when prolonged treatment of an emergency condition is necessary.

Sec. 95. Visitors to Michigan shall be billed for all services received under the system. The commissioner may establish intergovernmental arrangements with other states and countries to provide reciprocal coverage for temporary visitors.

Sec. 97. All persons eligible for health benefits from Michigan employers but who are working in another jurisdiction shall be eligible for health benefits under this act providing that they make payments equivalent to the payments they would be required to make if they were residing in Michigan.

Sec. 99. Unmarried, unemancipated minors shall be deemed to have the residency of their parent or guardian. If a minor's parents are deceased and a legal guardian has not been appointed,

or if a minor has been emancipated by court order, the minor may establish his or her own residency.

Sec. 101. (1) An individual shall be presumed to be eligible if he or she arrives at a health facility and is unconscious, comatose, or otherwise unable, because of his or her physical or mental condition, to document eligibility or to act in his or her own behalf, or if the patient is a minor, the patient shall be presumed to be eligible, and the health facility shall provide care as if the patient were eligible.

(2) All health facilities subject to state and federal provisions governing emergency medical treatment shall continue to comply with those provisions.

Sec. 103. (1) Any eligible individual may choose to receive services under the Michigan health insurance system from any willing health care provider participating in the system.

(2) Covered benefits in the Michigan health insurance system shall include all medical care determined to be medically appropriate by the consumer's health care provider, subject to subsection (4). Covered benefits include, but are not limited to, all of the following:

(a) Inpatient and outpatient health facility services.

(b) Inpatient and outpatient professional health care provider services by licensed health care professionals.

(c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(d) Durable medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and

their repair.

(e) Rehabilitative care.

(f) Emergency transportation and necessary transportation for health care services for disabled and indigent persons.

(g) Language interpretation and translation for health care services, including sign language for those unable to speak or hear or who are language impaired, and Braille translation or other services for those with no or low vision.

(h) Child and adult immunizations and preventive care.

(i) Health education.

(j) Hospice care.

(k) Home health care.

(*l*) Prescription drugs that are listed on the system formulary. Nonformulary prescription drugs may be included where standards and criteria established by the commissioner are met.

(m) Mental and behavioral health care.

(n) Dental care.

(o) Podiatric care.

(p) Chiropractic care.

(q) Acupuncture.

(r) Blood and blood products.

(s) Emergency care services.

(t) Vision care.

(u) Adult day care.

(v) Case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting.

(w) Substance abuse treatment.

(x) Care of up to 100 days in a skilled nursing facility following hospitalization.

(y) Dialysis.

(z) Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization.

(3) The commissioner may expand benefits beyond the minimum benefits described in subsection (2) when expansion meets the intent of this act and when there are sufficient funds to cover the expansion.

(4) The following health care services shall be excluded from coverage by the Michigan health insurance system:

(a) Health care services determined to have no medical indication by the commissioner and the chief medical officer.

(b) Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care professional in the system.

(c) Private rooms in inpatient health facilities where appropriate nonprivate rooms are available, unless determined to be medically necessary by a qualified, licensed health care professional in the system.

(d) Services of a health care provider that is not licensed or accredited by the state except for approved services provided to a Michigan resident who is temporarily out of the state.

Sec. 105. (1) The commissioner shall institute no deductible payments or copayments other than for specialist visits that are unreferred by the primary care provider during the initial 2 years of the system's operation. The commissioner and the health insurance policy board shall review this policy annually, beginning in the third year of operation, and determine whether deductible payments or copayments should be established.

(2) Patients shall incur a copayment charge for unreferred specialist visits, the amount of which shall be established by the commissioner.

(3) If the commissioner establishes copayments as provided in subsection (1), they shall be limited to $250.00 per person per year and $500.00 per family per year. Copayments for unreferred specialist visits are not subject to this limit.

(4) If the commissioner establishes deductible payments consistent with subsection (1), they shall be limited to $250.00 per person per year and $500.00 per family per year.

