SENATE BILL No. 579

SENATE BILL No. 579

May 14, 2009, Introduced by Senators GEORGE, JANSEN, BIRKHOLZ and HARDIMAN and referred to the Committee on Health Policy.

A bill to promote the availability and affordability of health coverage in this state and to facilitate the purchase of that coverage; to create MI-Health; to provide for a determination of eligible health coverage plans; to provide for a determination of eligibility for assistance of certain enrollees; to provide for a health access surcharge; to prescribe certain powers and duties of certain officials and departments of this state; to provide for certain funds; to provide for the collection and disbursement of certain payments and surcharges; and to provide for certain reports.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 PART I MI-HEALTH

2 Sec. 1. This act shall be known and may be cited as the "MI-

3 Health act".

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1 Sec. 3. As used in this act:

2 (a) "Board" means the cover Michigan board created in section
3 5.

4 (b) "Carrier" means a health insurer, health maintenance
5 organization, or health care corporation.

6 (c) "Commissioner" means the commissioner of the office of
7 financial and insurance regulation.

8 (d) "Eligible health coverage plan" or "plan" means any
9 individual or nongroup contract, policy, or certificate of health,
10 accident, and sickness insurance or coverage issued by a carrier
11 that meets the eligibility requirements established by the board
12 under section 8 and is offered through MI-Health. Eligible health
13 coverage plan does not include a contract, policy, or certificate
14 that provides coverage only for dental, vision, specified accident
15 or accident-only coverage, credit, disability income, hospital
16 indemnity, short-term or 1-time limited duration policy or
17 certificate of no longer than 6 months, long-term care insurance,
18 medicare supplement, coverage issued as a supplement to liability
19 insurance, and specified disease insurance that is purchased as a
20 supplement and not as a substitute for an eligible health coverage
21 plan. Eligible health coverage plan does not include coverage
22 arising out of a worker's compensation law or similar law,
23 automobile medical payment insurance, insurance under which
24 benefits are payable with or without regard to fault, coverage
25 under a plan through medicare, and coverage issued under 10 USC
26 1071 to 1110, and any coverage issued as a supplement to that
27 coverage.

1 (e) "Eligible individual" means an individual who is a
2 resident of the state who meets the eligibility requirements in
3 section 11.
4 (f) "MI-Health" means MI-Health created in section 5.
5 (g) "Fund" means the MI-Health fund created in section 19.
6 (h) "Health care corporation" means a health care corporation
7 operating pursuant to the nonprofit health care corporation reform
8 act of 1980, 1980 PA 350, MCL 550.1101 to 550.1704.
9 (i) "Health insurer" means a health insurer with a certificate
10 of authority under the insurance code of 1956, 1956 PA 218, MCL
11 500.100 to 500.8302.
12 (j) "Health maintenance organization" means a health
13 maintenance organization with a license or certificate of authority
14 under the insurance code of 1956, 1956 PA 218, MCL 500.100 to
15 500.8302.
16 (k) "Medicaid" means a program for medical assistance
17 established under title XIX of the social security act, 42 USC 1396
18 to 1396v.
19 (*l*) "Medicare" means the federal medicare program established
20 under title XVIII of the social security act, 42 USC 1395 to
21 1395hhh.
22 (m) "MI-Health enrollee" or "enrollee" means an individual or
23 his or her dependent who is enrolled in a plan.
24 (n) "Premium assistance payment" means a payment of health
25 coverage premiums made by the board to a plan on behalf of a MI-
26 Health enrollee who is an eligible individual.
27 (o) "Premium contribution payment" means a payment made by a

1 MI-Health enrollee or employer on behalf of a Mi-Health enrollee
2 toward an eligible health coverage plan.
3 (p) "Resident" means a person living in the state, including a
4 qualified alien as defined in 8 USC 1641, or a person who is not a
5 citizen of the United States but who is otherwise permanently
6 residing in the United States under color of law; provided,
7 however, that the person has not moved into the state for the sole
8 purpose of securing health coverage under this act.
9 (q) "Uninsured" means a resident who is not covered by a
10 health insurance or coverage plan offered by a carrier, a self-
11 funded health coverage plan, medicaid, medicare, or a medical
12 assistance program.
13 Sec. 5. (1) MI-Health is created within the department of
14 community health and shall exercise its prescribed statutory
15 duties, powers, and functions independently of the director of the
16 department of community health. MI-Health is responsible for
17 facilitating the availability, choice, and purchase of eligible
18 health coverage plans by eligible individuals.
19 (2) MI-Health shall be governed by a board of directors called
20 the cover Michigan board consisting of the following 13 members:
21 (a) The director of the department of community health or his
22 or her designee.
23 (b) The director of the department of human services or his or
24 her designee, who shall serve as an ex officio nonvoting member.
25 (c) The commissioner or his or her designee.
26 (d) The deputy director for medical services administration or
27 his or her designee, who shall serve as an ex officio nonvoting

member.

