HOUSE BILL No. 6285

August 15, 2018, Introduced by Reps. Rabhi, Love, Wittenberg, Elder, Peterson, LaGrand, Geiss, Green, Hammoud, Chang, Hoadley, Sabo, Sowerby, Zemke and Ellison and referred to the Committee on Health Policy.

A bill to provide for the establishment of a universal and unified health care system and to reform the current payment system for health care coverage in this state; to create certain boards and committees and prescribe their powers and duties; to provide for the powers and duties of certain state and local governmental officers and agencies; to establish a fund; to provide for the promulgation of rules; and to prescribe penalties and provide remedies.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

CHAPTER 1

Sec. 101. This act shall be known and may be cited as the "MIcare act".

Sec. 102. As used in this act:

(a) "Ambulance" means that term as defined in section 20902 of

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the public health code, 1978 PA 368, MCL 333.20902.

(b) "Board" means the MIcare board created in section 302.

(c) "Department" means the department of health and human services.

(d) "Director" means the director of the department or his or her designee.

Sec. 103. As used in this act:

(a) "Exchange" means that term as defined in section 1261 of the insurance code of 1956, 1956 PA 218, MCL 500.1261.

(b) "Federal act" means the federal patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(c) "Fund" means the MIcare fund created in section 410.

Sec. 104. As used in this act:

(a) "Health carrier" means any of the following entities that are subject to the insurance laws and regulations of this state or otherwise subject to the jurisdiction of the director of the department of insurance and financial services:

(*i*) A health insurer operating under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(*ii*) A health maintenance organization operating under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(*iii*) A health care corporation operating under the nonprofit health care corporation reform act of 1980, 1980 PA 350, MCL 550.1101 to 550.1704.

(*iv*) A nonprofit dental care corporation operating under 1963

PA 125, MCL 550.351 to 550.373.

(*v*) Any other entity providing a plan of health insurance, health benefits, or health services.

(b) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed, registered, certified, or otherwise authorized by state law to provide professional health services.

(c) "Health care system" means the local, state, regional, or national system of delivering health services, including administrative costs, capital expenditures, preventive care, and wellness services.

(d) "Health service" means any treatment or procedure delivered by a health care professional to maintain an individual's physical or mental health or to diagnose or treat an individual's physical or mental health condition, including services ordered by a health care professional for chronic care management, preventive care, wellness services, and medically necessary services to assist in activities of daily living.

(e) "Hospice" means that term as defined in section 20106 of the public health code, 1978 PA 368, MCL 333.20106.

(f) "Hospital" means any of the following:

(*i*) That term as defined in section 20106 of the public health code, 1978 PA 368, MCL 333.20106.

(*ii*) A hospital located outside of this state.

(*iii*) That term as defined in section 100b of the mental health code, 1974 PA 258, MCL 330.1100b.

(g) "Integrated delivery system" means a group of health care

professionals, associated either through employment by a single entity or through a contractual arrangement, that provides health services for a defined population of patients.

Sec. 105. As used in this act:

(a) "Manufacturers of prescribed products" means any of the following:

(*i*) A manufacturer as defined in section 17706 of the public health code, 1978 PA 368, MCL 333.17706.

(*ii*) A caregiver as defined in section 3 of the Michigan medical marihuana act, 2008 IL 1, MCL 333.26423.

(*iii*) A person that holds a license as a grower, processor, provisioning center, or safety compliance facility under the medical marihuana facilities licensing act, 2016 PA 281, MCL 333.27101 to 333.27801.

(b) "Medicaid" means that term as defined in section 3801 of the insurance code of 1956, 1956 PA 218, MCL 500.3801.

(c) "Medicare" means that term as defined in section 3801 of the insurance code of 1956, 1956 PA 218, MCL 500.3801.

(d) "MIcare" means the universal health care system established under this act and designed to provide health care coverage through a simplified, public administrative system and single claims payment system.

(e) "MIChild" means the state child health plan in this state under title XXI of the social security act, 42 USC 1397aa to 1397mm.

(f) "Treatment of autism spectrum disorders" means that term as defined in section 3 of the autism coverage reimbursement act,

2012 PA 101, MCL 550.1833.

Sec. 107. (1) The director shall coordinate health care system reform efforts among executive branch agencies, departments, and offices and shall coordinate with the board.

(2) The director shall ensure that executive branch agencies, departments, and offices responsible for the development, improvement, and implementation of this state's health care system reform do so in a manner that is coordinated, timely, equitable, patient-centered, and evidence-based and that seeks to inform and improve the quality of patient care and public health, contain costs, and attract and retain well-paying jobs in this state.

