SENATE BILL No. 842

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February 14, 1996, Introduced by Senator A. SMITH and referred to the Committee on Health Policy and Senior Citizens.

A bill to provide for a health plan with universal access; to create the office of state health commissioner; to create a commission; to provide for certain powers and duties; to provide for certain powers and duties of certain state officers and agencies; to provide for certain taxes, fees, and contributions; and to provide for an appropriation.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 1. This act shall be known and may be cited as
2 "Michicare".
3 Sec. 2. As used in this act:
4 (a) "Commission" means the commission created in section 4.
5 (b) "Commissioner" means the state health commissioner.
6 (c) "Global budget" means an annual budget that includes all
7 expenses other than capital expenditures.

1 (d) "Health care facility" means a hospital, nursing home,
2 county medical care facility, hospice, health maintenance
3 organization, freestanding surgical outpatient facility, clinical
4 laboratory, community health center, migrant health center, ambu-
5 lance operation, advanced mobile emergency care service, or
6 limited advanced mobile emergency care service.
7 (e) "Health care provider" means a health care facility or a
8 person who is licensed or otherwise authorized under article 15
9 of Act No. 368 of the Public Acts of 1978, being sections
10 333.16101 to 333.18838 of the Michigan Compiled Laws, to provide
11 health care to individuals.
12 (f) "Health maintenance organization" means a not-for-profit
13 entity that delivers health services that are medically indicated
14 to enrollees under the terms of a health maintenance contract,
15 directly or through contracts with affiliated providers, without
16 regard to the frequency, extent, or kind of health services, and
17 that is responsible for the availability, accessibility, and
18 quality of the health services provided.
19 (g) "Hospice" means a health care program that provides a
20 coordinated set of services rendered at home or in outpatient or
21 institutional settings for individuals suffering from a disease
22 or condition with a terminal prognosis.
23 (h) "Hospital" means a facility offering inpatient, over-
24 night care, and services for observation, diagnosis, and treat-
25 ment of an individual with a medical, surgical, obstetric, chron-
26 ic, or rehabilitative condition requiring the daily direction or

1 supervision of a physician. The term includes a sanatorium
2 falling within the definition of "hospital" in title XVIII.
3 (i) "Nurse specialist" means a registered nurse who has
4 received a specialty certification as a nurse midwife, nurse
5 anesthetist, or nurse practitioner.
6 (j) "Office" means the office of state health commissioner
7 created in section 3.
8 (k) "Participating provider" means a health care provider
9 who signs a participation agreement developed pursuant to
10 section 7(n) authorizing him or her to receive payment from the
11 plan by means of a global budget, capitation amounts, or fee for
12 service, for furnishing covered services to plan members.
13 (*l*) "Physician" means an individual licensed in this state
14 to engage in the practice of medicine or osteopathic medicine and
15 surgery.
16 (m) "Plan" means the health plan established by this act.
17 (n) "Resident" means a person domiciled in this state and
18 who has been domiciled in this state for not less than 30 days,
19 except that a newborn domiciled in this state is a resident from
20 the moment of birth.
21 (o) "Title XVIII" means title XVIII of the social security
22 act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2,
23 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to
24 1395w-2, 1395w-4 to 1395ccc.
25 (p) "Title XIX" means title XIX of the social security act,
26 chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g, and 1396i to
27 1396v.

1 Sec. 3. (1) The office of state health commissioner is
2 created within the department of public health. The office shall
3 exercise its powers and functions, including the functions of
4 budgeting and procurement and management-related functions, as an
5 autonomous entity, independent of the director of the department
6 of public health. The head of the office of state health commis-
7 sioner shall be called the state health commissioner and shall be
8 elected pursuant to sections 21 and 23 of article V of the state
9 constitution of 1963.
10 (2) The commissioner shall appoint a deputy health commis-
11 sioner by not later than 30 days after the commissioner takes
12 office. If the commissioner is unable to perform the duties of
13 office, the deputy health commissioner may perform the duties of
14 office for a period not to exceed 90 days.
15 Sec. 4. (1) A commission is created within the office. The
16 commission shall consist of the directors of the departments of
17 public health, social services, and mental health, the commis-
18 sioner of insurance, and the director of the office of services
19 to the aging, who shall all be ex officio, nonvoting members of
20 the commission and the following 17 voting members appointed by
21 the commissioner:
22 (a) Five representatives of health care consumer advocacy
23 organizations that have a statewide constituency and who have
24 been involved in activities related to health care consumer advo-
25 cacy including issues of interest to low and moderate income
26 individuals.