(e) Three members appointed by the governor with the advice and consent of the senate, 1 of whom shall be a member in good standing of the American academy of actuaries, 1 of whom shall be a health economist, and 1 of whom shall represent a health care corporation.

(f) Three members appointed by the senate majority leader, 1 of whom shall represent health maintenance organizations but shall not be from a health maintenance organization owned by a health care corporation, 1 of whom shall represent low-income health care advocacy organizations, and 1 of whom shall represent health professionals.

(g) Three members appointed by the speaker of the house of representatives, 1 of whom shall represent the general public, 1 of whom shall represent health insurers, and 1 of whom shall represent hospitals.

(3) The members first appointed to the board shall be appointed within 30 days after the effective date of this act. Appointed board members shall serve for terms of 4 years or until a successor is appointed, whichever is later, except that of the members first appointed 2 shall serve for 1 year, 2 shall serve for 2 years, 2 shall serve for 3 years, and 3 shall serve for 4 years.

(4) If a vacancy occurs on the board, the vacancy shall be filled for the unexpired term in the same manner as the original appointment. An appointed board member is eligible for reappointment.

(5) The governor may remove a member of the board for

1 incompetency, dereliction of duty, malfeasance, misfeasance, or
2 nonfeasance in office, or any other good cause.
3 (6) The first meeting of the board shall be called by the
4 director of the department of community health, who shall serve as
5 chairperson. After the first meeting, the board shall meet at least
6 monthly, or more frequently at the call of the chairperson or if
7 requested by 7 or more members.
8 (7) Seven members of the board constitute a quorum for the
9 transaction of business at a meeting of the board. An affirmative
10 vote of 7 board members is necessary for official action of the
11 board.
12 (8) The business that the board may perform shall be conducted
13 at a public meeting of the board held in compliance with the open
14 meetings act, 1976 PA 267, MCL 15.261 to 15.275.
15 (9) A writing prepared, owned, used, in the possession of, or
16 retained by the board in the performance of an official function is
17 subject to the freedom of information act, 1976 PA 442, MCL 15.231
18 to 15.246.
19 (10) Board members shall serve without compensation. However,
20 board members may be reimbursed for their actual and necessary
21 expenses incurred in the performance of their official duties as
22 board members.
23 Sec. 7. The board shall do all of the following:
24 (a) Develop a plan of operation for MI-Health, which shall
25 include, but is not limited to, all of the following:
26 (*i*) Establishes procedures for MI-Health operations.
27 (*ii*) Establishes procedures and criteria for the approval of

1 eligible health coverage plans as provided in section 8.
2 (*iii*) Establishes procedures for the enrollment of individuals
3 in plans.
4 (*iv*) Establishes procedures for appeals of eligibility
5 decisions as provided in section 13.
6 (*v*) Establishes and manages a system of collecting and
7 depositing into the fund all premium payments made by, or on behalf
8 of, MI-Health enrollees, including any premium payments made by
9 enrollees, employers, unions, or other organizations.
10 (*vi*) Establishes and manages a system for remitting premium
11 assistance payments to carriers.
12 (*vii*) Establishes and manages a system for remitting premium
13 contribution payments to carriers.
14 (*viii*) Establishes a plan for publicizing the existence of MI-
15 Health and MI-Health's eligibility requirements and enrollment
16 procedures.
17 (*ix*) Develops criteria for determining that certain health
18 coverage plans shall no longer be made available through MI-Health.
19 (*x*) Develops a standard application form for individuals
20 seeking to purchase or obtain health coverage through MI-Health,
21 and for eligible individuals who are seeking a premium assistance
22 payment that includes information necessary to determine an
23 applicant's eligibility under section 11, previous and current
24 health coverage, and payment method.
25 (b) Determine each applicant's eligibility for purchasing
26 health coverage offered by MI-Health, including eligibility for
27 premium assistance payments.