(3) The director shall provide information and testimony on the efforts under this act to the senate and house of representatives standing committees on health issues on request.

CHAPTER 2

Sec. 201. (1) The health care reform efforts under this act must include simplified administration processes and delivery reform in order to have a publicly financed and publicly administered program of universal and unified health care operational after the occurrence of specific events, including the receipt of a waiver from the federal health benefit exchange requirement from the United States Department of Health and Human Services.

(2) In order to begin the planning efforts, the director shall establish a strategic plan that includes time lines and allocations of the responsibilities associated with health care system reform, to improve health outcomes, to further this state's existing health

care system reform efforts, and to further all of the requirements of this section.

Sec. 202. (1) As provided in chapter 4, all residents of this state are eligible for MIcare, a universal health care program that will provide health care coverage through a single payment system. To the maximum extent allowable under federal law and through waivers from requirements of federal law, MIcare includes health care coverage provided under Medicaid, under Medicare, under MIChild, by employers that choose to participate, and to state and local government employees including public school employees.

(2) If the federal act is modified by congressional, judicial, or federal administrative action that prohibits implementation of a health benefit exchange; eliminates federal funds available to individuals, employees, or employers; or eliminates the waiver under section 1332 of the federal act, 42 USC 18052, the director shall continue, and adjust as appropriate, the planning and cost-containment activities provided in this act related to MIcare and to creation of a unified, simplified administration and payment system, including identifying the financing impacts of such a modification on this state and its effects on the activities proposed in this act.

Sec. 205. The director shall supervise and oversee, as appropriate, the planning efforts, a continuation of the planning necessary to ensure an adequate, well-trained primary care workforce; necessary retraining for any employees dislocated from health care professionals or from health carriers because of the simplification in the administration of health care; consolidation

of multiple payment sources into a single payment system; and unification of health system planning, regulation, and public health.

Sec. 207. The director shall obtain waivers, exemptions, agreements, legislation, or a combination of these items to ensure that, to the extent possible under federal law, all federal payments provided within this state for health services are paid directly to MIcare. MIcare shall assume responsibility for the benefits and services previously paid for by the federal programs, including Medicaid, Medicare, MIChild, and, after implementation, the exchange. In obtaining the waivers, exemptions, agreements, legislation, or combination of those items, the director shall negotiate with the federal government a federal contribution for health care services in this state that reflects medical inflation, the state gross domestic product, the size and age of the population, the number of residents of this state living below the poverty level, the number of Medicare-eligible individuals, and other factors that may be advantageous to this state and that do not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of MIcare.

Sec. 209. The board, in collaboration with the director, shall develop a work plan for the board. The board may include in the work plan any necessary processes for implementation of the board's duties, a time line for implementation of the board's duties, and a plan for ensuring sufficient staff to implement the board's duties. The board shall submit the work plan developed under this section

to the senate and house of representatives standing committees on health issues within 3 months after the effective date of this act.

CHAPTER 3

Sec. 301. As a framework for reforming health care in this state, the director shall utilize and ensure that the health care system in this state satisfies all of the following principles:

(a) That universal access to and coverage for high-quality, medically necessary health services is ensured for all residents of this state.

(b) That systemic barriers, including, but not limited to, cost, inadequate information, transportation needs, and geographic distribution of providers, do not prevent residents of this state from accessing necessary health services.

(c) That all residents of this state receive affordable and appropriate health services at the appropriate time in the appropriate setting.

(d) That overall costs for health services are contained and that growth in health care spending in this state balances the health care needs of the population with the ability to pay for necessary health services.

(e) That the health care system in this state be transparent in design, efficient in operation, and accountable to the residents of this state. The director shall ensure public participation by residents of this state in the design, implementation, evaluation, and accountability mechanisms of the health care system.

(f) That primary care be preserved and enhanced so that residents of this state have health services available to them,

preferably within their own communities. Other aspects of this state's health care infrastructure, including, but not limited to, the educational and research missions of the state's academic medical institutions and other postsecondary educational institutions, the nonprofit missions of the community hospitals, population health missions of public and private community health organizations, and the critical access designation of rural hospitals, must be supported in such a way that all residents of this state have access to necessary health services and that these health services are sustainable.

(g) That every resident of this state is able to choose his or her health care professionals.

(h) That residents of this state are aware of the costs of the health services they receive. For this purpose, the cost of health services should be transparent and easy to understand.

