SENATE BILL No. 689

November 14, 2013, Introduced by Senators CASWELL, PAPPAGEORGE and COLBECK and referred to the Committee on Appropriations.

A bill to create health coverage options for certain residents of this state; to promote the availability and affordability of health coverage in this state; to create a mechanism for residents of this state to secure essential health care benefits; to create funds; to provide for the powers and duties of certain state and local governmental officers and entities; to allow for the promulgation of rules; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

PART 1. GENERAL PROVISIONS

Sec. 101. (1) This act shall be known and may be cited as the "patient-centered care act".

(2) As used in this act, the words and phrases defined in sections 103 to 111 have the meanings ascribed to them in those sections.

SENATE BILL No. 689

Sec. 103. (1) "Contracted health plan" means that term as defined in section 106 of the social welfare act, 1939 PA 280, MCL 400.106.

(2) "Covered primary care benefits" means the health care treatment and services that are covered under the group 1 health plan as established by the director under section 203.

(3) "Department" means the department of community health.

(4) "Director" means the director of the department.

Sec. 105. (1) "Exchange" means an entity certified under part 4 to provide a marketplace for residents to secure essential health benefits through a health plan or government assistance program. Exchange does not include an American health benefit exchange operating in this state that is operated by the federal government or pursuant to a federal-state partnership.

(2) "Federal act" means the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(3) "Federal poverty line" means the poverty line published periodically in the federal register by the United States department of health and human services under its authority to revise the poverty line under 42 USC 9902.

(4) "Government assistance" means financial assistance received from a government assistance program.

(5) "Government assistance program" means a program of health care assistance offered by a federal, state, or local governmental entity, including, but not limited to, medicaid, medicare, the MIChild program, the veterans health administration, and any other

program of health care assistance identified by the department.

Sec. 107. (1) "Group 1 eligible individual" means an individual who meets all of the following:

(a) Is a resident.

(b) Is not eligible to enroll in any other government assistance program.

(c) Has household income that does not exceed 100% of the federal poverty line, for the size of the family involved.

(d) Is not eligible for minimum essential coverage, as defined in section 5000A(f) of the internal revenue code of 1986, 26 USC 5000A, or is eligible for an employer-sponsored plan that is not affordable coverage as determined under section 5000A(e)(2) of the internal revenue code of 1986, 26 USC 5000A.

(2) "Group 1 health plan" means the Michigan group 1 health plan created in section 203.

(3) "Group 1 health plan fund" means the Michigan group 1 health plan trust fund created in section 201.

(4) "Group 1 member" means a group 1 eligible individual who is enrolled in the group 1 health plan and who fulfills all conditions of participation in the group 1 health plan as provided in part 2 or established by the department under part 2.

Sec. 109. (1) "Group 2 eligible individual" means an individual who meets all of the following:

(a) Is a resident.

(b) Is not eligible to enroll in the group 1 health plan or any other government assistance program.

(c) Has household income that does not exceed 133% of the

federal poverty line for the size of the family involved.

(d) Is not eligible for minimum essential coverage, as defined in section 5000A(f) of the internal revenue code of 1986, 26 USC 5000A, or is eligible for an employer-sponsored plan that is not affordable coverage as determined under section 5000A(e)(2) of the internal revenue code of 1986, 26 USC 5000A.

(2) "Group 2 health plan" means a certified group 2 health plan under part 3.

(3) "Group 2 health plan fund" means the Michigan group 2 health plan trust fund created in section 301.

(4) "Group 2 member" means a group 2 eligible individual who is enrolled in a group 2 health plan under part 3 and who fulfills all conditions of participation in the group 2 health plan as provided in part 3 or established by the department under part 3.

Sec. 111. (1) "Medicaid" or "medical assistance program" means the program of medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5, and administered by the department under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(2) "Medicare" means the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(3) "Resident" means an individual who is a citizen of the United States or is legally present in the United States, who voluntarily lives in this state with the intention of making his or her home in this state and not for a temporary purpose, who has lived in this state for 6 months or more, and who is not receiving

public or government assistance from another state.

Sec. 121. For the purpose of determining household income in this act, the director shall use the modified adjusted gross income-equivalent standards for this state that are approved under section 1902(e)(14)(E) of the social security act, 42 USC 1396a.

Sec. 123. The department may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, that it considers necessary or appropriate to implement and administer this act.

Sec. 125. The department shall request a determination from the appropriate federal agency as to whether an employer that has 50 or more employees and that is subject to a penalty under the federal act may, in lieu of paying the penalty, purchase a catastrophic-only health benefit plan for an employee who attempts to purchase a health benefit plan offered through an exchange or through an American health benefit exchange operating in this state pursuant to the federal law. If the federal agency approves the proposal described in this section, the department shall implement and administer a program to facilitate the purchase of a catastrophic-only health benefit plan by an employer described in this section.