1 (c) Seek and receive any funding from the federal government,
2 departments or agencies of the state, private foundations, and
3 other entities.
4 (d) Contract with professional service firms as may be
5 necessary and fix their compensation.
6 (e) Contract with companies that provide third-party
7 administrative and billing services for health coverage products.
8 (f) Adopt bylaws for the regulation of its affairs and the
9 conduct of its business.
10 (g) Adopt an official seal and alter the same.
11 (h) Maintain an office at such place or places as it may
12 designate.
13 (i) Sue and be sued in its own name.
14 (j) Approve the use of its trademarks, brand names, seals,
15 logos, and similar instruments by participating carriers,
16 employers, or organizations.
17 (k) Enter into interdepartmental agreements.
18 (*l*) Publish each year the premiums for eligible health coverage
19 plans.
20 (m) Subject to this act, review annually the publication of
21 the income levels for the federal poverty guidelines and devise a
22 schedule of a percentage of income for each 50% increment of the
23 federal poverty level at which an individual could be expected to
24 contribute a percentage of income toward the purchase of health
25 coverage and examine any contribution schedules, such as those set
26 for government benefits programs. The report shall be published
27 annually. Prior to publication, the schedule shall be reported to

1 the house of representatives and senate standing committees on
2 appropriations, health, and insurance issues.
3 Sec. 8. (1) MI-Health shall only offer eligible health
4 coverage plans that have been approved by the board.
5 (2) Each eligible health coverage plan offered through MI-
6 Health shall contain a detailed description of benefits offered,
7 including maximums, limitations, exclusions, and other benefit
8 limits. Each eligible health coverage plan shall reimburse health
9 care professionals and health facilities at medicare reimbursement
10 rates.
11 (3) No health coverage plan shall be offered through MI-Health
12 that excludes an individual from coverage because of race, color,
13 religion, national origin, sex, sexual orientation, marital status,
14 health status, personal appearance, political affiliation, source
15 of income, or age.
16 (4) MI-Health shall offer a variety of health coverage plans.
17 To be approved by the board, a health coverage plan shall meet all
18 requirements of health coverage plans required under state law,
19 rule, and regulation except that, in order to satisfy the goal of
20 universal health care coverage in this state, the board may permit
21 a health coverage plan provided through MI-Health to not provide
22 for the coverages or offerings required under section 3406a, 3406b,
23 3406c, 3406d, 3406e, 3406m, 3406n, 3406p, 3406q, 3406r, 3425,
24 3609a, 3613, 3614, 3615, 3616, or 3616a of the insurance code of
25 1956, 1956 PA 218, MCL 500.3406a, 500.3406b, 500.3406c, 500.3406d,
26 500.3406e, 500.3406m, 5003406n, 500.3406p, 500.3406q, 500.3604r,
27 500.3425, 500.3609a, 500.3613, 500.3614, 500.3615, 500.3616, and

1 500.3616a, or section 401b, 401f, 401g, 414a, 415, 416, 416a, 416b,
2 416c, 416d, or 417 of the nonprofit health care corporation reform
3 act of 1980, 1980 PA 350, MCL 550.1401b, 550.1401f, 550.1401g,
4 550.1414a, 550.1415, 550.1416, 550.1416a, 550.1416b, 550.1416c,
5 550.1416d, and 550.1417. In making the determination of which
6 provisions of section 3406a, 3406b, 3406c, 3406d, 3406e, 3406m,
7 3406n, 3406p, 3406q, 3406r, 3425, 3609a, 3613, 3614, 3615, 3616, or
8 3616a of the insurance code of 1956, 1956 PA 218, MCL 500.3406a,
9 500.3406b, 500.3406c, 500.3406d, 500.3406e, 500.3406m, 500.3406n,
10 500.3406p, 500.3406q, 500.3604r, 500.3425, 500.3609a, 500.3613,
11 500.3614, 500.3615, 500.3616, and 500.3616a, or section 401b, 401f,
12 401g, 414a, 415, 416, 416a, 416b, 416c, 416d, or 417 of the
13 nonprofit health care corporation reform act of 1980, 1980 PA 350,
14 MCL 550.1401b, 550.1401f, 550.1401g, 550.1414a, 550.1415, 550.1416,
15 550.1416a, 550.1416b, 550.1416c, 550.1416d, and 550.1417, are not
16 required to be provided in a health coverage plan offered through
17 MI-Health, the board shall determine whether real cost savings will
18 be achieved and affordability maximized.

