HOUSE BILL No. 4202

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February 7, 2007, Introduced by Rep. Cushingberry and referred to the Committee on Appropriations.

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

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 ARTICLE I GENERAL PROVISIONS

HOUSE BILL No. 4202

1 Sec. 1. This act shall be known and may be cited as the
2 "Michigan health insurance system act".
3 Sec. 3. As used in this act:
4 (a) "Agency" means the Michigan health insurance agency.
5 (b) "Commissioner" means the health insurance commissioner.
6 (c) "Direct care provider" means any licensed health care
7 professional that provides health care services through direct
8 contact with the patient.
9 (d) "Essential community provider" means a health facility
10 that has served as part of the state's health care safety net for
11 low income and traditionally underserved populations in Michigan
12 and that is 1 of the following:
13 (*i*) A "federally qualified health center" as defined under
14 section 1395x(aa)(4) or 1396d(*l*)(2) of the social security act, 42
15 USC 1395x and 1396d.
16 (*ii*) A "rural health clinic" as defined under section
17 1395x(aa)(2) or 1396d(*l*)(1) of the social security act, 42 USC 1395x
18 and 1396d.
19 (*iii*) Any clinic conducted, maintained, or operated by a
20 federally recognized Indian tribe or tribal organization, as
21 defined under 25 USC 1603.
22 (e) "Health care professional" means a person licensed or
23 registered under article 15 of the public health code, 1978 PA 368,
24 MCL 333.16101 to 333.18838. Health care professional does not
25 include a sanitarian or veterinarian.
26 (f) "Health care provider" means a health care professional,
27 health facility, or other person or institution licensed or

1 authorized by the state to deliver or furnish health care services.
2 (g) "Health facility" means a health facility or agency
3 licensed under article 17 of the public health code, 1978 PA 368,
4 MCL 333.20101 to 333.22260, or any other organized entity where a
5 health care professional provides health care to patients.
6 (h) "Health insurance fund" means the health insurance fund
7 created in section 41.
8 (i) "Hospital" means a health facility that is licensed under
9 part 215 of the public health code, 1978 PA 368, MCL 333.21501 to
10 333.21571.
11 (j) "Integrated health care delivery system" means a provider
12 organization that meets all of the following criteria:
13 (*i*) Is fully integrated operationally and clinically to provide
14 a broad range of health care services, including preventative care,
15 prenatal and well-baby care, immunizations, screening diagnostics,
16 emergency services, hospital and medical services, surgical
17 services, and ancillary services.
18 (*ii*) Is compensated using capitation or facility budgets,
19 except for copayments, for the provision of health care services.
20 (*iii*) Provides health care services primarily directly through
21 direct care providers who are either employees or partners of the
22 organization, or through arrangements with direct care providers or
23 1 or more groups of physicians, organized on a group practice or
24 individual practice basis.
25 (k) "Primary care provider" means a direct care provider that
26 is a family physician, internist, general practitioner,
27 pediatrician, an obstetrician/gynecologist, or a family certified

1 nurse practitioner or physician's assistant practicing under
2 supervision as defined under article 15 of the public health code,
3 1978 PA 368, MCL 333.16101 to 333.18838, or essential community
4 providers who employ primary care providers.

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

7 ARTICLE II MICHIGAN HEALTH INSURANCE SYSTEM AND GOVERNANCE

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

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

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

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

23 (a) The health insurance policy board.

24 (b) The office of consumer advocacy.

25 (c) The office of health care planning.

26 (d) The office of health care quality.

27 (e) The health insurance fund.

1 Sec. 7. The Michigan health insurance system shall have all of
2 the following purposes:
3 (a) To provide universal and affordable health insurance
4 coverage for all Michigan residents.
5 (b) To provide Michigan residents with an extensive benefit
6 package.
7 (c) To control health care costs and the growth of health care
8 spending.
9 (d) To achieve measurable improvement in health care outcomes.
10 (e) To prevent disease and disability and to maintain or
11 improve health and functionality.
12 (f) To increase health care provider, consumer, employee, and
13 employer satisfaction with the health care system.
14 (g) To implement policies that strengthen and improve
15 culturally and linguistically sensitive care.
16 (h) To develop an integrated population-based health care
17 database to support health care planning.
18 Sec. 11. (1) The commissioner shall be a citizen of this
19 state, shall have his or her office at the seat of government,
20 shall personally superintend the duties of the office, and shall
21 not be a stockholder or directly or indirectly connected with the
22 management of affairs of any insurer, pharmaceutical, or medical
23 equipment company that sells products to the Michigan health
24 insurance system for a period of 2 years prior to appointment as
25 commissioner. The commissioner shall be appointed by the governor
26 for a term of 4 years by and with the consent of the senate. The
27 first commissioner shall be appointed by the governor not less than

1 75 days following the effective date of this act and shall be
2 subject to confirmation by the senate within 30 days of nomination.
3 If the senate does not take up the nomination within 30 days, the
4 nominee shall be considered to have been confirmed and may take
5 office, except that, if the senate is not in session at the time
6 the governor appoints the commissioner, the senate shall take up
7 the confirmation of the nominee at the commencement of the next
8 legislative session. Should the senate, by a vote, fail to confirm
9 a nominee for the office of commissioner, the governor shall
10 appoint a new nominee, subject to the confirmation of the senate.
11 (2) If a vacancy occurs in the office of commissioner by
12 reason of death, removal, or otherwise, the governor shall fill
13 that vacancy by appointment, by and with the advice and consent of
14 the senate in the manner prescribed in subsection (1), for the
15 balance of the unexpired term.
16 (3) The commissioner shall not be a state legislator or a
17 member of the United States congress while holding the position of
18 commissioner.
19 (4) The commissioner shall receive an annual salary as the
20 legislature shall appropriate, payable as other state officers are
21 paid under the accounting laws of the state. Within 15 days from
22 the time of notice of his or her appointment, the commissioner
23 shall take and subscribe the constitutional oath of office and file
24 the oath in the office of the secretary of state, and shall also
25 within the same period give to the people of the state of Michigan
26 a bond in the penal sum of $50,000.00, with sureties to be approved
27 by the state treasurer, conditioned for the faithful discharge of

1 the duties of his or her office.
2 (5) For 2 years after completing service in the Michigan
3 health insurance system, the commissioner shall not receive
4 payments of any kind from, or be employed in any capacity or act as
5 a paid consultant to, an insurer, pharmaceutical, or medical
6 equipment company that sells products to the Michigan health
7 insurance system.
8 Sec. 13. (1) The commissioner shall be the chief officer of
9 the Michigan health insurance agency and shall administer all
10 aspects of the agency.
11 (2) The commissioner shall be responsible for the performance
12 of all duties, the exercise of all power and jurisdiction, and the
13 assumption and discharge of all responsibilities vested by law in
14 the agency. The commissioner shall perform all duties imposed upon
15 him or her by this act and other laws related to health care, and
16 shall enforce the execution of those related to health care, and
17 shall enforce the execution of those provisions and laws to promote
18 their underlying aims and purposes. These broad powers shall
19 include, but are not limited to, the power to establish the
20 Michigan health insurance system budget and to set rates, to
21 establish Michigan health insurance system goals, standards, and
22 priorities, to hire and fire and fix the compensation of agency
23 personnel, to make allocations to the health care regions, and to
24 promulgate generally binding rules and regulations concerning any
25 and all matters related to the implementation of this act and its
26 purposes.
27 (3) The commissioner shall appoint the deputy health insurance

1 commissioner, the director of the health insurance fund, the
2 consumer advocate, the chief medical officer, the chief enforcement
3 officer, the director of planning, the director of the partnerships
4 for health, the regional health planning directors, the chief
5 enforcement counsel, and legal counsel in any action brought by or
6 against the commissioner under or pursuant to any provision of any
7 law under the commissioner's jurisdiction, or in which the
8 commissioner joins or intervenes as to a matter within the
9 commissioner's jurisdiction, as a friend of the court or otherwise,
10 and stenographic reporters to take and transcribe the testimony in
11 any formal hearing or investigation before the commissioner or
12 before a person authorized by the commissioner.
13 (4) The personnel of the agency shall perform duties as
14 assigned to them by the commissioner.
15 (5) The commissioner shall adopt a seal bearing the
16 inscription: "Commissioner, Michigan Health Insurance Agency, State
17 of Michigan." The seal shall be affixed to or imprinted on all
18 orders and certificates issued by him or her and other instruments
19 as he or she directs. All courts shall take notice of this seal.
20 (6) The administration of the agency shall be supported from
21 the health insurance fund.
22 (7) The commissioner, as a general rule, shall publish or make
23 available for public inspection any information filed with or
24 obtained by the agency, unless the commissioner finds that this
25 availability or publication is contrary to law. This act does not
26 authorize the commissioner; any of the commissioner's assistants,
27 clerks, or deputies; or any other agency personnel to disclose any

1 information withheld from public inspection except among themselves
2 or when necessary or appropriate in a proceeding or investigation
3 under this act or to other federal or state regulatory agencies.
4 This act does not create or derogate from any privilege that exists
5 at common law or otherwise when documentary or other evidence is
6 sought under a subpoena directed to the commissioner; any of his or
7 her assistants, clerks, and deputies; or any other agency
8 personnel.
9 (8) It is unlawful for the commissioner; any of his or her
10 assistants, clerks, or deputies; or any other agency personnel to
11 use for personal benefit any information that is filed with or
12 obtained by the commissioner and that is not then generally
13 available to the public.
14 (9) The commissioner shall avoid political activity that may
15 create the appearance of political bias or impropriety. Prohibited
16 activities include, but are not limited to, leadership of, or
17 employment by, a political party or a political organization;
18 public endorsement of a political candidate; contribution of more
19 than $500.00 to any 1 candidate in a calendar year or a
20 contribution in excess of an aggregate of $1,000.00 in a calendar
21 year for all political parties or organizations; and attempting to
22 avoid compliance with this prohibition by making contributions
23 through a spouse or other family member.
24 (10) The commissioner shall not participate in making or in
25 any way attempting to use his or her official position to influence
26 a governmental decision in which he or she knows or has reason to
27 know that he or she or a family member or a business partner or

1 colleague has a financial interest.

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

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

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

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

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

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

19 (*iii*) The office of health care planning, pursuant to section
20 111.

21 (*iv*) The office of health care quality, pursuant to section
22 115.

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

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

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

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

1 (c) Establish health care regions, pursuant to section 31.
2 (d) Ensure the delivery of, and equal access to, high-quality
3 health care for Michigan residents.
4 (e) Establish evidence-based standards to guide delivery of
5 health care and ensure a smooth transition to delivery of health
6 care under statewide standards.
7 (f) Develop methods to measure and monitor the quality of
8 health care provided to Michigan residents and to make needed
9 improvements.
10 (g) Develop methods to measure and monitor the performance of
11 health care providers and to make needed improvements.
12 (h) Establish a capital management plan for the Michigan
13 health insurance system, including, but not limited to, a
14 standardized process and format for the development and submission
15 of regional operating and regional capital budget requests.
16 (i) Ensure the establishment of policies that support the
17 public health.
18 (j) Establish and maintain appropriate statewide and regional
19 health care databases.
20 (k) Establish a means to identify areas of medical practice
21 where standards of care do not exist and establish priorities and a
22 timetable for their development.
23 (*l*) Establish standards for mandatory reporting by health care
24 providers and remedies and penalties for failure to report.
25 (m) Establish a comprehensive budget that ensures adequate
26 funding to meet the health care needs of Michigan residents and the
27 compensation for providers for health care provided pursuant to

1 this act.