(5) No copayments or deductible payments shall be established for preventive care as determined by a patient's primary care provider.

(6) No copayments or deductible payments shall be established when prohibited by federal law.

(7) The commissioner shall establish standards and procedures for waiving copayments or deductible payments. Waivers of

copayments or deductible payments shall not affect the reimbursement of health care providers.

(8) Any copayments established pursuant to this section and collected by health care providers shall be transmitted to the department of treasury to be deposited to the credit of the health insurance fund.

(9) Nothing in this act shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(10) Nothing in this act shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this act.

Sec. 107. (1) All health care providers licensed or accredited to practice in Michigan may participate in the Michigan health insurance system. No health care provider whose license or accreditation is suspended or revoked may be a participating health care provider.

(2) Health care providers may accept eligible persons for care according to the provider's ability to provide services needed by the applicant and according to the number of patients a provider can treat without compromising safety and care quality. A provider may accept patients in the order of time of application.

(3) Persons eligible for health care services under this act may choose a primary care provider. Primary care providers include family practitioners, general practitioners, internists, pediatricians, and nurse practitioners and physician assistants

practicing under supervision as defined in Michigan law. Women may choose an obstetrician/gynecologist, in addition to a primary care provider.

(4) Persons who choose to enroll with integrated health care delivery systems, group medical practices, or essential community providers that offer comprehensive services shall retain membership for at least 1 year after an initial 3-month evaluation period during which time they may withdraw for any reason. The 3-month period shall commence on the date when an enrollee first sees a primary care provider. Persons who want to withdraw after the initial 3-month period shall request a withdrawal pursuant to dispute resolution procedures established by the commissioner and may request assistance from the consumer advocate in the dispute process. The dispute shall be resolved in a timely fashion and shall have no adverse effect on the care a patient receives.

(5) Persons needing to change primary care providers because of health care needs that their primary care provider cannot meet may change primary care providers at any time.

Sec. 109. (1) Primary care providers shall coordinate the health care a patient receives or shall ensure that a patient's care is coordinated.

(2) Patients shall have a referral from their primary care provider, or from an emergency provider rendering care to them in the emergency room or other accredited emergency setting, or from a health care professional treating a patient for an emergency condition in any setting, or from their obstetrician/gynecologist, to see a physician or nonphysician specialist whose services are

covered by this act, unless the patient agrees to assume the costs of care, in which case a referral is not needed. A referral shall not be required to see a dentist.

(3) Referrals shall be based on the medical needs of the patient and on guidelines which shall be established by the chief medical officer to support clinical decision making.

(4) Referrals shall not be restricted or provided solely because of financial considerations. The chief medical officer shall monitor referral patterns and intervene as necessary to assure that referrals are neither restricted nor provided solely because of financial considerations.

(5) Patients established with a specialist before the system is implemented do not need a referral to continue seeing the specialist or their designee.

(6) Where referral systems are in place prior to the initiation of the system, the chief medical officer shall review the referral systems to assure that they meet health insurance system standards for care quality and shall assure needed changes are implemented so that all Michigan residents receive the same standards of care quality.

(7) A specialist may serve as the primary care provider if the patient and the provider agree to this arrangement and if the provider agrees to coordinate the patient's care or to ensure that the care the patient receives is coordinated.

(8) The commissioner shall establish or ensure the establishment of a computerized referral registry to facilitate the referral process and to allow a specialist and a patient to easily

determine whether a referral has been made pursuant to this act.

(9) A patient may appeal the denial of a referral through grievance resolution procedures established under this act and may request the assistance of the consumer advocate during the grievance resolution process.

Sec. 111. (1) The purpose of the office of health care planning is to plan for the short- and long-term health needs of Michigan residents pursuant to the health care and finance standards established by the commissioner and by this act.

(2) The office shall be headed by a planning director appointed by the commissioner.