19 (5) Benefits provided in eligible health coverage plans for
20 MI-Health shall include, but are not limited to, all of the
21 following:

22 (a) Wellness services.

23 (b) Inpatient services.

24 (c) Outpatient services and preventive care.

25 (d) Value-based pharmaceutical benefit.

26 (6) All of the following apply for adjusting premiums for an
27 eligible health coverage plan:

1 (a) A carrier may establish up to 5 geographic areas in this
2 state.
3 (b) A health care corporation shall establish geographic areas
4 that cover all counties in this state.
5 (7) The rates charged to individuals for eligible health
6 coverage plans may include rate differentials based only on age,
7 tobacco use, body mass index, and other healthy behaviors and only
8 if the differentials are supported by sound actuarial principles
9 and a reasonable classification system and are related to actual
10 and credible loss statistics or reasonably anticipated experience
11 in the case of new eligible health coverage plans.
12 (8) Eligible health coverage plans are subject to part II.
13 (9) The board shall approve as eligible a health coverage plan
14 that the board determines satisfies this section, provides good
15 value to residents, and provides quality medical benefits and
16 administrative services.
17 (10) The board may remove a health coverage plan from being
18 offered through MI-Health only after notice to the carrier.
19 Sec. 9. (1) MI-Health shall provide subsidies to assist
20 eligible individuals in purchasing eligible health coverage plans,
21 provided that subsidies shall only be paid on behalf of an eligible
22 individual who is enrolled in an eligible health coverage plan, and
23 shall be made under a sliding-scale premium contribution payment
24 schedule for enrollees.
25 (2) Premium assistance payments under MI-Health shall be made
26 as provided in this act and under a schedule set annually by the
27 board in consultation with the department of community health. The

1 schedule shall be published annually. If amounts in the fund are
2 insufficient to meet the projected costs of enrolling new eligible
3 individuals, the board shall impose a cap on enrollment in MI-
4 Health and shall notify the governor and the house of
5 representatives and senate standing committees on appropriations,
6 health, and insurance issues.
7 (3) An enrollee with a household income that does not exceed
8 200% of the federal poverty level shall only be responsible for a
9 copayment toward the purchase of each pharmaceutical product and
10 for use of emergency room services in acute care hospitals for
11 nonemergency conditions equal to that required of enrollees in the
12 medicaid program. The board may waive copayments upon a finding of
13 substantial financial or medical hardship. The premium shall not
14 exceed 5% of the enrollee's gross household income and no other
15 deductible or cost-sharing shall apply to an enrollee described in
16 this subsection.
17 (4) An enrollee with a household income that exceeds 200% of
18 the federal poverty level but does not exceed 300% of the federal
19 poverty level shall be responsible for a premium contribution
20 payment, and copayments, deductibles, or other cost-sharing
21 measures, that are reasonably established so as to encourage and
22 promote maximum enrollment.
23 Sec. 11. An uninsured individual is eligible to participate in
24 MI-Health if all of the following are met:
25 (a) The individual's household income does not exceed the
26 federal poverty levels established in section 9.
27 (b) The individual has been a resident of the state for the

1 previous 6 months.
2 (c) The individual is not eligible for any government program,
3 medicaid, medicare, or the state children's health insurance
4 program authorized under title XXI of the social security act, 42
5 USC 1397aa to 1397jj.
6 (d) The individual's or family member's employer has not
7 provided health coverage in the last 6 months for which the
8 individual is eligible. This subdivision does not apply if health
9 coverage was not provided due to the individual's or family
10 member's loss of employment, loss of eligibility for coverage due
11 to loss of employment hours, or loss of dependency status.
12 (e) The individual has not accepted a financial incentive from
13 his or her employer to decline his or her employer's subsidized
14 health coverage plan.
15 Sec. 12. The board shall encourage eligible health coverage
16 plans to use incentives to provide health promotion, chronic care
17 management, and disease prevention. Incentives may include rewards,
18 premium discounts, or rebates or otherwise waive or modify
19 copayments, deductibles, or other cost-sharing measures. Incentives
20 shall be available to all similarly situated individuals, shall be
21 designed to promote health and prevent disease, and shall not be
22 used to impose higher costs on an individual based on a health
23 factor.
24 Sec. 13. A resident who has applied to MI-Health has the right
25 to receive a written determination of eligibility and, if
26 eligibility is denied, a written denial detailing the reasons for
27 the denial and the right to appeal any eligibility decision,