(i) That the health care system recognize the primacy of the relationship between a patient and his or her health care professionals, respecting the professional judgment of health care professionals and the informed decisions of patients.

(j) That this state's health care system seek continuous improvement of health care quality and safety and of the health of the residents of this state and reduce morbidity and increase life expectancy. For this reason, the director shall ensure that the system is evaluated regularly for improvements in access, outcomes, and cost containment.

(k) That appropriate rules and enforcement mechanisms are in place to ensure that health care provider work hours and staffing

ratios support the health and safety of both providers and patients.

(*l*) That this state's health care system include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs, by reducing costs that do not contribute to improved health outcomes, and by leveraging the unified payment system to negotiate prices. The director shall ensure that efforts to reduce overall health care costs identify sources of excess cost growth.

(m) That the system must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.

(n) That this state's health care system operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal governments.

Sec. 302. (1) The MIcare board is created as an autonomous entity in the department. The board is an independent body with the powers and duties as provided for under this act. The department shall provide suitable office space for the board and the employees of the board.

(2) The board shall promote the general good of this state by doing all of the following:

(a) Improving the health of the residents of this state as measured by rates of disability, disease, and life expectancy.

(b) Reducing the per-capita rate of growth in expenditures for health services in this state across all payers while ensuring that access to health services and the quality of health services

received by residents of this state are not compromised.

(c) Enhancing the patient and health care professional experience during the delivery of health services.

(d) Recruiting and retaining high-quality health care professionals.

(e) Achieving administrative simplification in health care financing and delivery.

(f) Consolidating as many payment sources as feasible into a unified claims payment system.

Sec. 303. (1) The board consists of 13 members, 1 of whom serves as chair. All of the members must be state employees and are exempt from the classified state civil service. The chair must receive compensation equal to that of a justice of the supreme court, and the remaining members must receive compensation equal to 2/3 of the amount received by the chair.

(2) The speaker and minority leader of the house of representatives shall nominate the members of the board using the qualifications described in this section. The governor shall appoint the members from the nominees with the advice and consent of the senate. The governor shall not appoint a nominee who was denied confirmation by the senate within the past 2 years.

(3) The members of the board shall elect the chair who shall serve for a term of 4 years. The term of office of each member other than the chair is 4 years, except that of the members first appointed, 3 each shall serve terms of 1 year, 2 years, 3 years, and 4 years.

(4) The speaker of the house of representatives and the

minority leader of the house of representatives shall each submit to the governor the names of 13 candidates they have determined are qualified to be appointed to the board. Of these 26 qualified candidates, the governor shall appoint 13 to the board subject to the advice and consent of the senate. The governor shall appoint no more than 7 members nominated by the same party, unless 1 or more candidates were nominated by both parties.

(5) Subject to the nomination and appointment process, a member may serve more than 1 term.

(6) A member of the board may be removed only for cause. The board shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to define the basis and process for removal.

(7) Except as otherwise provided in this subsection, a board member shall not, during his or her term on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board, or of any health carrier. However, for an individual health care professional, the employment restriction under this subsection applies only to administrative or managerial employment or affiliation with a hospital or other health care facility and does not limit generally the ability of the individual health care professional to practice his or her profession.

(8) A board member shall not participate in creating or applying any law, rule, or policy or in making any other determination if the board member, individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or

any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimis interest that could be substantially affected by the proceeding.

(9) Subsections (7) and (8) do not prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

(a) Being an insurance policyholder or receiving health services on the same terms as are available to the public generally.

(b) Owning a stock, bond, or other security in an entity subject to supervision or regulation by the board or any health carrier that is purchased by or through a mutual fund, blind trust, or other mechanism if a person other than the board member chooses the stock, bond, or security.

(c) Receiving retirement benefits through a defined benefit plan from an entity subject to supervision or regulation by the board or any health carrier.

(10) A board member shall not, during his or her term on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board or any health carrier.

(11) A former board member shall not appear before the board or any other executive branch agency, department, or office on behalf of a person subject to supervision or regulation by the board or any health carrier for a period of 1 year following his or

her last day as a member of the board.

(12) In nominating candidates for the board, the speaker and minority leader of the house of representatives shall assess candidates using the following criteria:

(a) Commitment to the principles expressed in section 301.

(b) Knowledge of or expertise in health care policy, health care delivery, or health care financing, and openness to alternative approaches to health care.