(3) The director shall do all the following:

(a) Administer all aspects of the office of health care planning.

(b) Serve on the health insurance policy board.

(c) Establish performance criteria in measurable terms for health care goals in consultation with the chief medical officer, the regional health officers, and directors and others with experience in health care outcomes measurement and evaluation and evaluate the performance criteria.

(d) Assist the health care regions to develop operating and capital requests pursuant to health care and finance guidelines established by the commissioner and by this act. In assisting regions, the director shall do all of the following:

(*i*) Identify medically underserved areas and health service shortages.

(*ii*) Identify disparities in health outcomes.

(*iii*) Support establishment of comprehensive health care databases using uniform methodology that is compatible between the regions and between the regions and the state health insurance agency.

(*iv*) Provide information to support effective regional planning.

(*v*) Provide information to support interregional planning, including planning for access to specialized centers that perform a high volume of procedures for conditions requiring highly specialized treatments, including emergency and trauma and other interregional access to needed health care, and planning for coordinated interregional capital investment.

(*vi*) Evaluate regional budget requests and make recommendations to the commissioner about regional revenue allocations.

(e) Estimate the health care workforce required to meet the health needs of Michigan residents pursuant to the standards and goals established by the commissioner, the costs of providing the needed workforce, and, in collaboration with regional planners, educational institutions, the governor, and the legislature, develop short- and long-term plans to meet those needs, including a plan to finance needed training.

(f) Estimate the number and types of health facilities required to meet the short- and long-term health care needs of the population and the projected costs of needed facilities. In collaboration with the commissioner, regional planning directors and health officers, the chief medical officer, the governor, and the legislature, develop plans to finance and build needed

facilities.

Sec. 113. The director of the office of health care planning shall establish the following electronic initiatives:

(a) Establish integrated statewide health care databases to support health care planning and determine which databases should be established on a statewide basis and which should be established on a regional basis.

(b) Assure that databases have uniform methodology and formats that are compatible between regions and between the regions and the state.

(c) Establish mandatory database reporting requirements and remedies and penalties for noncompliance. Monitor the effectiveness of reporting and make needed improvements.

(d) Establish electronic, online, scheduling systems for use in the health insurance system.

(e) Establish electronic provider patient communication systems that allow for e-visits, for use in the health insurance system.

(f) Establish electronic systems that allow standard of care guidelines, including disease management programs to be embedded in a patient's electronic medical records.

(g) Establish electronic systems that give information to providers about community-based patient care resources.

(h) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that link clinical guidelines to individual patient conditions, and guide clinicians through diagnosis and treatment algorithms based

on evidence-based research and best medical practices.

(i) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that offer providers access to guidelines that are appropriate for their specialty and that include current information on prevention and treatment of disease.

(j) In collaboration with the partnerships for health and regional health officers, establish web-based patient-centered information systems that assist people to promote health and provide information on health conditions and recent developments in treatment.

(k) Establish electronic systems and other means to provide patients with easily understandable information about the performance of health care providers. This shall include, but is not limited to, information about the experience that providers have in the field or fields in which they deliver care, the number of years they have practiced in their field, and, in the case of medical and surgical procedures, the number of procedures they have performed in their area or areas of specialization.

(*l*) Establish electronic systems that facilitate provider continuing medical education that meets licensure requirements.

(m) Establish means for anonymous reporting of suspected medical errors.

(n) Recommend to the commissioner means to link health care research with the goals and priorities of the health insurance system.

Sec. 115. (1) Within the agency, the commissioner shall

establish the office of health care quality.

(2) The office shall be headed by the chief medical officer.

(3) The office of health care quality shall have the following purposes:

(a) Support the delivery of high-quality, coordinated health care services that enhance health, prevent illness, disease, and disability, slow the progression of chronic diseases, and improve personal health management.

(b) Promote efficient health care delivery.

(c) Establish processes for measuring, monitoring, and evaluating the quality of care delivered in the health insurance system, including the performance of individual health professionals.