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

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

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

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

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

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

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

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

26 (v) Establish a capital management framework for the Michigan
27 health insurance system pursuant to this act to ensure that the

1 needs for capital health care infrastructure are met, pursuant to
2 the goals of the system.
3 (w) Ensure a smooth transition to Michigan health insurance
4 system oversight of capital health care planning.
5 (x) Establish an evidence-based formulary for all prescription
6 drugs and durable and nondurable medical equipment for use by the
7 Michigan health insurance system.
8 (y) Utilize the purchasing power of the state to negotiate
9 price discounts for prescription drugs and durable and nondurable
10 medical equipment for use by the Michigan health insurance system.
11 (z) Ensure that use of state purchasing power achieves the
12 lowest possible prices for the Michigan health insurance system.
13 (aa) Create incentives and guidelines for research needed to
14 meet the goals of the system and disincentives for research that
15 does not achieve Michigan health insurance system goals.
16 (bb) Implement eligibility standards for the system.
17 (cc) Provide support during the transition for training and
18 job placement for persons who are displaced from employment as a
19 result of the initiation of the new Michigan health insurance
20 system.
21 (dd) Establish an enrollment system that ensures all eligible
22 Michigan residents, including those who travel frequently; those
23 who have disabilities that limit their mobility, hearing, or
24 vision; those who cannot read; and those who do not speak or write
25 English, are aware of their right to health care and are formally
26 enrolled.
27 (ee) Oversee the establishment of a system for resolution of

1 grievances pursuant to this act.
2 (ff) Establish an electronic claims and payments system for
3 the Michigan health insurance system, to which all claims shall be
4 filed and from which all payments shall be made, and implement, to
5 the extent permitted by federal law, standardized claims and
6 reporting methods.
7 (gg) Establish a system of secure electronic medical records
8 that comply with state and federal privacy laws and that are
9 compatible across the system.
10 (hh) Establish an electronic referral system that is
11 accessible to providers and to patients.
12 (ii) Establish guidelines for mandatory reporting by health
13 care providers.
14 (jj) Establish a technology advisory committee to evaluate the
15 cost and effectiveness of new medical technology and make
16 recommendations for the inclusion of those technologies in the
17 benefit package.
18 (kk) Ensure that consumers of health care have access to
19 information needed to support choice of health care professionals.
20 (*ll*) Collaborate with the boards that license health facilities
21 to ensure that facility performance is monitored and that deficient
22 practices are recognized and corrected in a timely fashion and that
23 consumers and health care professionals have access to information
24 needed to support choice of health facility.
25 (mm) Establish a health insurance system internet website that
26 provides information to the public about the Michigan health
27 insurance system that includes, but is not limited to, information

1 that supports choice of health care providers and informs the
2 public about state and regional health insurance policy board
3 meetings and activities of the partnerships for health.
4 (nn) Procure funds, including loans, to lease or purchase
5 insurance for the system and its employees and agents.
6 (oo) Establish a process for the system to receive the
7 concerns, opinions, ideas, and recommendations of the public
8 regarding all aspects of the system.
9 (pp) Annually report to the legislature and the governor, on
10 or before October of each year and at other times pursuant to this
11 act, on the performance of the Michigan health insurance system,
12 its fiscal condition and need for rate adjustments, consumer
13 copayments or consumer deductible payments, recommendations for
14 statutory changes, receipt of payments from the federal government,
15 whether current year goals and priorities are met, future goals,
16 and priorities, and major new technology or prescription drugs or
17 other circumstances that may affect the cost of health care.
18 Sec. 17. (1) The commissioner shall establish a health
19 insurance policy board and shall serve as the president of the
20 board.
21 (2) The board shall do all of the following:
22 (a) Establish health insurance system goals and priorities,
23 including research and capital investment priorities.
24 (b) Establish the scope of services to be provided to Michigan
25 residents.
26 (c) Determine when an increase in health insurance premiums or
27 when a change in the health insurance premium structure is needed.

1 (d) Establish guidelines for evaluating the performance of the
2 health insurance system, health care regions, and health care
3 providers.
4 (e) Establish guidelines for ensuring public input on health
5 insurance system policy, standards, and goals.
6 (3) The board shall consist of the following members:
7 (a) The commissioner.
8 (b) The deputy health insurance commissioner.
9 (c) The director of the health insurance fund.
10 (d) The consumer advocate.
11 (e) The chief medical officer.
12 (f) The director of health care planning.
13 (g) The director of the partnerships for health.
14 (h) The director of the payments board.
15 (i) Two representatives from health care regional planning
16 boards. A regional representative shall serve a term of 1 year, and
17 terms shall be rotated in order to allow every region to be
18 represented within a 5-year period. A regional planning director
19 shall appoint the regional representative to serve on the board.
20 (4) It is unlawful for the board members or any of their
21 assistants, clerks, or deputies to use for personal benefit any
22 information that is filed with or obtained by the board and that is
23 not then generally available to the public.
24 Sec. 19. (1) The commissioner shall establish a public
25 advisory committee to advise the health insurance policy board on
26 all matters of health insurance system policy.
27 (2) Members of the public advisory committee shall include all

1 of the following:
2 (a) Four physicians, all of whom shall be board certified in
3 their field. The senate majority leader and the governor shall each
4 appoint 1 member. The speaker of the house of representatives shall
5 appoint 2 of these members, both of whom shall be primary care
6 providers.
7 (b) One registered nurse, to be appointed by the governor.
8 (c) One licensed vocational nurse, to be appointed by the
9 senate majority leader.
10 (d) One licensed health practitioner, to be appointed by the
11 speaker of the house of representatives.
12 (e) One mental health care provider, to be appointed by the
13 senate majority leader.
14 (f) One dentist, to be appointed by the governor.
15 (g) One representative of private hospitals, to be appointed
16 by the senate majority leader.
17 (h) One representative of public hospitals, to be appointed by
18 the governor.
19 (i) Four consumers of health care. The governor shall appoint
20 2 of these members, one of whom shall be a member of the disability
21 community. The senate majority leader shall appoint a member who is
22 65 years of age or older. The speaker of the house of
23 representatives shall appoint the fourth member.
24 (j) One representative of organized labor, to be appointed by
25 the speaker of the house of representatives.
26 (k) One representative of essential community providers, to be
27 appointed by the senate majority leader.

1 (*l*) One union member, to be appointed by the senate majority
2 leader.
3 (m) One representative of small business, to be appointed by
4 the governor.
5 (n) One representative of large business, to be appointed by
6 the speaker of the house of representatives.
7 (o) One pharmacist, to be appointed by the speaker of the
8 house of representatives.
9 (3) In making appointments pursuant to this section, the
10 governor, the senate majority leader, and the speaker of the house
11 of representatives shall make good faith efforts to assure that
12 their appointments, as a whole, reflect, to the greatest extent
13 feasible, the social and geographic diversity of the state.
14 (4) Any member appointed by the governor, the senate majority
15 leader, or the speaker of the house of representatives shall serve
16 for a 4-year term. These members may be reappointed for succeeding
17 4-year terms.
18 (5) Vacancies that occur shall be filled within 30 days after
19 the occurrence of the vacancy and shall be filled in the same
20 manner in which the vacating member was selected or appointed. The
21 commissioner shall notify the appropriate appointing authority of
22 any actual or expected vacancies on the board.
23 (6) Members of the advisory committee shall serve without
24 compensation, but shall be reimbursed for actual and necessary
25 expenses incurred in the performance of their duties.
26 (7) The advisory committee shall meet at least 6 times a year
27 in a place convenient to the public. All meetings of the board

1 shall be open to the public, pursuant to the open meetings act,
2 1976 PA 267, MCL 15.261 to 15.275.
3 (8) Appointed committee members shall have worked in the field
4 they represent on the committee for a period of at least 2 years
5 prior to being appointed to the committee.
6 (9) It is unlawful for the committee members or any of their
7 assistants, clerks, or deputies to use for personal benefit any
8 information that is filed with or obtained by the committee and
9 that is not generally available to the public.
10 Sec. 21. (1) There is within the agency an office of consumer
11 advocacy to represent the interests of the consumers of health
12 care. The goal of the office is to help Michigan residents secure
13 the health care services and benefits to which they are entitled
14 under the laws administered by the agency and to advocate on behalf
15 of and represent the interests of consumers in governance bodies
16 created by this act and in other forums.
17 (2) The office shall be headed by a consumer advocate
18 appointed by the commissioner.
19 (3) The consumer advocate shall establish an office in Lansing
20 and other offices throughout the state that shall provide
21 convenient access to Michigan residents.
22 (4) The consumer advocate shall do all the following:
23 (a) Administer all aspects of the office of the consumer
24 advocate.
25 (b) Assure that services of the consumer advocate are
26 available to all Michigan residents.
27 (c) Serve on the health insurance policy board and participate

in the regional partnership for health.

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

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

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

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

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

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

(j) Report annually to the public, the commissioner, and the legislature about the consumer perspective on the performance of

1 the health insurance system, including recommendations for needed
2 improvements.
3 (5) Nothing in this act prohibits a consumer or class of
4 consumers or the consumer advocate from seeking relief through the
5 judicial system.
6 (6) The consumer advocate in pursuit of his or her duties
7 shall have unlimited access to all nonconfidential and all
8 nonprivileged documents in the custody and control of the agency.
9 (7) It is unlawful for the consumer advocate or any of his or
10 her assistants, clerks, or deputies to use for personal benefit any
11 information that is filed with or obtained by the agency and that
12 is not then generally available to the public.
13 Sec. 23. (1) There is within the office of the attorney
14 general an office of the inspector general for the Michigan health
15 insurance system. The inspector general shall be appointed by the
16 governor with the advice and consent of the senate.
17 (2) The inspector general shall have broad powers to
18 investigate, audit, and review the financial and business records
19 of individuals, public and private agencies and institutions, and
20 private corporations that provide services or products to the
21 system, the costs of which are reimbursed by the system.
22 (3) The inspector general shall investigate allegations of
23 misconduct on the part of an employee or appointee of the agency
24 and on the part of any health care provider of services that are
25 reimbursed by the system and shall report any findings of
26 misconduct to the attorney general.
27 (4) The inspector general shall investigate patterns of

1 medical practice that may indicate fraud and abuse related to
2 overutilization or underutilization or other inappropriate
3 utilization of medical products and services. The inspector general
4 shall arrange for the collection and analysis of data needed to
5 investigate the inappropriate utilization of these products and
6 services.
7 (5) The inspector general shall conduct additional reviews or
8 investigations of financial and business records when requested by
9 the governor or by any member of the legislature and shall report
10 findings of the review or investigation to the governor and the
11 legislature.
12 (6) The inspector general shall establish a telephone hotline
13 for anonymous reporting of allegations of failure to make health
14 insurance premium payments established by this act. The inspector
15 general shall investigate information provided to the hotline and
16 shall report any findings of misconduct to the attorney general.
17 (7) The inspector general shall annually report
18 recommendations for improvements to the system or the agency to the
19 governor and the legislature.
20 Sec. 27. (1) The health insurance system shall be operational
21 no later than 2 years after the effective date of this act and
22 shall be funded from a loan from the general fund and from private
23 sources identified by the commissioner.
24 (2) The commissioner shall assess health plans and insurers
25 for care provided by the system in those cases in which a person's
26 health care coverage extends into the time period in which the new
27 system is operative.

1 (3) The commissioner shall implement means to assist persons
2 who are displaced from employment as a result of the initiation of
3 the new health insurance system, including the period of time
4 during which assistance shall be provided and possible sources of
5 funds to support retraining and job placement. That support shall
6 be provided for a period beginning on the effective date of this
7 act and ending 5 years after the effective date of this act.
8 Sec. 29. (1) The commissioner shall appoint a transition
9 advisory group to assist with the transition to the
10 system. The transition advisory group shall include, but is not
11 limited to, the following members:
12 (a) The commissioner.
13 (b) The consumer advocate.
14 (c) The chief medical officer.
15 (d) The director of health care planning.
16 (e) The director of the health insurance fund.
17 (f) Experts in health care financing and health care
18 administration.
19 (g) Direct care providers.
20 (h) Representatives of retirement boards.
21 (i) Employer and employee representatives.
22 (j) Hospital, essential community provider, and long-term care
23 facility representatives.
24 (k) Representatives from state departments and regulatory
25 bodies that shall or may relinquish some or all parts of their
26 delivery of health service to the system.
27 (*l*) Representatives of counties.

1 (m) Consumers of health care.