(c) Possession of desirable personal characteristics, including integrity, impartiality, empathy, experience, diligence, administrative and communication skills, social consciousness, public service, and regard for the public good.

(d) Knowledge, expertise, and characteristics that complement those of the other members of the board and demographic characteristics that contribute to the demographic representativeness of the board in relation to the population of this state.

(e) Impartiality and the ability to remain free from undue influence by a personal, business, or professional relationship with any person subject to supervision or regulation by the board or any health carrier.

(13) Subject to subsection (14), the board must include members with the following types of experience:

(a) Two members with experience or expertise in population health.

(b) One member with experience or expertise in health care financing or health care economics.

(c) Two members with experience or expertise in health care benefit design.

(d) One member with experience or expertise in health care administration.

(e) One member who is a licensed health care professional with recent experience in primary care.

(f) One member who is a licensed health care professional with recent experience in acute care.

(g) One member who is a licensed health care professional with recent experience in mental health care or behavioral health.

(h) One member who is a licensed health care professional with recent experience in dental care.

(i) One member who is a licensed physician.

(j) One member who is a registered nurse.

(k) One member who is eligible for community mental health services at the time of initial nomination.

(*l*) One member who is eligible for Medicare at the time of initial nomination.

(m) One member who is eligible for employer health coverage at the time of initial nomination.

(n) One member who is eligible for Medicaid at the time of initial nomination.

(14) The same member may fulfill 1 or more of the types of experience required under subsection (13).

(15) If a vacancy occurs on the board, or if an incumbent does not declare that he or she will be a candidate to succeed himself or herself, the speaker of the house of representatives and the

minority leader of the house of representatives shall each submit to the governor the names of as many qualified candidates as there are vacancies, providing to the governor a combined list of 2 candidates for each vacancy.

(16) The governor shall make an appointment to fill a vacancy on the board from the list of qualified candidates submitted under subsection (15). The appointment must not result in more than 7 simultaneously serving members of the board having been nominated by the same party, unless 1 or more members were nominated by both parties. The appointment is subject to the advice and consent of the senate.

Sec. 304. (1) The chair of the board has general charge of the offices and employees of the board but may hire a manager to oversee the administration and operation.

(2) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. A member of the advisory group under this subsection who is not a state employee or whose participation is not supported through his or her employment or association shall receive per diem compensation, and reimbursement of expenses up to $5,000.00 per year.

(3) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals and consumers demographically representative of the population of this state to the additional advisory groups and subcommittees as appropriate.

(4) In carrying out its duties under this act, the board shall

seek the advice of appropriate individuals and entities regarding the policies, procedures, and rules established under this act. Appropriate individuals and entities are those who represent the interests of residents of this state who are patients and consumers of health services and health care coverage and who may suggest policies, procedures, or rules to the board to protect those patients' and consumers' interests.

Sec. 305. (1) The board shall execute its powers and duties under this act consistent with the principles expressed in this chapter.

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

(a) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in the costs of health services and maintain health care quality in this state.

(b) As provided in this subdivision, promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to implement methodologies for achieving payment reform and containing costs and improving outcomes. Rules may relate to the creation of health care professional cost-containment or outcome targets, bundled payments, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements. Before promulgating rules under this subdivision, the board shall report the board's proposed methodologies to the senate and house of representatives standing committees on health issues. In developing methodologies under this

subdivision, the board shall engage residents of this state in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(c) Review this state's health care information infrastructure work done by the health information technology commission created under section 2503 of the public health code, 1978 PA 368, MCL 333.2503, to ensure that the necessary standards, claims payment databases, electronic health records, and other infrastructure are in place to enable this state to achieve the principles expressed in this chapter.

(d) Set rates for health care professionals under section 306, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(e) Within 9 months after the effective date of this act and before promulgating rules, review the benefit package for qualified health plans under the exchange. The board shall report to the senate and house of representatives standing committees on health issues within 15 days after its review of the initial benefit package and any subsequent substantive changes to the benefit package.

(f) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures as follows:

(*i*) For determining public and health care professional satisfaction with the health care system.

(*ii*) For assessing the effectiveness of prevention and health

promotion programs.

(*iii*) For cost containment and limiting the growth in expenditures for health services.

(*iv*) For determining the adequacy of the supply and distribution of health care resources in this state.

(*v*) For determining and tracking rates of morbidity and premature mortality for relevant populations, and determining and tracking life expectancy and other quantifiable indicators of population health as appropriate.

(*vi*) For assessing the frequency and severity of medical errors and preventable adverse outcomes.