(d) Establish means to make changes needed to improve care quality, including innovative programs that improve quality.

(e) Promote patient, provider, and employer satisfaction with the health insurance system.

(f) Assist regional planning directors and medical officers in the development and evaluation of regional budget requests.

Sec. 117. (1) In supporting the goals of the office of health care quality, the chief medical officer shall do all of the following:

(a) Administer all aspects of the office.

(b) Serve on the health insurance policy board.

(c) Collaborate with regional medical officers, directors, health care providers, and consumers, the director of planning, the consumer advocate, and partnership for health directors to develop

community-based networks of solo providers, small group practices, essential community providers, and providers of patient care support services in order to offer comprehensive, multidisciplinary, coordinated services to patients.

(d) Establish evidence-based standards of care for the health insurance system which shall serve as guidelines to support providers in the delivery of high-quality health care. Standards shall be based on the best evidence available at the time and shall be continually updated. Standards are intended to support the clinical judgment of individual providers, not to replace it, and to support clinical decisions based on the needs of individual patients.

(2) In establishing standards under subsection (1), the chief medical officer shall do all of the following:

(a) Draw on existing standards established by Michigan health care institutions, on peer-created standards, and on standards developed by other institutions that have had a positive impact on care quality, such as the centers for disease control and the agency for health care quality and research.

(b) Collaborate with regional medical officers in establishing regional goals, priorities, and a timetable for implementation of standards of health care.

(c) Assure a process for patients to provide their views on standards of health care to the consumer advocate who shall report those views to the chief medical officer.

(d) Collaborate with the director of planning and regional medical officers to support the development of computer software

systems that link clinical guidelines to individual patient conditions, guide clinicians through diagnosis and treatment algorithms based on evidence-based research and best medical practices, offer access to guidelines appropriate to each medical specialty, and offer current information on disease prevention and treatment and that support continuing medical education.

(e) Where referral systems for access to specialty health care are in place prior to the initiation of the health insurance system, the chief medical officer shall review the referral systems to assure that they meet health insurance system standards for care quality and shall assure that needed changes are implemented so that all Michigan residents receive the same standards of care quality.

(3) In collaboration with the director of planning and regional medical officer, the chief medical officer shall implement means to measure and monitor the quality of health care delivered in the health insurance system. Monitoring systems shall include, but are not limited to, peer and patient performance reviews.

(4) The chief medical officer shall establish means to support individual providers and health systems in correcting quality of care problems, including time frames for making needed improvements and means to evaluate the effectiveness of interventions.

(5) In collaboration with regional medical officers and directors and the director of planning, the chief medical officer shall establish means to identify medical errors and their causes and develop plans to prevent them.

(6) The chief medical officer shall convene an annual

statewide conference to discuss medical errors that occurred during the year, their causes, means to prevent errors, and the effectiveness of efforts to decrease errors.

(7) The chief medical officer shall recommend to the commissioner an evidence-based benefits package for the health insurance system, including priorities for needed benefit improvements. In making recommendations, the chief medical officer shall do all of the following:

(a) Identify safe and effective treatments.

(b) Evaluate and draw on existing benefit packages.

(c) Receive comments and recommendations from health care providers about benefits that meet the needs of their patients.

(d) Receive comments and recommendations made directly by patients or indirectly through the consumer advocate.

(e) Identify and recommend to the commissioner and the health insurance policy board innovative approaches to health promotion, disease and injury prevention, education, research, and care delivery for possible inclusion in the benefit package.

(f) Identify complementary and alternative modalities that have been shown by the national institutes of health, division of complementary and alternative medicine to be safe and effective for possible inclusion as covered benefits.

(g) Recommend to the commissioner and update, as appropriate, evidence-based pharmaceutical and durable and nondurable medical equipment formularies. In establishing the formularies, the chief medical officer shall establish a pharmacy and therapeutics committee composed of pharmacy and medical health care providers,

representatives of health facilities and organizations that have system formularies in place at the time the system is implemented, and other experts that shall do all the following:

(*i*) Identify safe and effective pharmaceutical agents for use in the Michigan health insurance system.