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

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

9 (a) The department of community health.

10 (b) The department of human services.

11 (c) The office of services to the aging.

12 (d) The mental health and substance abuse administration.

13 (e) The office of financial and insurance services.

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

18 ARTICLE III REGIONALIZATION

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

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

24 (a) Patterns of utilization.

25 (b) Health care resources, including workforce resources.

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

1 (d) Geography.

2 (e) Population and demographic characteristics.

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

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

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

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

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

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

27 (b) Establish regional goals and priorities pursuant to

1 standards, goals, priorities, and guidelines established by the
2 commissioner.
3 (c) Assure that regional administrative costs meet standards
4 established by this act.
5 (d) Seek innovative means to lower the costs of administration
6 in the region.
7 (e) Plan for the delivery of, and equal access to, high
8 quality and culturally and linguistically sensitive health care
9 that meets the needs of all regional residents pursuant to
10 standards established by the commissioner.
11 (f) Seek innovative means to improve health care quality.
12 (g) Appoint regional planning board members and serve as
13 president of the board.
14 (h) Implement policies established by the commissioner to
15 provide support to persons displaced from employment as a result of
16 the initiation of the new system.
17 (i) Make needed revenue sharing arrangements so that
18 regionalization in no way limits a patient's choice of health care
19 provider.
20 (j) Implement procedures established by the commissioner for
21 the resolution of grievances.
22 (k) Implement processes established by the commissioner to
23 permit the public to share concerns and provide ideas, opinions,
24 and recommendations regarding all aspects of the system policy.
25 (*l*) Report regularly to the public and, at intervals determined
26 by the commissioner, and pursuant to this act, to the commissioner,
27 on the status of the regional health insurance system, including

1 evaluating access to health care, quality of health care delivered,
2 and health care provider performance and recommending needed
3 improvements.
4 (m) Identify and prioritize regional health care needs and
5 goals, in collaboration with the regional medical officer, regional
6 health care providers, the regional planning board, and the
7 regional director of partnerships for health.
8 (n) Identify and maintain an inventory of regional health care
9 assets.
10 (o) Establish and maintain regional health care databases.
11 (p) Convene meetings of regional health care providers to
12 facilitate coordinated regional health care planning.
13 (q) Establish and implement a regional capital management plan
14 pursuant to the capital management plan established by the
15 commissioner for the system.
16 (r) Implement standards and formats established by the
17 commissioner for the development and submission of operating budget
18 requests.
19 (s) Support regional health care providers in developing
20 operating and capital budget requests.
21 (t) Receive, evaluate, and prioritize health care provider
22 operating and capital budget requests pursuant to standards and
23 criteria established by the commissioner.
24 (u) Prepare a 3-year regional budget request that meets the
25 health care needs of the region pursuant to this act, for
26 submission to the commissioner.
27 (v) Establish a comprehensive 3-year regional health insurance

1 budget using funds allocated to the region by the commissioner.
2 (w) Regularly assess projected revenues and expenditures to
3 ensure fiscal solvency of the regional health insurance system.
4 Sec. 35. (1) The regional medical officers shall do all of the
5 following:
6 (a) Administer all aspects of the regional office of health
7 care quality.
8 (b) Serve as a member of the regional health insurance board.
9 (c) Support the delivery of high-quality health care to all
10 residents of the region pursuant to this act.
11 (d) Ensure a smooth transition to health care delivery by
12 regional health care providers under evidence-based standards that
13 guide clinical decision making.
14 (e) Support the development and distribution of user-friendly
15 software for use by health care providers in order to support the
16 delivery of high-quality health care.
17 (f) In collaboration with the chief medical officer, evaluate
18 evidence-based standards of health care in use at the time the
19 Michigan health insurance system becomes operative.
20 (g) Assure the implementation of improvements needed so that
21 all standards of health care are used to guide clinical decision
22 making in the system.
23 (h) Assure the delivery of uniformly high standards of health
24 care to all Michigan residents.
25 (i) In collaboration with the regional planning director,
26 oversee a regional effort to assure the establishment of community-
27 based networks of solo providers, small group practices, essential

1 community providers, and providers of auxiliary Michigan health
2 insurance system services that support health care providers in,
3 and assure the delivery of, comprehensive, coordinated health care
4 to Michigan residents.
5 (j) Assure the evaluation and measurement of the quality of
6 health care delivered in the region, including assessment of the
7 performance of individual health care providers, pursuant to
8 standards and methods established by the chief medical officer.
9 (k) Provide feedback to and support and supervision of health
10 care providers needed to improve the quality of health care they
11 deliver.
12 (*l*) Assure the provision of information to assist consumers in
13 evaluating the performance of health care providers.
14 (m) Identify areas of medical practice where standards have
15 not been established, and collaborate with the chief medical
16 officer to establish priorities in developing needed standards.
17 (n) Collaborate with regional public health officers to
18 establish regional health policies that support the public health.
19 (o) Establish a regional program to monitor and decrease
20 medical errors and their causes pursuant to standards and methods
21 established by the chief medical officer.
22 (p) Support the development and implementation of innovative
23 means to provide high-quality health care and assist providers in
24 securing funds for innovative demonstration projects that seek to
25 improve health care quality.
26 (q) Establish means to assess the impact of health insurance
27 system policies intended to assure the delivery of high-quality

1 health care and evidence-based standards.
2 (r) Collaborate with the chief medical officer and the
3 director of planning in the development and maintenance of regional
4 health care databases.
5 (s) Ensure the enforcement of health insurance system
6 reporting requirements.
7 (t) Support health care providers in developing regional
8 budget requests.
9 (u) Collaborate with the regional planning director of the
10 partnerships for health to develop patient education on appropriate
11 utilization of health care services.
12 (v) Annually report to the public, the regional planning
13 board, and the chief medical officer on the status of regional
14 health care programs, needed improvements, and plans to implement
15 and evaluate delivery of health care improvements.
16 Sec. 37. (1) Each region shall have a regional health
17 insurance board consisting of 13 members who shall be appointed by
18 the regional planning director. Members shall serve 8-year terms
19 that coincide with the term of the regional planning director and
20 may be reappointed for a second term.
21 (2) Regional planning board members shall have resided for a
22 minimum of 2 years in the region in which they serve prior to
23 appointment to the board.
24 (3) Regional planning board members shall reside in the region
25 they serve while on the board.
26 (4) The board shall consist of the following members:
27 (a) The regional planning director, the regional medical

1 officer, the regional director of the partnerships for health, and
2 a public health officer from 1 of the regional counties. When there
3 is more than 1 county in a region, the public health officer board
4 position shall rotate among the public health county officers on a
5 timetable to be established by each regional planning board.
6 (b) A representative from the office of consumer advocacy.
7 (c) One expert in health care financing.
8 (d) One expert in health care planning.
9 (e) Two members who are direct patient care providers in the
10 region.
11 (f) One member who represents ancillary health care workers in
12 the region.
13 (g) One member representing hospitals in the region.
14 (h) One member representing essential community providers in
15 the region.
16 (i) One member representing the public.
17 (5) The regional planning director shall serve as chair of the
18 board.
19 (6) The purpose of the regional planning boards is to advise
20 and make recommendations to the regional planning director on all
21 aspects of regional health policy.
22 (7) Meetings of the board shall be open to the public pursuant
23 to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.
24 ARTICLE IV FUNDING
25 Sec. 41. (1) There is established in the department of
26 treasury the health insurance fund. The fund shall be administered
27 by a director appointed by the commissioner.

1 (2) All money collected, received, and transferred pursuant to
2 this act, including money collected as a remedy or penalty for
3 violations of this act, shall be transmitted to the department of
4 treasury to be deposited to the credit of the health insurance fund
5 for the purpose of financing the Michigan health insurance system.
6 All money in the fund at the close of the fiscal year shall remain
7 in the fund, shall not lapse, and shall be carried forward to the
8 following year.
9 (3) All claims for health care services rendered shall be made
10 to the health insurance fund through an electronic claims and
11 payments system; however, alternative provisions shall be made for
12 providers without electronic systems.
13 (4) All payments made for health care services shall be
14 disbursed from the health insurance fund through an electronic
15 claims and payments system; however, alternative provisions shall
16 be made for providers without electronic systems.
17 (5) The director of the fund shall serve on the health
18 insurance policy board.
19 Sec. 43. (1) The director of the health insurance fund shall
20 establish the following accounts within the health insurance fund:
21 (a) A system account to provide for all annual state
22 expenditures for health care.
23 (b) A reserve account.
24 (2) During the first 5 years of operation of the system, the
25 director shall maintain a reserve account.
26 Sec. 45. (1) The director of the health insurance fund shall
27 immediately notify the commissioner when regional or statewide

1 revenue and expenditure trends indicate that expenditures appear to
2 exceed revenues.
3 (2) If the commissioner determines that statewide revenue
4 trends indicate the need for statewide cost control measures, the
5 commissioner shall convene the health insurance policy board to
6 discuss the need for cost control measures and shall immediately
7 report to the public regarding the possible need for cost control
8 measures.
9 (3) Cost control measures include any or all of the following:
10 (a) Changes in the health insurance system or health facility
11 administration that improve efficiency.
12 (b) Changes in the delivery of health care services that
13 improve efficiency and care quality.
14 (c) Postponement of introduction of new benefits or benefit
15 improvements.
16 (d) Postponement of planned capital expenditures.
17 (e) Limitations on the reimbursement of Michigan health
18 insurance system managers and upper level managers.
19 (f) Limitations on health care provider reimbursement above a
20 specified amount of aggregate billing for employers other than the
21 Michigan health insurance system administration, whose compensation
22 is determined by the payment board and who are not subject to state
23 civil service statutes.
24 (g) Limitations on aggregate reimbursements to manufacturers
25 of pharmaceutical and durable and nondurable medical equipment.
26 (h) Deferred funding of the reserve account.
27 (i) Imposition of copayments or deductible payments. Any

1 copayment or deductible payments imposed shall be subject to all of
2 the following requirements:
3 (*i*) No copayment or deductible may be established when
4 prohibited by federal law.
5 (*ii*) All copayments and deductibles shall meet federal
6 guidelines for copayments and deductible payments that may lawfully
7 be imposed on persons with low income.
8 (*iii*) The commissioner shall establish standards and procedures
9 for waiving copayments or deductible payments and a waiver card
10 which shall be issued to a patient or to a family to indicate the
11 waiver. Copayment and deductible waivers shall be reviewed annually
12 by the regional planning director.
13 (*iv*) Waivers shall not affect the reimbursement of health care
14 providers.
15 (*v*) Any copayments or deductible payments established pursuant
16 to this section shall be transmitted to the department of treasury
17 to be deposited to the credit of the health insurance fund.
18 (*vi*) No copayments shall be established for preventive care as
19 determined by a patient's primary provider.
20 (j) Imposition of an eligibility waiting period if the
21 commissioner determines that large numbers of people are emigrating
22 to the state for the purpose of obtaining health care through the
23 Michigan health insurance system.
24 (4) Nothing in this act shall be construed to diminish the
25 benefits that an individual has under a collective bargaining
26 agreement.
27 (5) Nothing in this act shall preclude employees from

1 receiving benefits available to them under a collective bargaining
2 agreement or other employee-employer agreement that are superior to
3 benefits under this act.
4 (6) Cost control measures implemented by the commissioner and
5 the health insurance policy board shall remain in place in the
6 state until the commissioner and the health insurance policy board
7 determine that the cause of a revenue shortfall has been corrected.
8 (7) If the health insurance policy board determines that cost
9 control measures described in subsection (3) will not be sufficient
10 to meet a revenue shortfall, the commissioner shall report to the
11 legislature and to the public on the causes of the shortfall and
12 the reasons for the failure of cost controls and shall recommend
13 measures to correct the shortfall, including an increase in health
14 insurance system premium payments.
15 Sec. 47. (1) If the commissioner or a regional planning
16 director determines that regional revenue and expenditure trends
17 indicate a need for regional cost control measures, the regional
18 planning director shall convene the regional planning board to
19 discuss the possible need for cost control measures and to make a
20 recommendation about appropriate measures to control costs. These
21 may include any of the following:
22 (a) Changes in health insurance system or health facility
23 administration that improve efficiency.
24 (b) Changes in the delivery of health services that improve
25 efficiency or care quality.
26 (c) Postponement of planned regional capital expenditures.
27 (d) Limitation on reimbursement of health care providers,

1 upper level managers, or pharmaceutical or medical equipment
2 manufacturers above a specified amount of aggregate billing.
3 (2) If a regional planning board is convened to implement cost
4 control measures, the commissioner shall participate in the
5 regional planning board meeting.
6 (3) The regional planning director, in consultation with the
7 commissioner, shall determine if cost control measures are
8 warranted and those measures that shall be implemented.
9 (4) Imposition of copayments or deductibles, postponement of
10 new benefits or benefit improvements, deferred funding of the
11 reserve account, establishment of eligibility waiting periods, and
12 increases in health insurance premium payments may occur on a
13 statewide basis only and with the concurrence of the commissioner
14 and the health insurance policy board.
15 (5) If a regional planning director and regional planning
16 board are considering imposition of cost control measures, the
17 regional planning director shall immediately report to the
18 residents of the region regarding the possible need for cost
19 control measures.
20 (6) Cost control measures shall remain in place in a region
21 until the regional planning director and the commissioner determine
22 that the cause of a revenue shortfall has been corrected.
23 Sec. 49. (1) The commissioner annually shall prepare a health
24 insurance system budget that includes all expenditures, specifies a
25 limit on total annual state expenditures, and establishes
26 allocations for each health care region that shall cover a 3-year
27 period and that shall be disbursed on a quarterly basis.