(*vii*) For assessing the care received by MIcare beneficiaries in relation to evidence-based clinical practice guidelines.

(*viii*) For assessing the adequacy of staffing ratios and health provider work hour rules and enforcement in protecting patients and providers.

(*ix*) For assessing the contribution of health care costs to personal and business bankruptcies in this state before and after implementation of MIcare.

(*x*) For determining timeliness of health care service delivery.

(*xi*) To address access to and quality of mental health and substance abuse services.

(*xii*) For other indicators as determined by the board.

(g) Within 18 months after the effective date of this act, study the feasibility of replacing health coverage for accidental bodily injury currently provided by motor vehicle insurers under

section 3105 of the insurance code of 1956, 1956 PA 218, MCL 500.3105, with MIcare coverage. The board shall report to the senate and house of representatives standing committees on health issues and insurance within 15 days after completing its study on the differences in covered benefits, projected costs, projected reductions in motor vehicle insurance premiums, assets available to the catastrophic claims association created under section 3104 of the insurance code of 1956, 1956 PA 218, MCL 500.3104, to pay motor vehicle health claims, and proposed additional revenue sources.

(h) Within 24 months after the effective date of this act, study the feasibility of replacing health coverage currently provided under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, with MIcare coverage. The board shall report to the senate and house of representatives standing committees on health issues and insurance within 15 days after completing its study on the differences in covered benefits, federal requirements for state worker's compensation systems, projected costs, projected reductions in worker's compensation insurance premiums, assets available in the funds under chapter 5 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.501 to 418.561, to pay worker's compensation health claims, and proposed additional revenue sources.

(i) Within 12 months after the effective date of this act, study the feasibility of including long-term care in the MIcare benefits package. The board shall report to the senate and house of representatives standing committees on health issues and insurance within 15 days after completing its study on the need for long-term

care services in this state, the relative value of covering attendant and home care services to enable care in the least restrictive environment, the advisability of setting separate procedures to establish residency for long-term care coverage eligibility, projected costs, federal funding available to pay long-term care claims, and proposed additional revenue sources.

(3) The board shall do all of the following with regard to MIcare:

(a) Before implementing MIcare, consider recommendations from the department and the director of the department of insurance and financial services, and define the MIcare benefit package within the parameters established in chapter 4.

(b) When providing its recommendations for the benefit package under subdivision (a), present a report on the benefit package proposal to the senate and house of representatives standing committees on health issues. The report must describe the health services to be covered in the MIcare benefit package. If the legislature is not in session at the time that the board makes its recommendations, the board shall send its report electronically or by first-class mail to each member of the senate and house of representatives standing committees on health issues.

(c) Before implementing MIcare and annually after implementation, recommend to the legislature and the governor a 3-year MIcare budget under section 409, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to

tax rates, fees, and other assessments, if any.

(4) On or before the first January 15 after the effective date of this act and on or before each January 15 after that date, the board shall submit a report of its activities for the preceding state fiscal year to the senate and house of representatives standing committees on health issues. The report must include any changes to the payment rates for health care professionals under section 306, any new developments with respect to health information technology, the evaluation criteria adopted under subsection (2)(f) and any related modifications, the results of the systemwide performance and quality evaluations required by subsection (2)(f) and any resulting recommendations, the process and outcome measures used in the evaluation, any recommendations for modifications to state law, and any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs. The report must identify how the work of the board comports with the principles expressed in this chapter.

(5) All reports prepared by the board must be available to the public on request and must be posted on the board's internet website.

(6) The board is subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

Sec. 306. (1) The board shall ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and that will permit health care professionals to

provide, on a solvent basis, effective and efficient health services that are in the public interest. The board shall ensure that the amount paid to health care professionals is sufficient to enlist enough health care professionals to ensure that health services are available to all residents of this state and are distributed equitably.

(2) The board shall set reasonable rates for health care professionals, manufacturers and retailers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies under section 305, in order to have a consistent reimbursement amount accepted by these persons. The board shall also set rates for covered benefits provided by persons who are not licensed health care professionals that provide services such as home services and transportation services. In establishing rates, the board may consider legitimate differences in costs among health care professionals, including the cost of providing a specific necessary service or services that may not be available elsewhere in this state, and the need for health care professionals in particular areas of this state, particularly in underserved geographic or practice shortage areas. This subsection does not limit the ability of a health care professional to accept less than the rate established in this subsection from a patient without health insurance or other coverage for the health service received.