(*ii*) Draw on existing standards and formularies.

(*iii*) Identify experimental drugs and drug treatment protocols for possible inclusion in the formulary.

(*iv*) Review formularies in a timely fashion to ensure that safe and effective drugs are available and that unsafe drugs are removed from use.

(*v*) Assure the timely dissemination of information needed to prescribe safely and effectively to all Michigan providers.

(*vi*) Establish standards and criteria and a process for providers to seek authorization for prescribing pharmaceutical agents and durable and nondurable medical equipment that are not included in the system formulary. No standard or criteria shall impose an undue administrative burden on patients, health care providers, including pharmacies and pharmacists, and none shall delay the care a patient needs.

(*vii*) Develop standards and criteria and a process for providers to request authorization for services and treatments, including experimental treatments that are not included in the system benefit package. Where processes are in place when the health insurance system is initiated, the chief medical officer shall review the systems to assure that they meet health insurance system standards for care quality and shall assure that needed

changes are implemented so that all Michigan residents receive the same standards of care quality. No standard or criteria shall impose an undue administrative burden on a provider or a patient, and none shall delay the care a patient needs.

(h) In collaboration with the director of planning, regional planning directors, and regional medical officers, identify appropriate ratios of general medical providers to specialty medical providers on a regional basis that meet the health care needs of the population and the goals of the health insurance system.

(i) Recommend to the commissioner and to the payments board financial and nonfinancial incentives and other means to achieve recommended provider ratios.

(j) Collaborate with the director of planning and regional medical officers and consumer advocates in development of electronic initiatives, pursuant to section 113.

(k) Collaborate with the commissioner, the regional health officers, the directors of the payments board and the health insurance fund to formulate a provider reimbursement model that promotes the delivery of coordinated, high-quality health services in all sectors of the health insurance system and creates financial and other incentives for the delivery of high-quality health care.

(*l*) Establish or assure the establishment of continuing medical education programs about advances in the delivery of high-quality health care.

(m) Convene an annual statewide quality of care conference to discuss problems with health care quality and to make

recommendations for changes needed to improve health care quality. Participants shall include regional medical directors, health care providers, other providers, patients, policy experts, experts in quality of care measurement, and others.

(n) Annually report to the commissioner, the health insurance policy board, and the public on the quality of care delivered in the health insurance system, including improvements that have been made and problems that have been identified during the year, goals for health care improvement in the coming year, and plans to meet these goals.

(8) No person working within the agency, or on a pharmacy and therapeutics committee or serving as a consultant to the agency or a pharmacy and therapeutics committee, may receive fees or remuneration of any kind from a pharmaceutical company.

Sec. 119. (1) The consumer advocate, in collaboration with the chief medical officer, the regional consumer advocates, medical officers, and directors, shall establish a program in the state health insurance agency and in each region called the "Partnerships for Health".

(2) The purpose of the partnerships for health is to improve health through community health initiatives, to support the development of innovative means to improve health care quality, to promote efficient health care delivery, and to educate the public about the following:

(a) Personal maintenance of health.

(b) Prevention of disease.

(c) Improvement in communication between patients and

providers.

(d) Improving quality of care.

(3) The consumer advocate shall work with the community and health care providers in proposing partnerships for health projects and in developing project budget requests that shall be included in the regional budget request to the commissioner.

(4) In developing educational programs, the partnerships for health shall collaborate with educators in the region.

(5) Partnerships for health shall support the coordination of Michigan health insurance system and public health system programs.

Sec. 121. (1) The consumer advocate shall do all of the following:

(a) Establish and maintain a grievance resolution system approved by the commissioner under which enrollees may submit their grievances to the system. The system shall provide reasonable procedures in accordance with state rules and regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(b) Inform enrollees upon enrollment in the system and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(c) Provide printed and electronic access for enrollees who wish to register grievances. The forms used by the system shall be approved by the commissioner in advance as to format.