1 (b) Four representatives of labor organizations.
2 (c) Four representatives of business and industry.
3 (d) One representative of hospitals.
4 (e) One representative of nursing homes.
5 (f) One representative of physicians.
6 (g) One representative of licensed health care professionals
7 who are not physicians.
8 (2) The members first appointed to the commission shall be
9 appointed within 30 days after the commissioner takes office.
10 (3) Members of the commission shall serve for 4-year terms,
11 or until a successor is appointed, whichever is later.
12 (4) If a vacancy occurs on the commission, the commissioner
13 shall make an appointment for the unexpired term in the same
14 manner as the original appointment.
15 (5) The commissioner may remove a commission member for
16 incompetency, dereliction of duty, malfeasance, misfeasance, or
17 nonfeasance in office, or any other good cause.
18 (6) The first meeting of the commission shall be held within
19 45 days after the commissioner takes office. At the first meet-
20 ing, the commission shall elect from among its members a chair-
21 person and other officers as it considers necessary or
22 appropriate. After the first meeting, the commission shall meet
23 at least quarterly or more often upon the call of the chair or as
24 provided by the commission.
25 (7) Nine commission members constitute a quorum for the
26 transaction of business at a commission meeting. Nine commission
27 members are necessary for official commission action.

1 (8) The business that the commission may perform shall be
2 conducted at a public meeting of the commission held in compli-
3 ance with the open meetings act, Act No. 267 of the Public Acts
4 of 1976, being sections 15.261 to 15.275 of the Michigan Compiled
5 Laws.

6 (9) A writing prepared, owned, used, in possession of, or
7 retained by the commission in the performance of an official
8 function is subject to the freedom of information act, Act
9 No. 442 of the Public Acts of 1976, being sections 15.231 to
10 15.246 of the Michigan Compiled Laws.

11 (10) Commission members shall serve without compensation.
12 However, commission members may be reimbursed for their actual
13 and necessary expenses incurred in the performance of their offi-
14 cial duties as commission members.

15 Sec. 5. (1) There is created a health plan to provide com-
16 prehensive health care coverage including long-term care and
17 mental health and substance abuse services to all residents of
18 this state, using a unified, publicly funded, financing
19 mechanism.

20 (2) Every resident of this state is a member of the plan. A
21 nonresident of this state who is employed in this state may
22 choose to become a member by paying the requisite contributions
23 under section 25.

24 (3) Membership in the plan does not impinge upon a member's
25 right to consent to or to refuse treatment or other services
26 offered under the plan.

1 (4) A member in the plan shall have free choice of health
2 care providers.
3 (5) The plan shall pay for covered services provided to a
4 plan member in the amounts and subject to the conditions as are
5 prescribed by rules promulgated under this act. Hospitals, nurs-
6 ing homes, health maintenance organizations, community health
7 centers, and migrant health centers shall receive global
8 budgets. Other participating providers shall be directly reim-
9 bursed on a fee-for-service basis.
10 Sec. 7. The commission shall do all of the following:
11 (a) Establish policies and procedures for the operation of
12 the plan.
13 (b) Develop a budget for the plan, with separate line items
14 for prevention, services, training, capital expenditures, and
15 administrative costs.
16 (c) Recommend and pursuant to public hearings implement cost
17 containment strategies consistent with the studies called for in
18 subdivision (t) that will provide controls on the total plan
19 budget.
20 (d) Develop a schedule of covered services, which shall
21 include those services listed in section 21. The commission
22 shall hold public hearings as part of this process.
23 (e) Establish a review process for assessing and modifying
24 covered services and renegotiating the reimbursement schedule
25 based upon research on the effectiveness of particular health
26 tests and procedures required under subdivision (t).

1 (f) Assure that prevention and primary health care services
2 are available to all members and encourage all members to select
3 a primary health care provider to manage their care.
4 (g) Negotiate an annual, global budget with each participat-
5 ing hospital, nursing home, health maintenance organization, com-
6 munity health center, and migrant health center.
7 (h) After consultation and negotiation with health care pro-
8 viders, develop a reimbursement schedule for covered services.
9 (i) Decide which types of health care providers are eligible
10 to be participating providers.
11 (j) Create a plan fund to receive earmarked tax revenues and
12 federal funds, and to pay for covered services, capital expendi-
13 tures, administrative costs, and other costs allowable under this
14 act.
15 (k) Establish procedures for the handling and accounting of
16 plan assets and money.
17 (*l*) Develop a system to handle claims in an expeditious
18 manner to avoid undue delay in participating providers receiving
19 payment.
20 (m) Develop and implement a program to publicize the plan's
21 existence, the services covered, and how and where to obtain
22 these services. All printed material shall be in language and in
23 languages that plan members can understand.
24 (n) Develop a participation agreement for providers that
25 includes, but is not limited to, all of the following:
26 (*i*) Agreement not to discriminate against plan members on
27 the basis of race, sex, age, ethnicity, handicap, or income.