(3) The board shall approve payment methodologies that encourage cost containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-

management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles. The payment methodologies must be consistent with evidence-based practices and may include fee-for-service payments if the board determines those payments to be appropriate.

(4) To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (1), the board shall facilitate and supervise the participation of health care professionals in the process described in subsection (2).

(5) As a base rate for any benefit described in section 405(1) that is covered by Medicare Part A or B, the board shall set a rate that is 10% more than the rate provided by Medicare. The board may adjust the base rate to ensure access to services in specific geographic areas or types of care, or to improve outcomes or control costs in accordance with section 305.

(6) As a base rate for coverage of a medical device or prescription drug that is covered by the Department of Veterans Affairs, the board shall set the rate equal to the rate provided by the Department of Veterans Affairs. The board may adjust the base rate to ensure access to medically necessary devices or drugs, or to improve outcomes or control costs in accordance with section 305.

Sec. 309. The director shall ensure that, in accordance with state and federal privacy laws, the board has access to data and analysis held by any executive branch agency, department, or office that is necessary to carry out the board's powers and duties as

described in this act.

Sec. 310. The board may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, as needed to carry out this chapter.

Sec. 311. (1) The board shall adopt procedures for administrative appeals of its actions, orders, or other determinations. The procedures must provide for the issuance of a final order and the creation of a record sufficient to serve as the basis for judicial review under subsection (2).

(2) A person aggrieved by a final action, order, or other determination of the board is entitled, on exhaustion of all administrative appeals available under subsection (1), to judicial review as provided in chapter 6 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.301 to 24.306.

CHAPTER 4

Sec. 401. MIcare is established to provide, as a public good, comprehensive, affordable, high-quality, publicly financed, and publicly administered health care coverage for all residents of this state in a seamless and equitable manner regardless of income, assets, health status, or availability of other health coverage. MIcare must improve value in health care by doing all of the following:

(a) Establishing innovative payment mechanisms to improve outcomes and contain costs.

(b) Reducing unnecessary administrative expenditures through a publicly administered system.

(c) Negotiating lower prices with the leverage of a unified

payment system.

Sec. 402. (1) MIcare must be implemented 90 days after the last of the following to occur:

(a) Receipt of a waiver under section 1332 of the federal act, 42 USC 18052, under subsection (2).

(b) Enactment of a law establishing the financing for MIcare.

(c) Approval by the board of the initial MIcare benefit package under section 305.

(d) Enactment of the appropriations for the initial MIcare benefit package proposed by the board under section 305.

(e) A determination by the board that each of the following conditions will be met:

(*i*) When implemented, MIcare will not have a negative aggregate impact on this state's economy.

(*ii*) The financing for MIcare is sustainable.

(*iii*) Administrative expenses will be reduced.

(*iv*) Cost-containment efforts will result in a reduction in the rate of growth in this state's per capita health care spending.

(*v*) Health care professionals will be reimbursed at levels sufficient to allow this state to recruit and retain high-quality health care professionals.

(2) As soon as allowed under federal law, the director shall seek a waiver to allow this state to suspend operation of the exchange and to enable this state to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the federal act. The director may seek a waiver from

other provisions of the federal act as necessary to ensure the operation of MIcare.

Sec. 403. (1) On implementation, a resident of this state is eligible for MIcare, regardless of whether an employer offers health insurance for which he or she is eligible. The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to establish standards for proof and verification that an individual is a resident of this state.

(2) Except as otherwise provided in this subsection, if an individual is determined to be eligible for MIcare based on information later found to be false, the department shall make reasonable efforts to recover from the individual the amounts expended through MIcare for health services on his or her behalf. In addition, if the individual knowingly provided the false information, he or she is subject to an administrative fine of not more than $5,000.00. The department shall include information on the MIcare application to provide notice to applicants of the penalty for knowingly providing false information as established in this subsection. An individual determined to be eligible for MIcare whose health services are paid in whole or in part by Medicaid funds who commits fraud is subject to the medicaid false claim act, 1977 PA 72, MCL 400.601 to 400.615, instead of the administrative penalty described in this subsection. This subsection does not limit or restrict prosecutions under any applicable provision of law, including the health care false claim act, 1984 PA 323, MCL 752.1001 to 752.1011.