(d) Provide for a written acknowledgment within 5 calendar days of the receipt of a grievance, except as otherwise provided.

The acknowledgment shall advise the complainant that the grievance has been received, the date of receipt, and the name of the system representative and the telephone number and address of the system representative who may be contacted about the grievance. Grievances received by telephone, by facsimile, by electronic mail, or online through the system's website that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the acknowledgement requirements and from subdivision (e). The consumer advocate shall maintain a log of all these grievances. The log shall be periodically reviewed by the consumer advocate and shall include the following information for each complaint:

(*i*) The date of the call.

(*ii*) The name of the complainant.

(*iii*) The complainant's system identification number.

(*iv*) The nature of the grievance.

(*v*) The nature of the resolution.

(*vi*) The name of the system representative who took the call and resolved the grievance.

(e) Provide enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the system's response. For grievances involving the delay, denial, or modification of health care services, the system response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the system, or 1 of its contracting

providers, issues a decision delaying, denying, or modifying health care services to an enrollee based in whole or in part on a finding that the proposed health care services are not a covered benefit in the system that applies to the enrollee, the decision shall clearly specify the system provisions that exclude that coverage.

(f) Keep in its files all copies of grievances, and the responses thereto, for a period of 5 years.

(g) Establish and maintain a website that shall provide an online form that enrollees can use to file a grievance online.

(2) The commissioner may require enrollees and subscribers to participate in a plan's grievance resolution system for up to 30 days before pursuing a grievance through the commissioner or the independent medical review system. However, the commissioner may not impose this waiting period for expedited review cases or in any other case where the commissioner determines that an earlier review is warranted. In any case determined by the consumer advocate to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function, or in any other case where the consumer advocate determines that an earlier review is warranted, an enrollee shall not be required to complete the grievance resolution system or to participate in the process for at least 30 days before submitting a grievance to the independent medical review system established pursuant to section 123.

(3) If the enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or

other designee of the enrollee, as appropriate, may submit the grievance to the consumer advocate as a designated agent of the enrollee. Further, a provider may join with, or otherwise assist, an enrollee, or the agent, to submit the grievance to the consumer advocate. In addition, following submission of the grievance to the consumer advocate, the enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the enrollee. For purposes of this section, a relative includes the parent, stepparent, spouse, domestic partner, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the enrollee.

(4) The consumer advocate shall review the written documents submitted with the enrollee's request for review. The consumer advocate may ask for additional information and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the enrollee. If, after reviewing the record, the consumer advocate concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to section 123, the consumer advocate shall immediately notify the enrollee of that option and shall, if requested orally or in writing, assist the enrollee in participating in the independent medical review system.

(5) The consumer advocate shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the enrollee, to any provider that has joined with or is otherwise assisting the enrollee, and to the commissioner, within 30 calendar

days of receipt of the request for review unless the consumer advocate, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to section 123, the consumer advocate's written notice shall include, at a minimum, the following:

(a) A summary of findings and the reasons why the consumer advocate found the system to be, or not to be, in compliance with any applicable laws, rules, regulations, or orders of the commissioner.

(b) A discussion of the consumer advocate's contact with any medical provider, or any other independent expert relied on by the consumer advocate, along with a summary of the views and qualifications of that provider or expert.

(c) If the enrollee's grievance is sustained in whole or in part, information about any corrective action taken.

(6) In any consumer advocate review of a grievance involving a disputed health care service, as defined in section 123, that is not eligible for the independent medical review system established pursuant to section 123, in which the consumer advocate finds that the system has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health insurance system contract, the consumer advocate's written notice shall order the system to promptly offer and provide those health care services

to the enrollee. The consumer advocate's order shall be binding on the system.