1 (2) The commissioner shall limit the growth of spending on a
2 statewide and on a regional basis, by reference to average growth
3 in state domestic product across multiple years; population growth,
4 actuarial demographics, and other demographic indicators;
5 differences in regional costs of living; advances in technology and
6 their anticipated adoption into the benefit plan; improvements in
7 efficiency of administration and care delivery; and improvements in
8 the quality of care, and by reference to projected future state
9 domestic product growth rates.
10 (3) The commissioner shall project health insurance system
11 revenues and expenditures for 3, 6, 9, and 12 years pursuant to
12 this act.
13 (4) The commissioner shall annually convene a health insurance
14 system revenue and expenditure conference to discuss revenue and
15 expenditure projections and future health insurance system policy
16 directions and initiatives, including means to lower the cost of
17 administration. Participants shall include regional health
18 directors and medical officers, directors of the health insurance
19 fund and payments board, the consumer advocate, state and regional
20 directors of the partnerships for health, and representatives of
21 the health insurance system facility upper level managers.
22 (5) The Michigan health insurance system budget shall include
23 all of the following:
24 (a) Providers and managers budget.
25 (b) Capitated budgets.
26 (c) Noncapitated operating budgets.
27 (d) Capital investment budget.

1 (e) Purchasing budget.
2 (f) Research and innovation budget.
3 (g) Workforce training and development budget.
4 (h) Reserve account.
5 (i) System administration system.
6 (j) Regional budgets.
7 (6) In establishing budgets, the commissioner shall make
8 adjustments based on all of the following:
9 (a) Costs of transition to the new system.
10 (b) Projections regarding the health services anticipated to
11 be used by Michigan residents.
12 (c) Differences in cost of living between the regions,
13 including the overhead costs of maintaining medical practices.
14 (d) Health risk of enrollees.
15 (e) Scope of services provided.
16 (f) Innovative programs that improve care quality,
17 administrative efficiency, and workplace safety.
18 (g) Unrecovered cost of providing health care to persons who
19 are not members of the Michigan health insurance system. The
20 commissioner shall seek to recover the costs of health care
21 provided to persons who are not members of the system.
22 (h) Costs of workforce training and development.
23 (i) Costs of correcting health outcome disparities and the
24 unmet needs of previously uninsured and underinsured enrollees.
25 (j) Relative usage of different health care providers.
26 (k) Needed improvements in access to health care.
27 (*l*) Projected savings in administrative costs.

1 (m) Projected savings due to provision of primary and
2 preventive health care to Michigan residents, including savings
3 from decreases in preventable emergency room visits and
4 hospitalizations.
5 (n) Projected savings from improvements in health care
6 quality.
7 (o) Projected savings from decreases in medical errors.
8 (p) Projected savings from systemwide management of capital
9 expenditures.
10 (q) Cost of incentives and bonuses to support the delivery of
11 high-quality health care, including incentives and bonuses needed
12 to recruit and retain an adequate supply of needed health care
13 providers and managers and to attract health care providers to
14 medically underserved areas.
15 (r) Costs of treating complex illnesses, including disease
16 management programs.
17 (s) Cost of implementing standards of health care, health care
18 coordination, electronic medical records, and other electronic
19 initiatives.
20 (t) Costs of new technology.
21 (u) Technology research and development costs and costs
22 related to health insurance system use of new technologies.
23 Sec. 51. The commissioner shall annually establish the total
24 funds to be allocated for provider and manager compensation
25 pursuant to this section. In establishing the provider and manager
26 budgets, the commissioner shall allot sufficient funds to assure
27 that Michigan can attract and retain those providers and managers

1 needed to meet the health needs of Michigan residents.
2 Sec. 53. (1) The commissioner shall establish the payments
3 board and shall appoint a director and members of the board.
4 (2) The payments board shall be composed of experts in health
5 care finance and insurance systems, a designated representative of
6 the commissioner, a designated representative of the health
7 insurance fund, and a representative of the regional planning
8 directors who shall serve a 2-year term. The position of regional
9 representative shall rotate among the directors of the regional
10 planning boards.
11 (3) The purpose of the board is to establish and maintain a
12 plan for the compensation of all of the following pursuant to the
13 manager and provider budget established by the commissioner:
14 (a) Upper level managers in private health care facilities,
15 including hospitals, integrated health care delivery systems, group
16 medical practices, and essential community facilities.
17 (b) Elected and appointed Michigan health insurance system
18 managers and officers who are exempt from statutes governing civil
19 service employment.
20 (c) Health care professionals including physicians,
21 osteopathic physicians, dentists, podiatrists, nurse practitioners,
22 physician assistants, chiropractors, acupuncturists, psychologists,
23 social workers, marriage, family, and child counselors, and other
24 health care professionals who are required by law to be licensed to
25 practice in Michigan and who provide services pursuant to this act.
26 (d) Health care providers licensed and accredited to provide
27 services in Michigan may choose to be compensated for their

1 services either by the Michigan health insurance system or by a
2 person to whom they provide services.
3 (e) Nothing in this act is intended to interfere with, change,
4 or affect the terms of compensation established under contracts
5 between unions and the health insurance system during negotiations
6 for the labor cost component of the health insurance system
7 operating budget.
8 (f) Health care providers electing to be compensated by the
9 Michigan health insurance system shall enter into a contract with
10 the health insurance system pursuant to provisions of this section.
11 (g) Health care providers electing to be compensated by
12 persons to whom they provide services, instead of by the Michigan
13 health insurance system, may establish charges for their services.
14 (4) Only the Michigan health insurance plan as provided under
15 this act shall be sold in Michigan for services provided by the
16 Michigan health insurance plan.
17 (5) Health care providers licensed or accredited to provide
18 services in Michigan, who choose to be compensated by the health
19 insurance system instead of by patients to whom they provide
20 services, may choose how they wish to be compensated under this
21 act, as fee-for-service providers or as salaried providers in
22 health care systems that provide comprehensive, coordinated
23 services.
24 (6) The compensation plan shall include all of the following:
25 (a) Actuarially sound payments for health care providers in
26 the fee-for-service sector and for health care providers working in
27 health systems where comprehensive and coordinated services are

1 provided, including the actuarial basis for them.

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

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

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

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

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

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

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

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

26 (7) Health care providers shall be paid for all services
27 provided pursuant to this act, including health care provided to

1 persons who are subsequently determined to be ineligible for the
2 Michigan health insurance system.
3 (8) Licensed health care providers who deliver services not
4 covered under the Michigan health insurance system may establish
5 rates for and charge patients for those services.
6 (9) Reimbursement to providers and managers shall not exceed
7 the amount allocated by the commissioner to provider and manager
8 annual budgets.
9 Sec. 55. (1) Fee-for-service health care providers shall
10 choose representatives to negotiate reimbursement rates with the
11 payments board on their behalf.
12 (2) The payments board shall establish a uniform system of
13 payments for all services provided pursuant to this act.
14 (3) Payment schedules shall be available to health care
15 providers in printed and in electronic documents.
16 (4) Payment schedules shall be in effect for 3 years, at which
17 time payment schedules may be renegotiated. Payment adjustments may
18 be made at the discretion of the payments board to meet the goals
19 of the health insurance system.
20 (5) In establishing a uniform system of payments, the payments
21 board shall collaborate with regional health directors and shall
22 take into consideration regional differences in the cost of living
23 and the need to recruit and retain skilled health care providers in
24 the region.
25 (6) Fee-for-service health care providers shall submit claims
26 electronically to the health insurance fund and shall be paid
27 promptly for claims filed in compliance with procedures established

1 by the health insurance fund. If a properly filed claim for
2 eligible services is not paid promptly, the provider shall be paid
3 interest on the claim at a rate of 12%, compounded annually.
4 Sec. 57. Compensation for health care providers and upper
5 level managers employed by integrated health care delivery systems,
6 group medical practices, and essential community providers that
7 provide comprehensive, coordinated services shall be determined
8 according to the following guidelines:
9 (a) Providers and upper level managers employed by systems
10 that provide comprehensive, coordinated health care services shall
11 be represented by their respective employers for the purposes of
12 negotiating reimbursement with the payments board.
13 (b) In negotiating reimbursement with systems providing
14 comprehensive, coordinated services, the payments board shall take
15 into consideration the need for comprehensive systems to have
16 flexibility in establishing provider and upper level manager
17 reimbursement.
18 (c) Payment schedules shall be in effect for 3 years. However,
19 payment adjustments may be made at the discretion of the payments
20 board to meet the goals of the health insurance system.
21 (d) The payments board shall take into consideration regional
22 differences in the cost of living and the need to recruit and
23 retain skilled providers and upper level managers to the regions.
24 (e) The payments board shall establish a timetable for
25 reimbursement negotiations. If an agreement on reimbursement is not
26 reached according to the timetable established by the payments
27 board, the payments board shall establish reimbursement rates,

1 which shall be binding.

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

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

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

21 Sec. 61. (1) The commissioner shall establish an allocation
22 for each region to fund regional operating budgets for a period of
23 3 years. Allocations shall be disbursed to the regions on a
24 quarterly basis.