(3) Except as otherwise provided in this section, a person who is not a resident of this state is not eligible for MIcare. Except as otherwise provided in this subsection, an individual covered under MIcare shall inform the department within 60 days after becoming a resident of another state. An individual who obtains or attempts to obtain health services through MIcare more than 60 days after becoming a resident of another state shall reimburse the department for the amounts expended for his or her care and is subject to an administrative penalty of not more than $1,000.00 for a first violation and not more than $2,000.00 for any subsequent violation. An individual whose health services are paid in whole or in part by Medicaid funds who obtains or attempts to obtain health services through MIcare more than 60 days after becoming a resident of another state is subject to the medicaid false claim act, 1977 PA 72, MCL 400.601 to 400.615, instead of the administrative penalty described in this subsection. This subsection does not limit or restrict prosecutions under any applicable provision of law, including the health care false claim act, 1984 PA 323, MCL 752.1001 to 752.1011.

(4) Administrative penalties collected under this section must be transmitted to the state treasurer for deposit into the fund.

Sec. 404. (1) The department shall establish a procedure to enroll residents of this state in MIcare. The department shall develop and implement a program to train department employees and community health workers to enroll residents in MIcare.

(2) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to

24.328, to establish a process to allow health care professionals to presume an individual is eligible based on the information provided on a simplified application. After submission of the application, the department shall collect additional information as necessary to determine whether Medicaid, Medicare, MIChild, or other federal funds may be applied toward the cost of the health services provided, but shall provide payment for any health services received by the individual from the time the application is submitted. If an individual presumed eligible for MIcare under this subsection is later determined not to be eligible for the program, the department shall make reasonable efforts to recover from the individual the amounts expended through MIcare for health services on his or her behalf.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to ensure that residents of this state who are temporarily out of the state and who intend to return and reside in this state remain eligible for MIcare while outside this state.

(4) A nonresident visiting this state, or his or her health carrier, must be billed for all health services received by that individual in this state. The department may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors and shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to carry out this subsection.

Sec. 405. (1) MIcare includes coverage for medically necessary

benefits, including, but not limited to, all of the following:

(a) Primary care.

(b) Preventive care.

(c) Chronic care.

(d) Acute episodic care.

(e) Hospital services.

(f) Mental health services.

(g) Prescription drugs.

(h) Medical devices.

(i) Dental care.

(j) Vision care.

(k) Hearing care.

(*l*) Care for substance use disorder.

(m) Reproductive health care and obstetrical care.

(n) Long-term care, including in-home care.

(o) Laboratory services, including blood lead testing for a child who is not 7 years of age, in accordance with Centers for Disease Control guidelines.

(p) Gender transition. As used in this subdivision, "gender transition" means the process of changing an individual's outward appearance, including physical sex characteristics, to accord with the individual's gender identity.

(q) Organ donation and transplantation.

(r) Treatment of autism spectrum disorders.

(s) Ambulance services.

(t) Hospice care.

(2) The benefits package for all MIcare recipients must, at a

minimum, include any essential benefits for plans under the federal act.

(3) MIcare must not include premiums or cost-sharing requirements. The board shall not impose deductibles, co-insurance, co-pays, or individual caps on coverage amounts. The board shall include all costs of covered benefits in the budget recommended to the legislature under section 409 without assuming any revenue will be derived from premiums or cost-sharing.

(4) MIcare must not discriminate in the design and administration of benefits or in the payment of claims because of sexual orientation, gender identity, disability, or any status for which discrimination is prohibited under section 102 of the Elliott-Larsen civil rights act, 1976 PA 453, MCL 37.2102. For all recipients, MIcare must comply with the nondiscrimination requirements in section 1557 of the federal act and with the final rule interpreting that section.

(5) MIcare must not limit coverage of preexisting conditions.

(6) The board shall approve the benefit package and present it to the legislature as part of its recommendations for the MIcare budget.

Sec. 406. (1) For individuals eligible for Medicaid or MIChild, the MIcare benefit package must include the benefits required by federal law, as well as any additional benefits provided as part of the MIcare benefit package.

(2) On implementation of MIcare, the benefit package for individuals eligible for Medicaid or MIChild must also include any optional Medicaid benefits under 42 USC 1396d or health services

covered under MIChild as provided in 42 USC 1397cc. Beginning with the second year of MIcare and going forward, the board may, consistent with federal law, modify these optional benefits, while at all times the benefit package for these individuals includes at least the benefits described in subsection (1).

(3) For children eligible for benefits paid for with Medicaid or MIChild funds, the MIcare benefit package must include early and periodic screening, diagnosis, and treatment services as defined under federal law.