(7) The consumer advocate shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(8) The grievance resolution system authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section does not preclude the use of any other remedy provided by law.

(9) Nothing in this section shall be construed to allow the submission to the consumer advocate of any provider grievance under this section.

Sec. 123. (1) As used in this section:

(a) "Coverage decision" means the approval or denial by the health insurance system, or by 1 of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health insurance system. Coverage decision does not encompass a plan or contracting provider decision regarding a disputed health care service.

(b) "Disputed health care service" means any health care service eligible for coverage and payment under the benefits package of the health insurance system that has been denied, modified, or delayed by a decision of the system, or by 1 of its

contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. If the system, or 1 of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the system, the statement of decision shall clearly specify the provisions of the system that exclude coverage.

(2) The consumer advocate shall establish the independent medical review system to act as an independent, external medical review process for the health insurance system to provide timely examinations of disputed health care services as defined in this section and coverage decisions as defined in this section regarding experimental and investigational therapies to ensure that the system provides efficient, appropriate, high-quality health care, and that the health care system is responsive to patient disputes.

(3) Coverage decisions regarding experimental or investigational therapies for individual enrollees who meet all of the following criteria are eligible for review by the independent medical review system:

(a) The enrollee has a life-threatening or seriously debilitating condition. As used in this subsection:

(*i*) "Life-threatening" means either or both of the following:

(A) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(B) Diseases or conditions with potentially fatal outcomes,

where the end point of clinical intervention is survival.

(*ii*) "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(b) The enrollee's physician certifies that the enrollee has a life-threatening or seriously debilitating condition, for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the enrollee, or for which there is no more beneficial standard therapy covered by the system than the therapy proposed pursuant to subdivision (c).

(c) Either the enrollee's physician, who is under contract with or employed by the system, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the enrollee than any available standard therapies, or the enrollee, or the enrollee's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's condition, has requested a therapy that, based on 2 documents from the medical and scientific evidence, is likely to be more beneficial for the enrollee than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the system to pay for the services of a nonparticipating provider provided pursuant to this subdivision that are not otherwise covered pursuant to the system benefits package.

(d) The enrollee has been denied coverage by the system for a drug, device, procedure, or other therapy recommended or requested pursuant to subdivision (c).

(e) The specific drug, device, procedure, or other therapy recommended pursuant to subdivision (c) would be a covered service, except for the system's determination that the therapy is experimental or investigational.

(4) All enrollee grievances involving a disputed health care service are eligible for review under the independent medical review system if the requirements of this act are met. If the consumer advocate finds that a grievance involving a disputed health care service does not meet the requirements of this act for review under the independent medical review system, the request for review shall be treated as a request for the consumer advocate to review the grievance pursuant to section 121.

(5) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical appropriateness, the consumer advocate shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this act.

(6) The consumer advocate shall be the final arbiter when there is a question as to whether a grievance is a disputed health care service or a coverage decision. The consumer advocate shall establish a process to complete an initial screening of a grievance. If there appears to be any medical appropriateness

issue, the grievance shall be resolved pursuant to an independent medical review as provided under this act.

(7) For purposes of this act, an enrollee may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the enrollee in seeking an independent medical review and may advocate on behalf of the enrollee.

(8) The independent medical review process authorized by this act is in addition to any other procedures or remedies that may be available.

(9) The office of the consumer advocate shall prominently display in every relevant informational brochure, on copies of health care system procedures for resolving grievances, on letters of denial issued by either the health care system or its contracting providers, on the grievance forms, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the health care system or by 1 of its contracting providers.

(10) An enrollee may apply to the consumer advocate for an independent medical review when all of the following conditions are met:

(a) One of the following applies:

(*i*) Except as otherwise provided in subparagraph (*iv*), the enrollee's health care provider has recommended a health care service as medically appropriate.

(*ii*) The enrollee has received urgent care or emergency

services that a provider determined were medically appropriate.