1 provided the appeal is conducted pursuant to the process
2 established by the board.
3 Sec. 15. The board shall enter into interagency agreements
4 with the department of treasury to verify income data for
5 participants in MI-Health. The written agreements shall include
6 provisions permitting the board to provide a list of individuals
7 participating in or applying for an eligible health coverage plan,
8 including any applicable members of the households of those
9 individuals, who would be counted in determining eligibility, and
10 to furnish relevant information, including, but not limited to,
11 name, social security number, if available, and other data required
12 to assure positive identification. The department of treasury shall
13 furnish the requested information, including, but not limited to,
14 name, social security number, and other data to ensure positive
15 identification, name and identification number of employer, and
16 amount of wages received and gross income from all sources.
17 Sec. 17. (1) The board may apply a surcharge to all eligible
18 health coverage plans, which shall be used only to pay actual
19 administrative and operational expenses of MI-Health and so long as
20 the surcharge is applied uniformly to all eligible health coverage
21 plans. A surcharge shall not be used to pay any premium assistance
22 payments.
23 (2) Each carrier offering an eligible health coverage plan
24 shall furnish such reasonable reports as the board determines
25 necessary under this act, including, but not limited to, detailed
26 loss-ratio and experience reports that identify administrative cost
27 and medical charge trends.

1 Sec. 19. (1) The MI-Health fund is created within the state
2 treasury.
3 (2) Premium contribution payments and surcharges collected
4 under MI-Health shall be deposited into the fund. The health access
5 surcharge collected under part II shall be deposited into the fund.
6 The state treasurer may receive money or other assets from any
7 source, including federal matching funds or stimulus funds, for
8 deposit into the fund. The state treasurer shall direct the
9 investment of the fund. The state treasurer shall credit to the
10 fund interest and earnings from fund investments.
11 (3) Money in the fund at the close of the fiscal year shall
12 remain in the fund and shall not lapse to the general fund.
13 (4) Money in the fund shall be expended only as provided in
14 this act. The department of community health shall be the
15 administrator of the fund for auditing purposes.
16 Sec. 21. The board shall keep an accurate account of all MI-
17 Health activities and of all its receipts and expenditures and
18 shall annually make a report thereof at the end of its fiscal year
19 to the governor, to the house of representatives and senate
20 standing committees on appropriations, health, and insurance
21 issues, and to the auditor general. The auditor general may
22 investigate the affairs of MI-Health, may severally examine its
23 properties and records, and may prescribe methods of accounting and
24 the rendering of periodical reports. MI-Health is subject to annual
25 audit by the auditor general.
26 PART II HEALTH ACCESS SURCHARGE
27 Sec. 31. As used in this part:

1 (a) "Paid claims" means all payments made by third-party
2 administrators or carriers, including payments made pursuant to a
3 service contract for administrative services or cost plus
4 arrangements under section 211 of the nonprofit health care
5 corporation reform act of 1980, 1980 PA 350, MCL 550.1211, for
6 health and medical services provided under individual, nongroup,
7 and group policies, certificates, or contracts delivered, issued
8 for delivery, or renewed in this state that insure or cover
9 residents of this state. If a carrier or third-party administrator
10 is contractually entitled to withhold certain amounts from payments
11 due to providers of health and medical services in order to help
12 ensure that the providers can fulfill any financial obligations
13 they may have under a managed care risk arrangement, the full
14 amounts due the providers before application of such withholds
15 shall be reflected in the calculation of paid claims. Paid claim
16 does not include any of the following:
17 (*i*) Claims-related expenses and general administrative
18 expenses.
19 (*ii*) Payments made to qualifying providers under a "pay for
20 performance" or other incentive compensation arrangement if the
21 payments are not reflected in the processing of claims submitted
22 for services rendered to specific covered individuals.
23 (*iii*) Claims paid by carriers and third-party administrators
24 with respect to dental, vision, specified accident or accidental
25 only coverage, credit, disability income, hospital indemnity, long-
26 term care insurance, medicare supplement, coverage issued as a
27 supplement to liability insurance, and specified disease insurance,