(4) For individuals eligible for Medicare, the MIcare benefit package must include the benefits provided to these individuals under federal law, and any additional benefits provided as part of the MIcare benefit package.

Sec. 407. (1) The department shall administer MIcare. The department shall not enter into contracts with nongovernmental entities to administer claims or payments, design benefits, administer appeals, or provide customer service.

(2) If the department receives a federal waiver to administer Medicaid or MIChild programs as part of MIcare, the department shall not renew any contract with a managed care organization.

(3) In hiring staff necessary to administer MIcare, the department shall develop and implement procedures consistent with civil service rules to preferentially recruit individuals displaced from health carriers and health provider administration because of efficiency gains in the administration of health care.

Sec. 408. (1) This chapter does not require an individual with health coverage other than MIcare to terminate that coverage.

(2) An individual enrolled in MIcare may elect to maintain supplemental health insurance if the individual so chooses.

(3) Residents of this state must not be billed any additional amount for the receipt of health services covered by MIcare.

(4) The department shall seek permission from the Centers for Medicare and Medicaid Services to be the administrator for the Medicare program in this state. If the department is unsuccessful in obtaining that permission, MIcare must be the secondary payer with respect to any health service that may be covered in whole or in part by Medicare.

(5) MIcare must be the secondary payer with respect to any health service that may be covered in whole or in part by any other health benefit plan, including, but not limited to, private health insurance, retiree health benefits, or federal health benefit plans offered by the Department of Veterans Affairs, by the military, or to federal employees.

(6) The department may seek a waiver under 42 USC 1315 to include Medicaid and under 42 USC 1397gg to include MIChild in MIcare. If the department is unsuccessful in obtaining 1 or both of these waivers, MIcare shall be the secondary payer with respect to any health service that may be covered in whole or in part by Medicaid or MIChild, as applicable.

(7) Any prescription drug coverage offered by MIcare must be consistent with the standards and procedures applicable under the pharmaceutical best practices initiative established under section 9703 of the public health code, 1978 PA 368, MCL 333.9703, or provided to a qualifying patient under the Michigan medical

marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430.

(8) MIcare must maintain a robust and adequate network of health care professionals located in this state or regularly serving residents of this state, including mental health and substance abuse professionals. The department shall contract with outside entities as needed to allow for the appropriate portability of coverage under MIcare for residents of this state who are temporarily out of this state.

(9) The department shall make available the necessary information, forms, access to eligibility or enrollment systems, and billing procedures to health care professionals to ensure immediate enrollment for individuals in MIcare at the point of service or treatment.

(10) An individual aggrieved by an adverse decision of the department or board may appeal that final decision in the manner provided in the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(11) The department, in collaboration with other relevant departments, shall monitor the extent to which residents of other states move to this state for the purpose of receiving health services and the impact, positive or negative, of any such migration on this state's health care system and on this state's economy, and make appropriate recommendations to the legislature based on its findings.

Sec. 409. The board, in collaboration with the department, shall annually develop a 3-year MIcare budget for proposal to the legislature and to the governor, to be adjusted annually in

response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments. The budget must not include cost-sharing or premiums.

Sec. 410. (1) The MIcare fund is created in the state treasury as the single source to finance health care coverage for MIcare.

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

(a) Transfers or appropriations from the general fund, authorized by the legislature.

(b) If authorized by a waiver from federal law, federal funds for Medicaid, Medicare, MIChild, and the exchange.

(c) The proceeds from grants, donations, contributions, taxes, and any other sources of revenue as may be provided by statute or by rule.

(d) Administrative fines collected under this act.

(3) Money in the fund at the close of the fiscal year must remain in the fund and must not lapse to the general fund. The department is the administrator of the fund for auditing purposes.

(4) The department shall expend money from the fund, on appropriation, only for 1 or more of the following purposes:

(a) The administration and delivery of and payment for health services covered by MIcare as provided in this act.

(b) Expenses related to the duties and operation of the board.

Sec. 411. This chapter does not limit the ability of collective bargaining units to negotiate for health care coverage pursuant to law. This act does not supersede existing collective bargaining agreements.

Sec. 412. The department shall provide a process for soliciting public input on the MIcare benefit package on an ongoing basis, including a mechanism by which members of the public may request inclusion of particular benefits or services. The process may include receiving written comments on proposed new or amended rules or holding public hearings, or both.

Sec. 413. The department may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to carry out the purposes of this chapter. If promulgating rules relating to the MIcare benefit package, the director shall ensure that the rules are consistent with the benefit package defined by the board under this act.