(*iii*) The enrollee seeks coverage for experimental or investigational therapies.

(*iv*) The enrollee, in the absence of a provider recommendation under subparagraph (*i*) or the receipt of urgent care or emergency services from a provider under subparagraph (*ii*), has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The health insurance system shall expedite access to a contracting provider upon request of an enrollee. The contracting provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review. For purposes of this act, the enrollee's provider may be a nonparticipating provider. However, the health insurance system shall have no liability for payment of services provided by a nonparticipating provider, except as otherwise provided in this act.

(b) The disputed health care service has been denied, modified, or delayed by the health insurance system, or by 1 of its contracting providers, based in whole or in part on a decision that the health care service is not medically appropriate.

(c) The enrollee has filed a grievance with the consumer advocate and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee is not required to participate in the health insurance system's grievance resolution system for more than 30 days. For a grievance that requires expedited review, the enrollee is not required to participate in the health insurance system's grievance resolution system for more

than 3 days.

(11) An enrollee may apply to the consumer advocate for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically appropriate, within 6 months of any of the qualifying periods or events under this section. The consumer advocate may extend the application deadline beyond 6 months if the circumstances of a case warrant the extension.

(12) The enrollee shall pay no application or processing fees of any kind.

(13) Upon notice from the consumer advocate that the enrollee has applied for an independent medical review, the health insurance system or its contracting providers shall provide to the independent medical review organization designated by the consumer advocate a copy of all of the following documents within 3 business days of the health insurance system's receipt of the consumer advocate's notice of a request by an enrollee for an independent review:

(a) A copy of all of the enrollee's medical records in the possession of the health insurance system or its contracting providers relevant to each of the following:

(*i*) The enrollee's medical condition.

(*ii*) The health care services being provided by the health insurance system and its contracting providers for the condition.

(*iii*) The disputed health care services requested by the enrollee for the condition.

(b) Any newly developed or discovered relevant medical records in the possession of the health insurance system or its contracting providers after the initial documents are provided. The system shall concurrently provide a copy of medical records required by this subdivision to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(c) A copy of all information provided to the enrollee by the system and any of its contracting providers concerning health insurance system and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the health insurance system and to the system's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance. The confidentiality of any medical information shall be maintained pursuant to applicable state and federal laws.

(d) A copy of any other relevant documents or information used by the health insurance system or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the system and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The system shall concurrently provide a copy of documents required by this subdivision, except for any information

found by the consumer advocate to be legally privileged information, to the enrollee and the enrollee's provider. The consumer advocate and the independent review organization shall maintain the confidentiality of any information found by the consumer advocate to be the proprietary information of the health insurance system.

Sec. 125. (1) Upon receiving the decision adopted by the consumer advocate pursuant to section 123 that a disputed health care service is medically appropriate, the health insurance system shall promptly implement the decision. In the case of reimbursement for services already rendered, the health insurance system shall reimburse the provider or enrollee, whichever applies, within 5 working days. In the case of services not yet rendered, the health insurance system shall authorize the services within 5 working days of receipt of the written decision from the consumer advocate, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization.

(2) The health insurance system shall not engage in any conduct that has the effect of prolonging the independent review process.

(3) The consumer advocate shall require the health insurance system to promptly reimburse the enrollee for any reasonable costs associated with those services when the consumer advocate finds that the disputed health care services were a covered benefit pursuant to this act and either the enrollee's decision to secure the services outside of the health insurance system provider

network was reasonable under the emergency or urgent medical circumstances, or the health insurance system does not require or provide prior authorization before the health care services are provided to the enrollee.

(4) In addition to requiring system compliance regarding subsections (1), (2), and (3), the consumer advocate shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including remedies and penalties, may be appropriate. In particular, where substantial harm to a patient has already occurred because of the decision of the health care system, or 1 of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically appropriate, the consumer advocate shall impose remedies or penalties.

Sec. 131. The commissioner may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, as necessary to implement this act.