1 (*ii*) Agreement to honor plan members' rights.
2 (*iii*) Agreement to establish a means for plan members to
3 gain access to their own medical records.
4 (o) Establish procedures under which members and providers
5 may appeal decisions to an impartial body on issues of eligibili-
6 ty, medical necessity, and reimbursement amount.
7 (p) Provide an effective system of quality assurance and
8 develop agreements with medical providers to establish protocols
9 on peer review and medical provider discipline and provide tech-
10 nical assistance to providers to improve quality of care and
11 establish a graduated system of disciplinary action to assist
12 providers in improving quality of care.
13 (q) Provide a system to ensure the confidentiality of member
14 identified records.
15 (r) File an annual report with the governor, the secretary
16 of the senate, and the clerk of the house of representatives sum-
17 marizing the activities of the plan in the preceding calendar
18 year, including a financial report of money received, benefits
19 paid, expenses of administration and other payments, and data on
20 complaints received about the plan. The annual report shall be
21 available to the public.
22 (s) Arrange for an independent, annual audit of plan
23 operations.
24 (t) Conduct studies, as necessary, on remaining problems of
25 access and steps necessary to address those problems; the effi-
26 cacy of cost containment measures in the plan; the effectiveness
27 of particular health tests or procedures; provider performance;

1 plan member satisfaction; the general health of plan members; the
2 effect of the plan on the need for nursing home care; whether the
3 plan has affected employment opportunities of plan members; and
4 on any other health plan related issue. All studies upon their
5 completion shall be available to the public.
6 (u) Issue recommendations, as necessary, to the legislature
7 for changes to this act and other state law, and to congress for
8 changes in federal law, to improve access to health care, ensure
9 health care quality, and control health care costs.
10 Sec. 8. The commissioner shall do all of the following:
11 (a) Administer the plan. The commissioner's goal in admin-
12 istering the plan shall be to provide comprehensive health care
13 coverage for all plan members within the limits of dedicated rev-
14 enues available, to ensure access to covered services for all
15 members, and to ensure the quality of those services.
16 (b) Seek necessary waivers, execute agreements, and comply
17 with requirements to enable all payments available under title
18 XVIII, title XIX, and other federal health programs to be cred-
19 ited to the plan.
20 (c) Develop interdepartmental agreements with the depart-
21 ments of social services, public health, mental health, transpor-
22 tation, education, including Michigan rehabilitation service and
23 disability determination service, and with other appropriate
24 departments and offices including the office of services to the
25 aging to facilitate access to services under the plan.
26 (d) Promulgate rules pursuant to the administrative
27 procedures act of 1969, Act No. 306 of the Public Acts of 1969,

1 being sections 24.201 to 24.328 of the Michigan Compiled Laws, as
2 necessary to implement this act.
3 Sec. 9. (1) The commissioner is authorized to pay for all
4 of the following out of plan funds:
5 (a) Member health care claims.
6 (b) Administrative expenses acquired under the plan.
7 (c) Capital expenditures of hospitals, nursing homes, commu-
8 nity health centers, and migrant health centers, that may include
9 construction, renovation, and equipment costs.
10 (d) Education aimed at health promotion and the prevention
11 of illness or injury.
12 (e) Part or all of the education and training expenses of
13 medical and nursing students and graduates in return for a com-
14 mitment to practice in medically underserved areas in this
15 state.
16 (f) Part or all of the malpractice premiums of participating
17 providers upon conditions set by the plan.
18 (2) The plan may provide funds to county health departments
19 to effect any plan goal.
20 Sec. 11. The commissioner may do all of the following:
21 (a) Hire and supervise staff to work for the plan.
22 (b) Enter into contracts necessary or proper to carry out
23 the provisions and purposes of this act.
24 (c) Contract for any of the tasks in section 8, or, with the
25 commission's approval, section 7, if such action is cost
26 effective.

