No. 69
STATE OF MICHIGAN

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96th Legislature
REGULAR SESSION OF 2011

Senate Chamber, Lansing, Tuesday, September 20, 2011.

10:00 a.m.

The Senate was called to order by the Assistant President pro tempore, Senator Goeffrey M. Hansen.

The roll was called by the Secretary of the Senate, who announced that a quorum was present.

Anderson—present
Bieda—present
Booher—present
Brandenburg—present
Casperson—present
Caswell—present
Colbeck—present
Emmons—present
Gleason—present
Green—present
Gregory—present
Hansen—present
Hildenbrand—present
Hood—present
Hopgood—present
Hune—present
Hunter—present
Jansen—present
Johnson—present
Jones—present
Kahn—present
Kowall—present
Marleau—present
Meekhof—present
Moolenaar—present
Nofs—present
Pappageorge—present
Pavlov—present
Proos—present
Richardville—present
Robertson—present
Rocca—present
Schuitmaker—present
Smith—present
Walker—present
Warren—present
Whitmer—present
Young—excused

Senator John Proos of the 21st District offered the following invocation:

Heavenly Father, we gather today as Your humble stewards thankful for the many blessings that You have bestowed upon each of us: gifts of love, family, fellowship, and the abundance of grace that has given us a path to serve together in this chamber.

Father, help us to seek a humble spirit, guided by Your grace, to know the path toward prosperity and growth for our great state. Enable each of us to hear Your one true voice as we make decisions that affect so many of our neighbors and friends.

Be with each of us today and throughout this week ahead that we may do Your will.

In Your heavenly name, we all pray. Amen.

The Assistant President pro tempore, Senator Hansen, led the members of the Senate in recital of the *Pledge of Allegiance*.

Motions and Communications

Senator Hood entered the Senate Chamber.

Senator Meekhof moved that Senator Kahn be temporarily excused from today's session.
The motion prevailed.

Senator Hunter moved that Senator Johnson be temporarily excused from today's session.
The motion prevailed.

Senator Hunter moved that Senator Young be excused from today's session.
The motion prevailed.

The Secretary announced that the following House bills were received in the Senate and filed on Thursday, September 15:

House Bill Nos. 4683 4770 4771 4929

The Secretary announced that the following official bills were printed on Thursday, September 15, and are available at the legislative website:

Senate Bill Nos. 645 646
House Bill Nos. 4969 4970 4971 4972 4973 4974 4975 4976 4977 4978 4979

The Secretary announced that the following official bills were printed on Friday, September 16, and are available at the legislative website:

Senate Bill Nos. 647 648 649 650 651 652 653 654 655 656 657 658 659 660
661 662 663 664 665 666 667 668 669 670 671 672 673 674
675 676 677 678 679 680 681
House Bill Nos. 4980 4981 4982 4983 4984 4985 4986 4987 4988 4989

Messages from the Governor

The following message from the Governor was received:

September 14, 2011

Attached is a copy of my Special Message on Health and Wellness to the First Session of the 96th Michigan Legislature. This message transmitting information on the affairs of state and recommending measures I consider necessary and desirable is presented to the Michigan Senate pursuant to Section 17 of Article V of the Michigan Constitution of 1963.

Sincerely,
Rick Snyder
Governor

The special message is as follows:

September 14, 2011

To build a stronger Michigan, we must build a healthier Michigan. My vision is for Michiganders to be healthy, productive individuals, living in communities that support health and wellness, with ready access to an affordable, patient-centered and community-based system of care.

There is much to like about our health care system. As we enter the 21st century, significant advances in medical science have saved many lives. Scientific research has led to the development of evidence-based practice standards, and new advances regularly occur that have increased life expectancy and improved health status.

But our health care system is also costly and often confusing. Duplication of services, inconsistent clinical outcomes, and insufficient community-based access are areas of concern. We also have too few physicians and other health care providers to meet demand. This shortage will grow substantially when more than 1 million uninsured Michiganders obtain coverage under federal health care reform.