Sec. 127. (1) Beginning April 1, 2015, the department shall submit an annual report of its activities under this act to the senate majority leader, the speaker of the house of representatives, the chair of the house and senate appropriations committees, the chair of the house and senate appropriations subcommittees on community health, and the chair of the house and

senate appropriations subcommittees on human services. The chair of the house or senate appropriations committee may request that specific information regarding the department's activities under this act be included in an annual report required under this subsection. The department shall include information requested by a committee chair in its next annual report required under this subsection.

(2) In addition to information provided in an annual report under subsection (1), the chair of the house or senate appropriations committee may request information regarding the department's activities under this act from the department at any time. The department shall respond in a timely manner to a request for information under this subsection.

PART 2. GROUP 1 HEALTH PLAN

Sec. 201. (1) The Michigan group 1 health plan trust fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source for deposit into the group 1 health plan fund. The state treasurer shall direct the investment of the group 1 health plan fund. The state treasurer shall credit to the group 1 health plan fund interest and earnings from group 1 health plan fund investments.

(3) Money in the group 1 health plan fund at the close of the fiscal year shall remain in the group 1 health plan fund and shall not lapse to the general fund.

(4) The department is the administrator of the group 1 health plan fund for auditing purposes.

(5) The director shall expend money from the group 1 health plan fund to administer this part and, if money is available, to provide additional benefits for group 1 members, including, but not limited to, increasing the limit on inpatient hospitalization coverage under section 203(3)(e)(*ii*).

Sec. 203. (1) The Michigan group 1 health plan is created in the department. The director shall implement and administer the group 1 health plan so that it is in compliance with this part and is operational by January 1, 2014.

(2) The director shall do all of the following under this part:

(a) Implement the group 1 health plan so that group 1 eligible individuals enroll in the group 1 health plan through an exchange.

(b) Implement the group 1 health plan so that group 1 eligible individuals are enrolled in the group 1 health plan with a contracted health plan. The director shall ensure that health care professionals who participate with a contracted health plan will accept as a patient a group 1 eligible individual who enrolls in that contracted health plan under this section.

(c) Establish or provide for the establishment of an enrollment process that identifies whether an individual who is attempting to enroll in the group 1 health plan is eligible for enrollment in a government assistance program and that directs that individual to enroll in the government assistance program.

(d) Implement a financial participation requirement so that group 1 members pay a monthly household premium based on household income for the size of the family involved as follows:

(*i*) For a household with income that is 25% or less of the federal poverty line, a monthly household premium of $5.00.

(*ii*) For a household with income that is more than 25% and 50% or less of the federal poverty line, a monthly household premium of $10.00.

(*iii*) For a household with income that is more than 50% and 79% or less of the federal poverty line, a monthly household premium of $15.00.

(*iv*) For a household with income that is more than 79% and 100% or less of the federal poverty line, a monthly household premium of $20.00.

(e) Implement the group 1 health plan so that payments to federally qualified health centers for a covered primary care benefit are no more than the medical assistance program paid for the covered primary care benefit at the levels provided for in the 2011-2012 state fiscal year.

(f) Implement the group 1 health plan in a manner that ensures that the group 1 health plan is the payor of last resort.

(g) Implement the group 1 health plan so that any cost-sharing requirements are equal to those required under the medical assistance program. For the purposes of this subdivision, cost-sharing requirement includes a copayment, coinsurance, or deductible.

(3) The director shall establish or modify the health care treatment and services that will be covered primary care benefits, subject to all of the following:

(a) Except as otherwise specifically provided in this part,

include at a minimum essential health benefits as described in 42 USC 18022(b).

(b) Provide for the coverage of primary care and preventive services in the same manner as provided for under medicaid diagnosis related group codes and at the levels provided for in the 2011-2012 state fiscal year.

(c) Except as otherwise provided in this subdivision, provide for the coverage of prescription drugs and require the use of generic prescription drugs if a generic alternative exists for a brand-name product, as recommended by the group 1 member's prescribing provider and as is consistent with section 109h of the social welfare act, 1939 PA 280, MCL 400.109h, and part 97 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709.

(d) Provide for the coverage of certain specified outpatient hospital procedures.

(e) Provide for the coverage of inpatient hospitalization with coverage limited as follows:

(*i*) Except as otherwise provided in subparagraph (*ii*), to an amount not to exceed the amount that would have been payable for that coverage under the medical assistance program at the levels provided for in the 2011-2012 state fiscal year.