1 except that claims paid for dental services covered under a medical
2 policy are included.
3 (*iv*) Claims paid for services rendered to nonresidents of this
4 state.
5 (*v*) Claims paid under retiree health benefit plans that are
6 separate from and not included within benefit plans for existing
7 employees.
8 (*vi*) Claims paid for services rendered to persons covered under
9 a benefit plan for federal employees.
10 (*vii*) Claims paid for services rendered outside of this state
11 to a person who is a resident of this state.
12 (b) "Claims-related expenses" includes the following:
13 (*i*) Payments for utilization review, care management, disease
14 management, risk assessment, and similar administrative services
15 intended to reduce the claims paid for health and medical services
16 rendered to covered individuals, usually either by attempting to
17 ensure that needed services are delivered in the most efficacious
18 manner possible or by helping those covered individuals to maintain
19 or improve their health.
20 (*ii*) Payments that are made to or by organized groups of
21 providers of health and medical services in accordance with managed
22 care risk arrangements or network access agreements, which payments
23 are unrelated to the provision of services to specific covered
24 individuals.
25 (c) "Health and medical services" includes, but is not limited
26 to, any services included in the furnishing of medical care, dental
27 care to the extent covered under a medical insurance policy,

1 pharmaceutical benefits, or hospitalization, including, but not
2 limited to, services provided in a hospital or other medical
3 facility; ancillary services, including, but not limited to,
4 ambulatory services; physician and other practitioner services,
5 including, but not limited to, services provided by a physician's
6 assistant, nurse practitioner, or midwife; and behavioral health
7 services, including, but not limited to, mental health and
8 substance abuse services.
9 Sec. 33. All carriers and third-party administrators shall pay
10 a health access surcharge that shall not exceed 1.8% on all paid
11 claims. All of the following apply to the health access surcharge:
12 (a) The surcharge applies to paid claims beginning July 1,
13 2010.
14 (b) Surcharge payments shall be made monthly to the Mi-Health
15 fund beginning August 2010, are due not less than 15 days after the
16 end of the month, and shall accrue interest at 12% per annum on or
17 after the due date, except that surcharge payments for third-party
18 administrators for groups of 500 or fewer members may be made
19 annually not less than 60 days after the close of the plan year.
20 Sec. 35. The commissioner may suspend or revoke, after notice
21 and hearing, the certificate of authority of any carrier to
22 transact insurance in this state or the license of any third-party
23 administrator to operate in this state that fails to pay a health
24 access surcharge.
25 PART III REPORTS
26 Sec. 51. (1) By 18 months after the effective date of this
27 act, the board shall report on whether the health coverage plans

1 offered through MI-Health are affordable and competitively priced
2 in the individual market. In making this determination, the board
3 shall consider all of the following:
4 (a) The extent to which any carrier controls all or a portion
5 of the health coverage plan market.
6 (b) Whether the total number of carriers offering eligible
7 health coverage plans in this state is sufficient to provide
8 multiple options to individuals.
9 (c) Whether underwriting needs to be expanded or restricted
10 for MI-Health eligible health coverage plans.
11 (d) The availability of eligible health coverage plans to
12 individuals in all geographic areas.
13 (e) The overall rate level that is not excessive, inadequate,
14 or unfairly discriminatory.
15 (2) The report under subsection (1) shall be forwarded to the
16 governor, the clerk of the house, the secretary of the senate, and
17 all the members of the senate and house of representatives standing
18 committees on insurance and health issues.
19 Sec. 53. No later than 2 years after MI-Health begins
20 operation and every year thereafter, the board shall conduct a
21 study of MI-Health and the persons enrolled in eligible health
22 coverage plans and shall submit a written report to the governor
23 and the house of representatives and senate standing committees on
24 appropriations, health, and insurance issues on the status and
25 activities of MI-Health based on data collected in the study. The
26 report shall also be available to the general public upon request.
27 The study shall review all of the following for the immediately

preceding year:

(a) The operation, administration, and costs of MI-Health.

(b) What health coverage plans are available to individuals through MI-Health and the experience of those plans including any adverse selection trends. The experience of the plans shall include data on number of enrollees in the plans, plans' expenses, claims statistics, and complaints data. Health information obtained under this act is subject to the federal health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(c) The number of MI-Health enrollees and the total amount of premium assistance payments made under each eligible health coverage plan.

(d) The amount and reasonableness of a surcharge applied pursuant to section 17 and its impact on premiums.

(e) Other information considered pertinent by the board.

Enacting section 1. This act does not take effect unless all of the following bills of the 95th Legislature are enacted into law:

(a) Senate Bill No. 580.

(b) Senate Bill No. 581.

(c) Senate Bill No. 582.