25 (2) Integrated health care delivery systems, essential
26 community providers, and group medical practices that provide
27 comprehensive, coordinated services may choose to be reimbursed on

1 the basis of a capitated operating budget or a system operating
2 budget that covers all costs of providing health care services.
3 (3) Health care providers choosing to function on the basis of
4 a capitated or system operating budget shall submit 3-year
5 operating budget requests to the regional planning director,
6 pursuant to standards and guidelines established by the
7 commissioner.
8 (4) Health care providers may include in their operating
9 budget requests reimbursement for ancillary health care or social
10 services that were previously funded by money now received and
11 disbursed by the health insurance fund.
12 (5) No payment may be made from an operating or a capitated
13 budget for a capital expense except as stipulated in section 69.
14 (6) Regional planning directors shall negotiate operating
15 budgets with regional health care entities, which shall cover a
16 period of 3 years.
17 (7) Operating and capitated budgets shall include health care
18 workforce labor costs. Where unions represent employees working in
19 systems functioning under operating or capitated budgets, unions
20 shall represent those employees in negotiations with the regional
21 planning director for the purpose of establishing their
22 reimbursement.
23 Sec. 63. (1) Health systems and medical practices functioning
24 under operating and capitated budgets shall immediately report any
25 projected operating deficit to the regional planning director. The
26 regional planning director shall determine whether projected
27 deficits reflect appropriate increases in utilization, in which

1 case the director shall make an adjustment to the operating budget.
2 If the director determines that deficits are not justifiable, no
3 adjustment shall be made.
4 (2) If a regional planning director determines that
5 adjustments to operating budgets will cause a regional revenue
6 shortfall and that cost control measures may be required, the
7 regional planning director shall report the possible revenue
8 shortfall to the commissioner and take actions required pursuant to
9 section 45.
10 Sec. 65. (1) No payment may be made from a health system
11 operating budget or from a capitated budget to provide a
12 shareholder dividend.
13 (2) The inspector general shall monitor operating budgets to
14 determine whether an unlawful payment has been made pursuant to
15 this section.
16 (3) The commissioner shall establish and enforce remedies and
17 penalties for violations of this section.
18 (4) Money collected for violations of this section shall be
19 remitted to the health insurance fund for use in the Michigan
20 health insurance system.
21 Sec. 67. (1) Margins generated by a facility operating under a
22 health system capitated budget or from an operating budget may be
23 retained and used to meet the health care needs of the population.
24 (2) No margin may be retained if that margin was generated
25 through inappropriate limitations on access to health care or
26 compromises in the quality of health care or in any way that
27 adversely affected or is likely to adversely affect the health of

1 the persons receiving services from a health facility, integrated
2 health care delivery system, group medical practice, or essential
3 community provider functioning under an operating or capitated
4 budget.

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

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

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

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

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

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

27 (b) Assessment and prioritization of short- and long-term

1 Michigan health insurance system capital needs on statewide and
2 regional bases.
3 (c) Assessment of capital assets and capital health care
4 shortages on a regional and statewide basis.
5 (d) Development by the commissioner of a health insurance
6 system capital budget that supports health insurance system goals,
7 priorities, and performance standards and meets the health needs of
8 Michigan residents.
9 (e) Development, as part of the Michigan health insurance
10 system capital budget, of regional capital allocations that shall
11 cover a period of 3 years.
12 (f) Exploration and evaluation of, and support for,
13 noninvestment means to meet health care needs, including, but not
14 limited to, improvements in administrative efficiency, health care
15 quality, and innovative service delivery, use, adaptation, or
16 refurbishment of existing land and property and identification of
17 publicly owned land or property that may be available to the
18 Michigan health insurance system and that may meet a capital need.
19 (g) Development of capital inventories on a regional basis,
20 including the condition, utilization capacity, maintenance plan and
21 costs, deferred maintenance of existing capital inventory, and
22 excess capital capacity.
23 (h) A process whereby those intending to make capital
24 investments or acquisitions shall prepare a business case for
25 making the investment or acquisition, including the full life-cycle
26 costs of the project or acquisition, an environmental impact report
27 that meets existing state standards, and a demonstration of how the

1 investment or acquisition meets the health needs of Michigan
2 residents it is intended to serve. Acquisitions include the
3 acquisition of land, operational property, or administrative office
4 space.
5 (i) Standards and a process whereby the regional planning
6 directors shall evaluate, accept, reject, or modify a business plan
7 for a capital investment or acquisition. Decisions of a regional
8 planning director may be appealed through a grievance resolution
9 process established by the commissioner.
10 (j) Standards for binding project contracts between the health
11 insurance system and the party developing a capital project or
12 making a capital acquisition that shall govern all terms and
13 conditions of capital investments and acquisitions, including terms
14 and conditions for health insurance system grants, loans, lines of
15 credit, and lease purchase arrangements.
16 (k) A process and standards whereby the health insurance fund
17 shall negotiate terms and conditions of the Michigan health
18 insurance system loans, grants, lines of credit, and lease purchase
19 arrangements for capital investments and acquisitions. Terms and
20 conditions negotiated by the health insurance fund shall be
21 included in project contracts.
22 (*l*) A plan for the commissioner and for the regional planning
23 directors to issue requests for proposals and to oversee a process
24 of competitive bidding for the development of capital projects that
25 meet the needs of the Michigan health insurance system.
26 (m) Responses to requests for proposals and competitive bids
27 shall include a description of how a project meets the service

1 needs of the region and addresses the environmental impact report
2 and shall include the full life-cycle costs of a capital asset.
3 (n) Requests for proposals shall address how intellectual
4 property will be handled and shall include conflict-of-interest
5 guidelines.
6 (o) A process and standards for periodic revisions in the
7 capital management plan, including annual meetings in each region
8 to discuss the plan and make recommendations for improvements in
9 the plan.
10 (p) Standards for determining when a violation of these
11 provisions shall be referred to the attorney general for
12 investigation and possible prosecution of the violation.
13 (q) Development of performance standards and a process to
14 monitor and measure performance of those making capital health care
15 investments and acquisitions, including those making capital
16 investments pursuant to a state competitive bidding process.
17 (r) A process for earned autonomy from state capital
18 investment oversight for those who demonstrate the ability to
19 manage capital investment and capital assets effectively in
20 accordance with Michigan health insurance system standards, and
21 standards for loss of earned autonomy when capital management is
22 ineffective.
23 (2) Terms and conditions of capital project oversight by the
24 Michigan health insurance system shall be based on the performance
25 history of the project developer. Health care providers may earn
26 autonomy from oversight if they demonstrate effective capital
27 planning and project management, pursuant to the goals and

guidelines established by the commissioner. Health care providers who do not demonstrate such proficiency shall remain subject to oversight by the regional planning director or shall lose autonomy from oversight.

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

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

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

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

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

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

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

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

1 (2) Services provided as a result of capital investments or
2 acquisitions that do not meet the terms of the regional capital
3 development plan and the capital management plan developed by the
4 commissioner shall not be reimbursed by the Michigan health
5 insurance system.

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

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

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

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

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

27 (2) The commissioner shall use the purchasing power of the

1 state to obtain the lowest possible prices for prescription drugs
2 and durable and nondurable medical equipment.
3 (3) The commissioner shall make discounted prices available to
4 all Michigan residents, health care providers, and prescription
5 drug and medical equipment wholesalers and retailers of products
6 approved for use in and included in the benefit package of the
7 Michigan health insurance system.
8 Sec. 79. (1) The commissioner shall establish a budget to
9 support research and innovation that has been recommended by the
10 chief medical officer, the director of planning, the consumer
11 advocates, the partnerships for health, and others as required by
12 the commissioner.
13 (2) The research and innovation budget shall support the goals
14 and standards of the Michigan health insurance system.
15 Sec. 81. (1) The commissioner shall establish a budget to
16 support the training, development, and continuing education of
17 health care providers and the health care workforce needed to meet
18 the health care needs of Michigan residents and the goals and
19 standards of the health insurance system.
20 (2) The commissioner shall establish guidelines for giving
21 special consideration for employment to persons who have been
22 displaced as a result of the transition to the new health insurance
23 system.
24 Sec. 83. (1) The commissioner shall seek all necessary
25 waivers, exemptions, agreements, or legislation so that all current
26 federal payments to the state for health care be paid directly to
27 the Michigan health insurance system, which shall then assume

1 responsibility for all benefits and services previously paid for by
2 the federal government with those funds.
3 (2) In obtaining the waivers, exemptions, agreements, or
4 legislation, the commissioner shall seek from the federal
5 government a contribution for health care services in Michigan that
6 shall not decrease in relation to the contribution to other states
7 as a result of the waivers, exemptions, agreements, or legislation.
8 (3) The commissioner shall seek all necessary waivers,
9 exemptions, agreements, or legislation so that all current state
10 payments for health care shall be paid directly to the system,
11 which shall then assume responsibility for all benefits and
12 services previously paid for by state government with those funds.
13 (4) In obtaining the waivers, exemptions, agreements, or
14 legislation, the commissioner shall seek from the legislature a
15 contribution for health care services that shall not decrease in
16 relation to state government expenditures for health care services
17 in the year that this act was enacted, except that it may be
18 corrected for change in state gross domestic product, the size and
19 age of population, and the number of residents living below the
20 federal poverty level.
21 (5) The commissioner shall establish formulae for equitable
22 contributions to the Michigan health insurance system from all
23 Michigan counties and other local government agencies.
24 (6) The commissioner shall seek all necessary waivers,
25 exemptions, agreements, or legislation so that all county or other
26 local government agency payments shall be paid directly to the
27 Michigan health insurance system.

1 (7) The system's responsibility for providing care shall be
2 secondary to existing federal, state, or local governmental
3 programs for health care services to the extent that funding for
4 these programs is not transferred to the health insurance fund or
5 that the transfer is delayed beyond the date on which initial
6 benefits are provided under the system.
7 (8) In order to minimize the administrative burden of
8 maintaining eligibility records for programs transferred to the
9 system, the commissioner shall strive to reach an agreement with
10 federal, state, and local governments in which their contributions
11 to the health insurance fund shall be fixed to the rate of change
12 of the state gross domestic product, the size and age of
13 population, and the number of residents living below the federal
14 poverty level.
15 Sec. 85. (1) The commissioner shall pursue all reasonable
16 means to secure a repeal or a waiver of any provision of federal
17 law that preempts any provision of this act. If a repeal or a
18 waiver of law or regulations cannot be secured, the commissioner
19 shall exercise his or her powers to promulgate rules and
20 regulations, or seek conforming state legislation, consistent with
21 federal law, in an effort to best fulfill the purposes of this act.
22 (2) To the extent permitted by federal law, an employee
23 entitled to health or related benefits under a contract or plan
24 that, under federal law, preempts provisions of this act shall
25 first seek benefits under that contract or plan before receiving
26 benefits from the system under this act.
27 (3) No benefits shall be denied under the system created by

1 this act unless the employee has failed to take reasonable steps to
2 secure like benefits from the contract or plan, if those benefits
3 are available.
4 (4) Nothing in this section shall preclude a person from
5 receiving benefits from the system under this act that are superior
6 to benefits available to the person under an existing contract or
7 plan.
8 (5) Nothing in this act is intended, nor shall this act be
9 construed, to discourage recourse to contracts or plans that are
10 protected by federal law.
11 (6) To the extent permitted by federal law, a health care
12 provider shall first seek payment from the contract or plan before
13 submitting bills to the Michigan health insurance system.
14 Sec. 87. (1) It is the intent of this act to establish a
15 single public payer for all health care in Michigan. However, until
16 such time as the role of all other payers for health care has been
17 terminated, health care costs shall be collected from collateral
18 sources whenever medical services provided to an individual are, or
19 may be, covered services under a policy of insurance, health care
20 service plan, or other collateral source available to that
21 individual, or for which the individual has a right of action for
22 compensation to the extent permitted by law.
23 (2) As used in this act, collateral source includes all of the
24 following:
25 (a) Insurance policies written by insurers, including the
26 medical components of automobile, homeowners, and other forms of
27 insurance.