1 (d) Enter into contracts with plans in other states for
2 coverage of emergency or urgent care of members while present in
3 other states, and for coverage of residents of other states while
4 present in this state.
5 (e) Pay for covered services received by a member in emer-
6 gency or urgent situations while in another state.
7 (f) Pay for covered services received by a nonmember in
8 emergency or urgent situations and seek reimbursement directly
9 from the nonmember and through subrogation from a third party
10 payer.
11 (g) Make loans to providers for start-up costs of an indi-
12 vidual or group practice in medically underserved areas in this
13 state.
14 (h) Invest plan funds as permitted by law.
15 Sec. 12. (1) The commission shall establish in each local
16 department of public health a community health planning
17 committee.
18 (2) The community health planning committee shall be com-
19 posed of 9 members providing proportionate representation from
20 business, labor, health care providers, and consumers and con-
21 sumer organizations in the community. Members shall be appointed
22 by the bodies that appoint the director of the local department
23 of public health and shall serve 3-year terms. A member shall
24 not serve for more than 2 terms.
25 (3) The health planning committee shall assist the commis-
26 sion in carrying out its functions under section 7. The health
27 planning committee shall hold at least 2 public hearings each

1 year to receive testimony from experts and the public on the
2 status of health care, access to health care, and health care
3 costs in the community.
4 (4) The health care planning committee shall present an
5 annual report to the commission and to the public summarizing the
6 findings of its hearings and its meetings, detailing actions it
7 has taken concerning health care access, quality, and costs in
8 the community, and listing any recommendations it proposes for
9 the coming year.
10 Sec. 13. (1) A physician, nurse specialist, or other eligi-
11 ble health care provider may become a participating provider by
12 signing a participation agreement. A participating provider
13 shall be eligible for reimbursement for covered services provided
14 to a plan member that are within the scope of authorized practice
15 of the individual or institution providing the services.
16 (2) The plan shall revoke the right of participation of any
17 health care provider who loses his or her license as a health
18 care provider or who is convicted of health care fraud.
19 Sec. 15. Each participating hospital, long-term care facil-
20 ity, community health center, and migrant health center shall
21 negotiate with the plan for an annual budget based on past per-
22 formance and projected changes in the number or scope of
23 services. Requests for payment of capital costs shall be submit-
24 ted separately through the certificate of need process.
25 Sec. 17. A participating provider that is not paid on a
26 capitation basis or by global budget shall submit his or her
27 accounts for payment of covered services performed for plan

1 members directly to the plan for payment and shall look solely to
2 the plan for payment of services rendered under the plan.
3 Payment by the plan shall constitute payment in full for the
4 service. A participating provider shall not collect from a plan
5 member any money for a covered service rendered under the plan.
6 Sec. 19. The commissioner shall design and maintain a
7 system of processing claims to ensure that providers receive
8 timely payment in the correct amount for allowable claims with a
9 minimum of paperwork.
10 Sec. 21. Covered services shall include at least the fol-
11 lowing services if medically necessary and approved by a physi-
12 cian or appropriate professional:
13 (a) Professional services for health maintenance, preven-
14 tion, diagnosis and treatment of injuries, illnesses, and
15 conditions. Treatment shall include services for acute care,
16 rehabilitation, and health maintenance.
17 (b) Ongoing community based support services, including per-
18 sonal assistance services and respite care.
19 (c) Rehabilitative services, including physical, occupation-
20 al, and speech therapy to enable a member to recover and maintain
21 health.
22 (d) Hospital services, including in-patient hospitalization
23 for the treatment of mental and emotional disorders.
24 (e) Outpatient mental health services.
25 (f) Nursing home services.
26 (g) Services of a licensed hospice.

1 (h) Services of a home health agency.
2 (i) Services by a licensed ambulance or emergency medical
3 treatment team.
4 (j) Dental services, including artificial teeth.
5 (k) Prenatal care, well child care, and immunizations.
6 (ℓ) Diagnostic tests, including hearing and vision
7 examinations.
8 (m) Prescription drugs.
9 (n) Blood and blood products, anesthetics, and oxygen.
10 (o) Orthoses and prostheses.
11 (p) Eyeglasses, hearing aids, and rental or purchase of
12 durable medical equipment.
13 (q) Diagnostic X-rays and laboratory tests.
14 Sec. 23. A medical policy, certificate, or contract that
15 provides reimbursement on an expense-incurred or indemnity basis
16 for any service or services covered under the plan shall not be
17 sold to a plan member.
18 Sec. 25. The plan shall be funded through an employee
19 health care contribution, the health portions of worker's compen-
20 sation and no-fault automobile insurance, a sales tax on serv-
21 ices, and federal funds from existing mental health programs,
22 public health programs, substance abuse programs, title XIX, and
23 title XVIII.
24 Sec. 27. Each year the legislature shall appropriate to the
25 plan the amount of all earmarked taxes, the amount of all federal
26 funds for health care anticipated to be received, and additional
27 funds the legislature shall consider appropriate. The earmarked

1 taxes and federal funds shall not be appropriated by the state
2 for other purposes.