(*ii*) To an amount not to exceed $35,000.00 a year, or a higher limit if increased under section 201(5), for each covered individual.

(f) Provide coverage for substance use disorder treatment services, which services must be bid out based on performance objectives established by the department.

(g) Provide coverage for mental health services that are obtained through a specialty prepaid health plan under the medical assistance program or that are bid out based on performance objectives established by the department.

Sec. 205. The department shall transmit all money received under this part, including all financial participation payments from group 1 members required under section 203, to the state treasurer for deposit into the group 1 health plan fund.

Sec. 207. A contracted health plan shall comply with this part to enroll group 1 eligible individuals as members of the group 1 health plan. A contracted health plan shall comply with performance objectives established by the department under this part. The department shall establish clear performance objectives in order to ensure success of the group 1 health plan in this state.

Sec. 209. Upon enrollment, a group 1 member shall comply with all conditions of participation in the group 1 health plan, including any financial participation requirements established under this part. A group 1 member who violates this section may be removed from enrollment in the group 1 health plan. An individual who is removed from enrollment in the group 1 health plan is not eligible for covered primary care benefits under the group 1 health plan for a period of at least 3 months. An individual who has been removed from enrollment in the group 1 health plan under this section may reapply for enrollment in the group 1 health plan after the 3-month penalty period has expired if the individual has paid any previously unsatisfied financial participation requirements.

Sec. 211. This part is repealed effective January 1, 2017.

PART 3. GROUP 2 HEALTH PLANS

Sec. 301. (1) The Michigan group 2 health plan trust fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source for deposit into the group 2 health plan fund. The state treasurer shall direct the investment of the group 2 health plan fund. The state treasurer shall credit to the group 2 health plan fund interest and earnings from group 2 health plan fund investments.

(3) Money in the group 2 health plan fund at the close of the fiscal year shall remain in the group 2 health plan fund and shall not lapse to the general fund.

(4) The department is the administrator of the group 2 health plan fund for auditing purposes.

(5) Except as otherwise provided in subsection (6), the director shall expend money from the group 2 health plan fund only for the purposes of implementing and administering this part and for any other purpose enumerated in this part.

(6) Except as otherwise provided in this subsection, the director shall expend money from the group 2 health plan fund that is attributable to deposits pursuant to section 105g of the social welfare act, 1939 PA 280, MCL 400.105g, only as a deposit into a health savings account for use by the group 2 member to which that deposit is directed or to pay for the package of benefits selected by a group 2 member to which that deposit is directed, or both. The department shall expend money from the group 2 health plan that is in excess of the amount necessary for the purposes described in

this subsection for use by group 2 members to cover any expenses related to obtaining quality health care that are not covered under the package of benefits selected by the group 2 member under this part.

Sec. 303. (1) For the purpose of health plan choices for residents, the department shall certify as a group 2 health plan a benefit plan that complies with 42 USC 18021 or 42 USC 18022 and that meets the requirements of this section. If the federal act is repealed or the department determines that it is no longer effective in this state, a benefit plan does not need to comply with 42 USC 18021 or 42 USC 18022 to be certified as a group 2 health plan under this section.

(2) In certifying a benefit plan as a group 2 health plan under this section, the director shall ensure that the benefit plan meets all of the following requirements:

(a) Is offered by a health insurer issuer as described in 42 USC 18021(a)(1)(C).

(b) Offers access to quality health care by providing coverage under a package of benefits that is equal to or greater than that required as an essential health benefits package as defined in 42 USC 18022. The department shall consider all of the following when making its determination under this subdivision:

(*i*) The availability in the package of benefits under a traditional insurance option.

(*ii*) The availability in the package of direct primary care services.

(*iii*) The availability in the package of fee-for-service

options, but only if there is a sufficient balance in the group 2 member's health savings account to cover minimum essential benefits in combination with other coverage.

(*iv*) The availability in the package of the benefits available under Medicaid.

(*v*) The availability in the package of any combination of the options described in subparagraphs (*i*) to (*iv*).

(c) Enrolls group 2 eligible individuals in a group 2 health plan through an exchange.

(d) For a group 2 member who receives money from the group 2 health plan fund that is attributable to a deposit pursuant to section 105g of the social welfare act, 1939 PA 280, MCL 400.105g, provides coverage for elective abortions only by an optional rider. To be eligible to purchase a rider described in this subdivision, a group 2 member shall deposit money from his or her personal money into a health savings account sufficient to cover the cost of the rider.