1 (b) Health care service plans and pension plans.
2 (c) Employers.
3 (d) Employee benefit contracts.
4 (e) Government benefit programs.
5 (f) A judgment for damages for personal injury.
6 (g) Any third party who is or may be liable to an individual
7 for health care services or costs.
8 (3) "Collateral source" does not include either of the
9 following:
10 (a) A contract or plan that is subject to federal preemption.
11 (b) Any governmental unit, agency, or service, to the extent
12 that subrogation is prohibited by law. An entity described in
13 subsection (2) is not excluded from the obligations imposed by this
14 act by virtue of a contract or relationship with a governmental
15 unit, agency, or service.
16 (4) The commissioner shall attempt to negotiate waivers, seek
17 federal legislation, or make other arrangements to incorporate
18 collateral sources in Michigan into the Michigan health insurance
19 system.
20 (5) Whenever an individual receives health care services under
21 the system and he or she is entitled to coverage, reimbursement,
22 indemnity, or other compensation from a collateral source, he or
23 she shall notify the health care provider and provide information
24 identifying the collateral source, the nature and extent of
25 coverage or entitlement, and other relevant information. The health
26 care provider shall forward this information to the commissioner.
27 The individual entitled to coverage, reimbursement, indemnity, or

1 other compensation from a collateral source shall provide
2 additional information as requested by the commissioner.
3 (6) The Michigan health insurance system shall seek
4 reimbursement from the collateral source for services provided to
5 the individual and may institute appropriate action, including
6 suit, to recover the reimbursement. Upon demand, the collateral
7 source shall pay to the health insurance fund the sums it would
8 have paid or expended on behalf of the individual for the health
9 care services provided by the system.
10 Sec. 89. (1) If a collateral source is exempt from subrogation
11 or the obligation to reimburse the system as provided in this act,
12 the commissioner may require that an individual who is entitled to
13 medical services from the source first seek those services from
14 that source before seeking those services from the system.
15 (2) To the extent permitted by federal law, contractual
16 retiree health benefits provided by employers shall be subject to
17 the same subrogation as other contracts, allowing the Michigan
18 health insurance system to recover the cost of services provided to
19 individuals covered by the retiree benefits, unless and until
20 arrangements are made to transfer the revenues of the benefits
21 directly to the Michigan health insurance system.
22 ARTICLE V ELIGIBILITY AND BENEFITS
23 Sec. 91. (1) All Michigan residents are eligible for the
24 Michigan health insurance system. Residency shall be based upon
25 physical presence in the state with the intent to reside. The
26 commissioner shall establish standards and a simplified procedure
27 to demonstrate proof of residency.

1 (2) The commissioner shall establish a procedure to enroll
2 eligible residents and provide each eligible individual with
3 identification that can be used by health care providers to
4 determine eligibility for services.
5 Sec. 93. (1) The Michigan health insurance system shall
6 provide health care coverage to Michigan residents who are
7 temporarily out of the state. The commissioner shall determine
8 eligibility standards for residents temporarily out of state for
9 longer than 90 days who intend to return and reside in Michigan and
10 for nonresidents temporarily employed in Michigan.
11 (2) Coverage for emergency care obtained out of state shall be
12 at prevailing local rates. Coverage for nonemergency care obtained
13 out of state shall be according to rates and conditions established
14 by the commissioner. The commissioner may require that a resident
15 be transported back to Michigan when prolonged treatment of an
16 emergency condition is necessary.
17 Sec. 95. Visitors to Michigan shall be billed for all services
18 received under the system. The commissioner may establish
19 intergovernmental arrangements with other states and countries to
20 provide reciprocal coverage for temporary visitors.
21 Sec. 97. All persons eligible for health benefits from
22 Michigan employers but who are working in another jurisdiction
23 shall be eligible for health benefits under this act providing that
24 they make payments equivalent to the payments they would be
25 required to make if they were residing in Michigan.
26 Sec. 99. Unmarried, unemancipated minors shall be deemed to
27 have the residency of their parent or guardian. If a minor's

1 parents are deceased and a legal guardian has not been appointed,
2 or if a minor has been emancipated by court order, the minor may
3 establish his or her own residency.

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

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

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

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

22 (a) Inpatient and outpatient health facility services.

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

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

27 (d) Durable medical equipment, appliances, and assistive

1 technology, including prosthetics, eyeglasses, and hearing aids and
2 their repair.
3 (e) Rehabilitative care.
4 (f) Emergency transportation and necessary transportation for
5 health care services for disabled and indigent persons.
6 (g) Language interpretation and translation for health care
7 services, including sign language for those unable to speak or hear
8 or who are language impaired, and Braille translation or other
9 services for those with no or low vision.
10 (h) Child and adult immunizations and preventive care.
11 (i) Health education.
12 (j) Hospice care.
13 (k) Home health care.
14 (*l*) Prescription drugs that are listed on the system formulary.
15 Nonformulary prescription drugs may be included where standards and
16 criteria established by the commissioner are met.
17 (m) Mental and behavioral health care.
18 (n) Dental care.
19 (o) Podiatric care.
20 (p) Chiropractic care.
21 (q) Acupuncture.
22 (r) Blood and blood products.
23 (s) Emergency care services.
24 (t) Vision care.
25 (u) Adult day care.
26 (v) Case management and coordination to ensure services
27 necessary to enable a person to remain safely in the least

1 restrictive setting.

2 (w) Substance abuse treatment.

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

5 (y) Dialysis.

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

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

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

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

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

25 (c) Private rooms in inpatient health facilities where
26 appropriate nonprivate rooms are available, unless determined to be
27 medically necessary by a qualified, licensed health care

1 professional in the system.

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

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

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

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

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

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

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

27 (7) The commissioner shall establish standards and procedures

1 for waiving copayments or deductible payments. Waivers of
2 copayments or deductible payments shall not affect the
3 reimbursement of health care providers.
4 (8) Any copayments established pursuant to this section and
5 collected by health care providers shall be transmitted to the
6 department of treasury to be deposited to the credit of the health
7 insurance fund.
8 (9) Nothing in this act shall be construed to diminish the
9 benefits that an individual has under a collective bargaining
10 agreement.
11 (10) Nothing in this act shall preclude employees from
12 receiving benefits available to them under a collective bargaining
13 agreement or other employee-employer agreement that are superior to
14 benefits under this act.
15 Sec. 107. (1) All health care providers licensed or accredited
16 to practice in Michigan may participate in the Michigan health
17 insurance system. No health care provider whose license or
18 accreditation is suspended or revoked may be a participating health
19 care provider.
20 (2) Health care providers may accept eligible persons for care
21 according to the provider's ability to provide services needed by
22 the applicant and according to the number of patients a provider
23 can treat without compromising safety and care quality. A provider
24 may accept patients in the order of time of application.
25 (3) Persons eligible for health care services under this act
26 may choose a primary care provider. Primary care providers include
27 family practitioners, general practitioners, internists,

1 pediatricians, and nurse practitioners and physician assistants
2 practicing under supervision as defined in Michigan law. Women may
3 choose an obstetrician/gynecologist, in addition to a primary care
4 provider.
5 (4) Persons who choose to enroll with integrated health care
6 delivery systems, group medical practices, or essential community
7 providers that offer comprehensive services shall retain membership
8 for at least 1 year after an initial 3-month evaluation period
9 during which time they may withdraw for any reason. The 3-month
10 period shall commence on the date when an enrollee first sees a
11 primary care provider. Persons who want to withdraw after the
12 initial 3-month period shall request a withdrawal pursuant to
13 dispute resolution procedures established by the commissioner and
14 may request assistance from the consumer advocate in the dispute
15 process. The dispute shall be resolved in a timely fashion and
16 shall have no adverse effect on the care a patient receives.
17 (5) Persons needing to change primary care providers because
18 of health care needs that their primary care provider cannot meet
19 may change primary care providers at any time.
20 Sec. 109. (1) Primary care providers shall coordinate the
21 health care a patient receives or shall ensure that a patient's
22 care is coordinated.
23 (2) Patients shall have a referral from their primary care
24 provider, or from an emergency provider rendering care to them in
25 the emergency room or other accredited emergency setting, or from a
26 health care professional treating a patient for an emergency
27 condition in any setting, or from their obstetrician/gynecologist,

1 to see a physician or nonphysician specialist whose services are
2 covered by this act, unless the patient agrees to assume the costs
3 of care, in which case a referral is not needed. A referral shall
4 not be required to see a dentist.
5 (3) Referrals shall be based on the medical needs of the
6 patient and on guidelines which shall be established by the chief
7 medical officer to support clinical decision making.
8 (4) Referrals shall not be restricted or provided solely
9 because of financial considerations. The chief medical officer
10 shall monitor referral patterns and intervene as necessary to
11 assure that referrals are neither restricted nor provided solely
12 because of financial considerations.
13 (5) Patients established with a specialist before the system
14 is implemented do not need a referral to continue seeing the
15 specialist or their designee.
16 (6) Where referral systems are in place prior to the
17 initiation of the system, the chief medical officer shall review
18 the referral systems to assure that they meet health insurance
19 system standards for care quality and shall assure needed changes
20 are implemented so that all Michigan residents receive the same
21 standards of care quality.
22 (7) A specialist may serve as the primary care provider if the
23 patient and the provider agree to this arrangement and if the
24 provider agrees to coordinate the patient's care or to ensure that
25 the care the patient receives is coordinated.
26 (8) The commissioner shall establish or ensure the
27 establishment of a computerized referral registry to facilitate the

1 referral process and to allow a specialist and a patient to easily
2 determine whether a referral has been made pursuant to this act.
3 (9) A patient may appeal the denial of a referral through
4 grievance resolution procedures established under this act and may
5 request the assistance of the consumer advocate during the
6 grievance resolution process.
7 Sec. 111. (1) The purpose of the office of health care
8 planning is to plan for the short- and long-term health needs of
9 Michigan residents pursuant to the health care and finance
10 standards established by the commissioner and by this act.
11 (2) The office shall be headed by a planning director
12 appointed by the commissioner.
13 (3) The director shall do all the following:
14 (a) Administer all aspects of the office of health care
15 planning.
16 (b) Serve on the health insurance policy board.
17 (c) Establish performance criteria in measurable terms for
18 health care goals in consultation with the chief medical officer,
19 the regional health officers, and directors and others with
20 experience in health care outcomes measurement and evaluation and
21 evaluate the performance criteria.
22 (d) Assist the health care regions to develop operating and
23 capital requests pursuant to health care and finance guidelines
24 established by the commissioner and by this act. In assisting
25 regions, the director shall do all of the following:
26 (*i*) Identify medically underserved areas and health service
27 shortages.

1 (*ii*) Identify disparities in health outcomes.
2 (*iii*) Support establishment of comprehensive health care
3 databases using uniform methodology that is compatible between the
4 regions and between the regions and the state health insurance
5 agency.
6 (*iv*) Provide information to support effective regional
7 planning.
8 (*v*) Provide information to support interregional planning,
9 including planning for access to specialized centers that perform a
10 high volume of procedures for conditions requiring highly
11 specialized treatments, including emergency and trauma and other
12 interregional access to needed health care, and planning for
13 coordinated interregional capital investment.
14 (*vi*) Evaluate regional budget requests and make recommendations
15 to the commissioner about regional revenue allocations.
16 (e) Estimate the health care workforce required to meet the
17 health needs of Michigan residents pursuant to the standards and
18 goals established by the commissioner, the costs of providing the
19 needed workforce, and, in collaboration with regional planners,
20 educational institutions, the governor, and the legislature,
21 develop short- and long-term plans to meet those needs, including a
22 plan to finance needed training.
23 (f) Estimate the number and types of health facilities
24 required to meet the short- and long-term health care needs of the
25 population and the projected costs of needed facilities. In
26 collaboration with the commissioner, regional planning directors
27 and health officers, the chief medical officer, the governor, and

1 the legislature, develop plans to finance and build needed
2 facilities.
3 Sec. 113. The director of the office of health care planning
4 shall establish the following electronic initiatives:
5 (a) Establish integrated statewide health care databases to
6 support health care planning and determine which databases should
7 be established on a statewide basis and which should be established
8 on a regional basis.
9 (b) Assure that databases have uniform methodology and formats
10 that are compatible between regions and between the regions and the
11 state.
12 (c) Establish mandatory database reporting requirements and
13 remedies and penalties for noncompliance. Monitor the effectiveness
14 of reporting and make needed improvements.
15 (d) Establish electronic, online, scheduling systems for use
16 in the health insurance system.
17 (e) Establish electronic provider patient communication
18 systems that allow for e-visits, for use in the health insurance
19 system.
20 (f) Establish electronic systems that allow standard of care
21 guidelines, including disease management programs to be embedded in
22 a patient's electronic medical records.
23 (g) Establish electronic systems that give information to
24 providers about community-based patient care resources.
25 (h) Collaborate with the chief medical officer and regional
26 medical officers to assure the development of software systems that
27 link clinical guidelines to individual patient conditions, and

guide clinicians through diagnosis and treatment algorithms based on evidence-based research and best medical practices.

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

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

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

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

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

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

1 Sec. 115. (1) Within the agency, the commissioner shall
2 establish the office of health care quality.
3 (2) The office shall be headed by the chief medical officer.
4 (3) The office of health care quality shall have the following
5 purposes:
6 (a) Support the delivery of high-quality, coordinated health
7 care services that enhance health, prevent illness, disease, and
8 disability, slow the progression of chronic diseases, and improve
9 personal health management.
10 (b) Promote efficient health care delivery.
11 (c) Establish processes for measuring, monitoring, and
12 evaluating the quality of care delivered in the health insurance
13 system, including the performance of individual health
14 professionals.
15 (d) Establish means to make changes needed to improve care
16 quality, including innovative programs that improve quality.
17 (e) Promote patient, provider, and employer satisfaction with
18 the health insurance system.
19 (f) Assist regional planning directors and medical officers in
20 the development and evaluation of regional budget requests.
21 Sec. 117. (1) In supporting the goals of the office of health
22 care quality, the chief medical officer shall do all of the
23 following:
24 (a) Administer all aspects of the office.
25 (b) Serve on the health insurance policy board.
26 (c) Collaborate with regional medical officers, directors,
27 health care providers, and consumers, the director of planning, the

1 consumer advocate, and partnership for health directors to develop
2 community-based networks of solo providers, small group practices,
3 essential community providers, and providers of patient care
4 support services in order to offer comprehensive,
5 multidisciplinary, coordinated services to patients.
6 (d) Establish evidence-based standards of care for the health
7 insurance system which shall serve as guidelines to support
8 providers in the delivery of high-quality health care. Standards
9 shall be based on the best evidence available at the time and shall
10 be continually updated. Standards are intended to support the
11 clinical judgment of individual providers, not to replace it, and
12 to support clinical decisions based on the needs of individual
13 patients.
14 (2) In establishing standards under subsection (1), the chief
15 medical officer shall do all of the following:
16 (a) Draw on existing standards established by Michigan health
17 care institutions, on peer-created standards, and on standards
18 developed by other institutions that have had a positive impact on
19 care quality, such as the centers for disease control and the
20 agency for health care quality and research.
21 (b) Collaborate with regional medical officers in establishing
22 regional goals, priorities, and a timetable for implementation of
23 standards of health care.
24 (c) Assure a process for patients to provide their views on
25 standards of health care to the consumer advocate who shall report
26 those views to the chief medical officer.
27 (d) Collaborate with the director of planning and regional

1 medical officers to support the development of computer software
2 systems that link clinical guidelines to individual patient
3 conditions, guide clinicians through diagnosis and treatment
4 algorithms based on evidence-based research and best medical
5 practices, offer access to guidelines appropriate to each medical
6 specialty, and offer current information on disease prevention and
7 treatment and that support continuing medical education.
8 (e) Where referral systems for access to specialty health care
9 are in place prior to the initiation of the health insurance
10 system, the chief medical officer shall review the referral systems
11 to assure that they meet health insurance system standards for care
12 quality and shall assure that needed changes are implemented so
13 that all Michigan residents receive the same standards of care
14 quality.
15 (3) In collaboration with the director of planning and
16 regional medical officer, the chief medical officer shall implement
17 means to measure and monitor the quality of health care delivered
18 in the health insurance system. Monitoring systems shall include,
19 but are not limited to, peer and patient performance reviews.
20 (4) The chief medical officer shall establish means to support
21 individual providers and health systems in correcting quality of
22 care problems, including time frames for making needed improvements
23 and means to evaluate the effectiveness of interventions.
24 (5) In collaboration with regional medical officers and
25 directors and the director of planning, the chief medical officer
26 shall establish means to identify medical errors and their causes
27 and develop plans to prevent them.

1 (6) The chief medical officer shall convene an annual
2 statewide conference to discuss medical errors that occurred during
3 the year, their causes, means to prevent errors, and the
4 effectiveness of efforts to decrease errors.
5 (7) The chief medical officer shall recommend to the
6 commissioner an evidence-based benefits package for the health
7 insurance system, including priorities for needed benefit
8 improvements. In making recommendations, the chief medical officer
9 shall do all of the following:
10 (a) Identify safe and effective treatments.
11 (b) Evaluate and draw on existing benefit packages.
12 (c) Receive comments and recommendations from health care
13 providers about benefits that meet the needs of their patients.
14 (d) Receive comments and recommendations made directly by
15 patients or indirectly through the consumer advocate.
16 (e) Identify and recommend to the commissioner and the health
17 insurance policy board innovative approaches to health promotion,
18 disease and injury prevention, education, research, and care
19 delivery for possible inclusion in the benefit package.
20 (f) Identify complementary and alternative modalities that
21 have been shown by the national institutes of health, division of
22 complementary and alternative medicine to be safe and effective for
23 possible inclusion as covered benefits.
24 (g) Recommend to the commissioner and update, as appropriate,
25 evidence-based pharmaceutical and durable and nondurable medical
26 equipment formularies. In establishing the formularies, the chief
27 medical officer shall establish a pharmacy and therapeutics

1 committee composed of pharmacy and medical health care providers,
2 representatives of health facilities and organizations that have
3 system formularies in place at the time the system is implemented,
4 and other experts that shall do all the following:
5 (*i*) Identify safe and effective pharmaceutical agents for use
6 in the Michigan health insurance system.
7 (*ii*) Draw on existing standards and formularies.
8 (*iii*) Identify experimental drugs and drug treatment protocols
9 for possible inclusion in the formulary.
10 (*iv*) Review formularies in a timely fashion to ensure that safe
11 and effective drugs are available and that unsafe drugs are removed
12 from use.
13 (*v*) Assure the timely dissemination of information needed to
14 prescribe safely and effectively to all Michigan providers.
15 (*vi*) Establish standards and criteria and a process for
16 providers to seek authorization for prescribing pharmaceutical
17 agents and durable and nondurable medical equipment that are not
18 included in the system formulary. No standard or criteria shall
19 impose an undue administrative burden on patients, health care
20 providers, including pharmacies and pharmacists, and none shall
21 delay the care a patient needs.
22 (*vii*) Develop standards and criteria and a process for
23 providers to request authorization for services and treatments,
24 including experimental treatments that are not included in the
25 system benefit package. Where processes are in place when the
26 health insurance system is initiated, the chief medical officer
27 shall review the systems to assure that they meet health insurance

1 system standards for care quality and shall assure that needed
2 changes are implemented so that all Michigan residents receive the
3 same standards of care quality. No standard or criteria shall
4 impose an undue administrative burden on a provider or a patient,
5 and none shall delay the care a patient needs.
6 (h) In collaboration with the director of planning, regional
7 planning directors, and regional medical officers, identify
8 appropriate ratios of general medical providers to specialty
9 medical providers on a regional basis that meet the health care
10 needs of the population and the goals of the health insurance
11 system.
12 (i) Recommend to the commissioner and to the payments board
13 financial and nonfinancial incentives and other means to achieve
14 recommended provider ratios.
15 (j) Collaborate with the director of planning and regional
16 medical officers and consumer advocates in development of
17 electronic initiatives, pursuant to section 113.
18 (k) Collaborate with the commissioner, the regional health
19 officers, the directors of the payments board and the health
20 insurance fund to formulate a provider reimbursement model that
21 promotes the delivery of coordinated, high-quality health services
22 in all sectors of the health insurance system and creates financial
23 and other incentives for the delivery of high-quality health care.
24 (*l*) Establish or assure the establishment of continuing medical
25 education programs about advances in the delivery of high-quality
26 health care.
27 (m) Convene an annual statewide quality of care conference to

1 discuss problems with health care quality and to make
2 recommendations for changes needed to improve health care quality.
3 Participants shall include regional medical directors, health care
4 providers, other providers, patients, policy experts, experts in
5 quality of care measurement, and others.
6 (n) Annually report to the commissioner, the health insurance
7 policy board, and the public on the quality of care delivered in
8 the health insurance system, including improvements that have been
9 made and problems that have been identified during the year, goals
10 for health care improvement in the coming year, and plans to meet
11 these goals.
12 (8) No person working within the agency, or on a pharmacy and
13 therapeutics committee or serving as a consultant to the agency or
14 a pharmacy and therapeutics committee, may receive fees or
15 remuneration of any kind from a pharmaceutical company.
16 Sec. 119. (1) The consumer advocate, in collaboration with the
17 chief medical officer, the regional consumer advocates, medical
18 officers, and directors, shall establish a program in the state
19 health insurance agency and in each region called the "Partnerships
20 for Health".
21 (2) The purpose of the partnerships for health is to improve
22 health through community health initiatives, to support the
23 development of innovative means to improve health care quality, to
24 promote efficient health care delivery, and to educate the public
25 about the following:
26 (a) Personal maintenance of health.
27 (b) Prevention of disease.

1 (c) Improvement in communication between patients and
2 providers.
3 (d) Improving quality of care.
4 (3) The consumer advocate shall work with the community and
5 health care providers in proposing partnerships for health projects
6 and in developing project budget requests that shall be included in
7 the regional budget request to the commissioner.
8 (4) In developing educational programs, the partnerships for
9 health shall collaborate with educators in the region.
10 (5) Partnerships for health shall support the coordination of
11 Michigan health insurance system and public health system programs.
12 Sec. 121. (1) The consumer advocate shall do all of the
13 following:
14 (a) Establish and maintain a grievance resolution system
15 approved by the commissioner under which enrollees may submit their
16 grievances to the system. The system shall provide reasonable
17 procedures in accordance with state rules and regulations that
18 shall ensure adequate consideration of enrollee grievances and
19 rectification when appropriate.
20 (b) Inform enrollees upon enrollment in the system and
21 annually thereafter of the procedure for processing and resolving
22 grievances. The information shall include the location and
23 telephone number where grievances may be submitted.
24 (c) Provide printed and electronic access for enrollees who
25 wish to register grievances. The forms used by the system shall be
26 approved by the commissioner in advance as to format.
27 (d) Provide for a written acknowledgment within 5 calendar

1 days of the receipt of a grievance, except as otherwise provided.
2 The acknowledgment shall advise the complainant that the grievance
3 has been received, the date of receipt, and the name of the system
4 representative and the telephone number and address of the system
5 representative who may be contacted about the grievance. Grievances
6 received by telephone, by facsimile, by electronic mail, or online
7 through the system's website that are not coverage disputes,
8 disputed health care services involving medical necessity, or
9 experimental or investigational treatment and that are resolved by
10 the next business day following receipt are exempt from the
11 acknowledgement requirements and from subdivision (e). The consumer
12 advocate shall maintain a log of all these grievances. The log
13 shall be periodically reviewed by the consumer advocate and shall
14 include the following information for each complaint:
15 (*i*) The date of the call.
16 (*ii*) The name of the complainant.
17 (*iii*) The complainant's system identification number.
18 (*iv*) The nature of the grievance.
19 (*v*) The nature of the resolution.
20 (*vi*) The name of the system representative who took the call
21 and resolved the grievance.
22 (e) Provide enrollees with written responses to grievances,
23 with a clear and concise explanation of the reasons for the
24 system's response. For grievances involving the delay, denial, or
25 modification of health care services, the system response shall
26 describe the criteria used and the clinical reasons for its
27 decision, including all criteria and clinical reasons related to

1 medical necessity. If the system, or 1 of its contracting
2 providers, issues a decision delaying, denying, or modifying health
3 care services to an enrollee based in whole or in part on a finding
4 that the proposed health care services are not a covered benefit in
5 the system that applies to the enrollee, the decision shall clearly
6 specify the system provisions that exclude that coverage.
7 (f) Keep in its files all copies of grievances, and the
8 responses thereto, for a period of 5 years.
9 (g) Establish and maintain a website that shall provide an
10 online form that enrollees can use to file a grievance online.
11 (2) The commissioner may require enrollees and subscribers to
12 participate in a plan's grievance resolution system for up to 30
13 days before pursuing a grievance through the commissioner or the
14 independent medical review system. However, the commissioner may
15 not impose this waiting period for expedited review cases or in any
16 other case where the commissioner determines that an earlier review
17 is warranted. In any case determined by the consumer advocate to be
18 a case involving an imminent and serious threat to the health of
19 the patient, including, but not limited to, severe pain or the
20 potential loss of life, limb, or major bodily function, or in any
21 other case where the consumer advocate determines that an earlier
22 review is warranted, an enrollee shall not be required to complete
23 the grievance resolution system or to participate in the process
24 for at least 30 days before submitting a grievance to the
25 independent medical review system established pursuant to section
26 123.
27 (3) If the enrollee is a minor, or is incompetent or