Sec. 305. The department shall transmit all money received under this part to the state treasurer for deposit into the group 2 health plan fund. The department shall transmit all money received under section 105g of the social welfare act, 1939 PA 280, MCL 400.105g, designated for use under this part to the state treasurer for deposit into the group 2 health plan fund but only for the use described in section 301(6).

PART 4. MARKETPLACE

Sec. 401. (1) If money is received under section 105g of the social welfare act, 1939 PA 280, MCL 400.105g, and deposited into

the group 2 health fund, the director shall, subject to this section and section 301, expend the money to defray the cost to this state to pay for the package of benefits selected by a group 2 member, for deposit into group 2 member's health savings accounts, and to cover other expenses related to obtaining quality health care that are not covered under the package of benefits selected by group 2 members.

(2) The director shall not pay deductibles or make payments to cover other expenses as described in subsection (1) for services related to an elective abortion.

(3) The director shall pay deductibles and make payments to cover other expenses as described in subsection (1) for a group 2 member until such time as the group 2 member's individual health savings account balance is determined by the department to be actuarially sufficient to cover his or her deductibles and other expenses.

Sec. 403. (1) The department shall establish and administer a program to certify a private entity as an exchange eligible to enroll residents in the group 1 health plan or a group 2 health plan in this state. The granting of a certificate to a nongovernmental entity to be an exchange eligible to enroll residents in the group 1 health plan or a group 2 health plan in this state is governed solely by this act and is not subject to federal regulations governing the establishment and operation of an American health benefit exchange under the federal act. The department shall develop an application form and require the submission of documents and information sufficient to determine if

the applicant is eligible for a certificate or renewal of a certificate as an exchange eligible for a certificate under this section. The director shall issue a certificate or renewal of a certificate to a person who applies to be an exchange and who meets all of the following requirements:

(a) The individuals who are identified as being a part of or associated with the exchange are of good moral character as defined in section 1200 of the insurance code of 1956, 1956 PA 218, MCL 500.1200.

(b) The person submits with an application a plan of operation that details its ability to meet the requirements of this section.

(2) The department shall determine the merits of each application submitted by a person under this section. The department may request additional information from an applicant under this section. An applicant shall comply with requests for additional information from the department in a timely manner.

(3) In addition to criteria established by the department under this section, the department shall determine that the exchange to be operated by the applicant meets all of the following requirements before issuing a certificate or certificate renewal under this section:

(a) Is designed to enroll group 1 eligible individuals in the group 1 health plan under part 2.

(b) Is designed to offer 1 or more group 2 health plans and enroll a group 2 eligible individual in a group 2 health plan.

(c) Except as otherwise provided in this subdivision, is designed to offer 1 or more qualified health plans as that term is

defined in the federal act to residents. If the federal act is repealed or the department determines that it is no longer effective in this state, an exchange does not need to be designed to offer 1 or more qualified health plans to residents.

(d) Will comply with all data security requirements established by the department for an exchange.

(e) Is designed so that the enrollment process provides a resident with the option to provide information necessary to determine the resident's eligibility for government assistance programs.

(f) Will ensure accuracy in all aspects of the operation of the exchange.

(g) Will operate with fiscal solvency.

(h) Will seamlessly and securely make data transmissions that are required under this act.

(i) Will convey government assistance program eligibility information to residents.

(j) Will comply with any other applicable federal or state law governing the privacy of any personally identifying information or health or medical information of a resident.

(k) Will ensure that a resident who is eligible for a government assistance program receives a discount from the base cost of a benefit package in a manner that will enable the resident to realize 100% of the value of the government assistance program.

(*l*) If the department determines that the conveyance of government assistance through an exchange is not allowed under the federal act, will be authorized to issue a coupon to a resident who

is eligible for government assistance that may be redeemed by the resident at the government assistance portal or other appropriate state or local agency.

(4) In developing security standards and data transmission requirements applicable to an exchange under this act, the department shall ensure all of the following:

(a) That no information beyond that information necessary to determine eligibility for government assistance programs is transmitted to any person outside of the exchange.

(b) That a standardized data schema is used for exchanges to collect the information that is necessary to determine eligibility for government assistance programs and convey information pertaining to that eligibility.

Sec. 405. (1) The department shall develop and maintain a government assistance portal for use by exchanges and, if the department determines appropriate, by government assistance programs that facilitates the receipt and transmission of data but only for uses approved by the department under this act.

(2) The department shall reconcile an individual's eligibility for group 1 membership, for group 2 membership, and for multiple government assistance programs to ensure that enrollment or benefit eligibility is determined in the context of cumulative benefits received as a means of reducing duplication of benefits and fraud.

Enacting section 1. This act does not take effect unless Senate Bill No.680
of the 97th Legislature is enacted into law.