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

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

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

1 assisting the enrollee, and to the commissioner, within 30 calendar
2 days of receipt of the request for review unless the consumer
3 advocate, in his or her discretion, determines that additional time
4 is reasonably necessary to fully and fairly evaluate the relevant
5 grievance. In any case not eligible for the independent medical
6 review system established pursuant to section 123, the consumer
7 advocate's written notice shall include, at a minimum, the
8 following:
9 (a) A summary of findings and the reasons why the consumer
10 advocate found the system to be, or not to be, in compliance with
11 any applicable laws, rules, regulations, or orders of the
12 commissioner.
13 (b) A discussion of the consumer advocate's contact with any
14 medical provider, or any other independent expert relied on by the
15 consumer advocate, along with a summary of the views and
16 qualifications of that provider or expert.
17 (c) If the enrollee's grievance is sustained in whole or in
18 part, information about any corrective action taken.
19 (6) In any consumer advocate review of a grievance involving a
20 disputed health care service, as defined in section 123, that is
21 not eligible for the independent medical review system established
22 pursuant to section 123, in which the consumer advocate finds that
23 the system has delayed, denied, or modified health care services
24 that are medically necessary, based on the specific medical
25 circumstances of the enrollee, and those services are a covered
26 benefit under the terms and conditions of the health insurance
27 system contract, the consumer advocate's written notice shall order

1 the system to promptly offer and provide those health care services
2 to the enrollee. The consumer advocate's order shall be binding on
3 the system.
4 (7) The consumer advocate shall establish and maintain a
5 system of aging of grievances that are pending and unresolved for
6 30 days or more that shall include a brief explanation of the
7 reasons each grievance is pending and unresolved for 30 days or
8 more.
9 (8) The grievance resolution system authorized by this section
10 shall be in addition to any other procedures that may be available
11 to any person, and failure to pursue, exhaust, or engage in the
12 procedures described in this section does not preclude the use of
13 any other remedy provided by law.
14 (9) Nothing in this section shall be construed to allow the
15 submission to the consumer advocate of any provider grievance under
16 this section.
17 Sec. 123. (1) As used in this section:
18 (a) "Coverage decision" means the approval or denial by the
19 health insurance system, or by 1 of its contracting entities,
20 substantially based on a finding that the provision of a particular
21 service is included or excluded as a covered benefit under the
22 terms and conditions of the health insurance system. Coverage
23 decision does not encompass a plan or contracting provider decision
24 regarding a disputed health care service.
25 (b) "Disputed health care service" means any health care
26 service eligible for coverage and payment under the benefits
27 package of the health insurance system that has been denied,

1 modified, or delayed by a decision of the system, or by 1 of its
2 contracting providers, in whole or in part due to a finding that
3 the service is not medically necessary. A decision regarding a
4 disputed health care service relates to the practice of medicine
5 and is not a coverage decision. If the system, or 1 of its
6 contracting providers, issues a decision denying, modifying, or
7 delaying health care services, based in whole or in part on a
8 finding that the proposed health care services are not a covered
9 benefit under the system, the statement of decision shall clearly
10 specify the provisions of the system that exclude coverage.
11 (2) The consumer advocate shall establish the independent
12 medical review system to act as an independent, external medical
13 review process for the health insurance system to provide timely
14 examinations of disputed health care services as defined in this
15 section and coverage decisions as defined in this section regarding
16 experimental and investigational therapies to ensure that the
17 system provides efficient, appropriate, high-quality health care,
18 and that the health care system is responsive to patient disputes.
19 (3) Coverage decisions regarding experimental or
20 investigational therapies for individual enrollees who meet all of
21 the following criteria are eligible for review by the independent
22 medical review system:
23 (a) The enrollee has a life-threatening or seriously
24 debilitating condition. As used in this subsection:
25 (*i*) "Life-threatening" means either or both of the following:
26 (A) Diseases or conditions where the likelihood of death is
27 high unless the course of the disease is interrupted.

1 (B) Diseases or conditions with potentially fatal outcomes,
2 where the end point of clinical intervention is survival.
3 (*ii*) "Seriously debilitating" means diseases or conditions that
4 cause major irreversible morbidity.
5 (b) The enrollee's physician certifies that the enrollee has a
6 life-threatening or seriously debilitating condition, for which
7 standard therapies have not been effective in improving the
8 condition of the enrollee, for which standard therapies would not
9 be medically appropriate for the enrollee, or for which there is no
10 more beneficial standard therapy covered by the system than the
11 therapy proposed pursuant to subdivision (c).
12 (c) Either the enrollee's physician, who is under contract
13 with or employed by the system, has recommended a drug, device,
14 procedure, or other therapy that the physician certifies in writing
15 is likely to be more beneficial to the enrollee than any available
16 standard therapies, or the enrollee, or the enrollee's physician
17 who is a licensed, board-certified or board-eligible physician
18 qualified to practice in the area of practice appropriate to treat
19 the enrollee's condition, has requested a therapy that, based on 2
20 documents from the medical and scientific evidence, is likely to be
21 more beneficial for the enrollee than any available standard
22 therapy. The physician certification pursuant to this subdivision
23 shall include a statement of the evidence relied upon by the
24 physician in certifying his or her recommendation. Nothing in this
25 subdivision shall be construed to require the system to pay for the
26 services of a nonparticipating provider provided pursuant to this
27 subdivision that are not otherwise covered pursuant to the system

1 benefits package.

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

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

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

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

24 (6) The consumer advocate shall be the final arbiter when
25 there is a question as to whether a grievance is a disputed health
26 care service or a coverage decision. The consumer advocate shall
27 establish a process to complete an initial screening of a

1 grievance. If there appears to be any medical appropriateness
2 issue, the grievance shall be resolved pursuant to an independent
3 medical review as provided under this act.
4 (7) For purposes of this act, an enrollee may designate an
5 agent to act on his or her behalf. The provider may join with or
6 otherwise assist the enrollee in seeking an independent medical
7 review and may advocate on behalf of the enrollee.
8 (8) The independent medical review process authorized by this
9 act is in addition to any other procedures or remedies that may be
10 available.
11 (9) The office of the consumer advocate shall prominently
12 display in every relevant informational brochure, on copies of
13 health care system procedures for resolving grievances, on letters
14 of denial issued by either the health care system or its
15 contracting providers, on the grievance forms, and on all written
16 responses to grievances, information concerning the right of an
17 enrollee to request an independent medical review in cases where
18 the enrollee believes that health care services have been
19 improperly denied, modified, or delayed by the health care system
20 or by 1 of its contracting providers.
21 (10) An enrollee may apply to the consumer advocate for an
22 independent medical review when all of the following conditions are
23 met:
24 (a) One of the following applies:
25 (*i*) Except as otherwise provided in subparagraph (*iv*), the
26 enrollee's health care provider has recommended a health care
27 service as medically appropriate.

1 (*ii*) The enrollee has received urgent care or emergency
2 services that a provider determined were medically appropriate.
3 (*iii*) The enrollee seeks coverage for experimental or
4 investigational therapies.
5 (*iv*) The enrollee, in the absence of a provider recommendation
6 under subparagraph (*i*) or the receipt of urgent care or emergency
7 services from a provider under subparagraph (*ii*), has been seen by a
8 contracting provider for the diagnosis or treatment of the medical
9 condition for which the enrollee seeks independent review. The
10 health insurance system shall expedite access to a contracting
11 provider upon request of an enrollee. The contracting provider need
12 not recommend the disputed health care service as a condition for
13 the enrollee to be eligible for an independent review. For purposes
14 of this act, the enrollee's provider may be a nonparticipating
15 provider. However, the health insurance system shall have no
16 liability for payment of services provided by a nonparticipating
17 provider, except as otherwise provided in this act.
18 (b) The disputed health care service has been denied,
19 modified, or delayed by the health insurance system, or by 1 of its
20 contracting providers, based in whole or in part on a decision that
21 the health care service is not medically appropriate.
22 (c) The enrollee has filed a grievance with the consumer
23 advocate and the disputed decision is upheld or the grievance
24 remains unresolved after 30 days. The enrollee is not required to
25 participate in the health insurance system's grievance resolution
26 system for more than 30 days. For a grievance that requires
27 expedited review, the enrollee is not required to participate in

1 the health insurance system's grievance resolution system for more
2 than 3 days.
3 (11) An enrollee may apply to the consumer advocate for an
4 independent medical review of a decision to deny, modify, or delay
5 health care services, based in whole or in part on a finding that
6 the disputed health care services are not medically appropriate,
7 within 6 months of any of the qualifying periods or events under
8 this section. The consumer advocate may extend the application
9 deadline beyond 6 months if the circumstances of a case warrant the
10 extension.
11 (12) The enrollee shall pay no application or processing fees
12 of any kind.
13 (13) Upon notice from the consumer advocate that the enrollee
14 has applied for an independent medical review, the health insurance
15 system or its contracting providers shall provide to the
16 independent medical review organization designated by the consumer
17 advocate a copy of all of the following documents within 3 business
18 days of the health insurance system's receipt of the consumer
19 advocate's notice of a request by an enrollee for an independent
20 review:
21 (a) A copy of all of the enrollee's medical records in the
22 possession of the health insurance system or its contracting
23 providers relevant to each of the following:
24 (*i*) The enrollee's medical condition.
25 (*ii*) The health care services being provided by the health
26 insurance system and its contracting providers for the condition.
27 (*iii*) The disputed health care services requested by the

1 enrollee for the condition.

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

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

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

1 documents required by this subdivision, except for any information
2 found by the consumer advocate to be legally privileged
3 information, to the enrollee and the enrollee's provider. The
4 consumer advocate and the independent review organization shall
5 maintain the confidentiality of any information found by the
6 consumer advocate to be the proprietary information of the health
7 insurance system.
8 Sec. 125. (1) Upon receiving the decision adopted by the
9 consumer advocate pursuant to section 123 that a disputed health
10 care service is medically appropriate, the health insurance system
11 shall promptly implement the decision. In the case of reimbursement
12 for services already rendered, the health insurance system shall
13 reimburse the provider or enrollee, whichever applies, within 5
14 working days. In the case of services not yet rendered, the health
15 insurance system shall authorize the services within 5 working days
16 of receipt of the written decision from the consumer advocate, or
17 sooner if appropriate for the nature of the enrollee's medical
18 condition, and shall inform the enrollee and provider of the
19 authorization.
20 (2) The health insurance system shall not engage in any
21 conduct that has the effect of prolonging the independent review
22 process.
23 (3) The consumer advocate shall require the health insurance
24 system to promptly reimburse the enrollee for any reasonable costs
25 associated with those services when the consumer advocate finds
26 that the disputed health care services were a covered benefit
27 pursuant to this act and either the enrollee's decision to secure

1 the services outside of the health insurance system provider
2 network was reasonable under the emergency or urgent medical
3 circumstances, or the health insurance system does not require or
4 provide prior authorization before the health care services are
5 provided to the enrollee.
6 (4) In addition to requiring system compliance regarding
7 subsections (1), (2), and (3), the consumer advocate shall review
8 individual cases submitted for independent medical review to
9 determine whether any enforcement actions, including remedies and
10 penalties, may be appropriate. In particular, where substantial
11 harm to a patient has already occurred because of the decision of
12 the health care system, or 1 of its contracting providers, to
13 delay, deny, or modify covered health care services that an
14 independent medical review determines to be medically appropriate,
15 the consumer advocate shall impose remedies or penalties.
16 Sec. 131. The commissioner may promulgate rules pursuant to
17 the administrative procedures act of 1969, 1969 PA 306, MCL 24.201
18 to 24.328, as necessary to implement this act.