The increasing cost of health care is one of the most significant economic challenges facing Michigan and the United States. In 1970, annual health care spending in the United States averaged $356 per resident and accounted for 7.2% of the U.S. gross domestic product (GDP). For 2011, these amounts are projected to increase to $8,648.50 in spending per resident and 17.6% of GDP. Both employees and employers are experiencing increased costs. From 2001 to 2009, the average employee contribution for family health coverage nearly doubled, from $1,741 to $3,474. Employer contributions increased at roughly the same pace. These increased costs are depressing wages and causing some employers to stop providing health care coverage.

Wellness and economics are linked. For example, costs due to coronary heart disease (CHD), the most prevalent and preventable form of heart disease, exceed $5.9 billion per year in Michigan. Treatment of heart disease accounts for 1 in every 6 health care dollars spent. But even modest improvements in wellness can significantly reduce our risk of CHD and similar chronic conditions. While economic considerations are certainly important, the real value of a healthy lifestyle is quality of life. The good news is that evidence-based practices have demonstrated that each of us can significantly improve our personal health by practicing four key healthy behaviors:

(1) maintain a healthy diet;
(2) engage in regular exercise;
(3) get an annual physical examination; and
(4) avoid all tobacco use.

In conjunction with these key healthy behaviors, we should all be aware of four key health measures that are closely tied to the incidence of chronic disease:

(1) body mass index (BMI);
(2) blood pressure;
(3) cholesterol level; and
(4) blood sugar level.

Taking personal responsibility to manage these measures can significantly increase life expectancy, avoid disability, and improve overall quality of life. Taken together, these four behaviors, and four measures, can be characterized as the Michigan 4x4 plan. If each of us practice the Michigan 4x4 plan, our lives will be fuller, our health costs dramatically reduced, and our ability to take advantage of all that is Michigan enhanced.

But, as we individually take these steps, there are other steps that Michigan institutions need to take. To have a health care system that works for Michiganders, we need to develop a primary-care based system with a patient-centered medical home, where care is coordinated, patients receive appropriate preventive services, such as cancer screenings and dental care, electronic health records are utilized, and health information is shared in a secure and efficient manner.

To help track our progress, we have created a new Michigan health dashboard with key public health metrics to measure our progress on a statewide level. Local communities will be able to join our efforts by using the County Health Rankings, available at http://www.countyhealthrankings.org/michigan, to identify local health priorities, develop evidence-based programs and policies, and evaluate the success of their efforts.

Building a healthier Michigan will be no easy task, but the benefits will be real and sustainable if we seize the opportunity.

Health and Wellness

Health and wellness are important across the continuum of life from prenatal care, to providing children and adults with opportunities for nutritious food and physical activity, to the option of home-based long-term care for seniors who need it. Michigan can and must do better in all of these areas.

As a first step, Michigan must focus on the health and wellness of state employees and their families. Michigan's voluntary employee wellness programs include confidential health risk assessments, on-line tools and coaching, confidential on-line depression and substance abuse screening services, smoking cessation services, and weight loss services. To help state employees and their families achieve healthy lifestyles and avoid or better manage chronic health conditions, we need to increase awareness of these programs and encourage participation. I will be asking the Civil Service Commission to join me in efforts to dramatically increase state employee participation in these services.

Infant Mortality & Teen Pregnancy

Infant mortality is a critical indicator of the overall health and welfare of Michigan and the quality and accessibility of prenatal care for women. While the rate of infant mortality generally has been decreasing in the United States, it has increased

in Michigan over the past three years. To address this problem, the Michigan Department of Community Health (MDCH) has called a summit of health experts and stakeholders to develop solutions to reverse this trend. The summit, *Michigan Call to Action to Reduce and Prevent Infant Mortality*, will identify and prioritize strategies to mobilize partners across multiple sectors to prevent infant mortality in our state. The summit will convene in Ypsilanti on October 17, 2011, with the welcome support of several Michigan foundations. I expect the participants in the infant mortality summit to develop practical, implementable, and sustainable policy recommendations that will move the needle in the right direction on infant mortality.

Because infant mortality is principally a problem in urban centers and among low-income groups, we need a targeted plan. Although infant mortality is not limited to young mothers, it is related to the problem of teenage pregnancy. Babies of teenage mothers are more likely to die in the first year of life nationally and in Michigan. Because teen mothers and newborn babies face numerous health risks, it is imperative that young mothers take full advantage of available medical care to give themselves and their children the best chance to thrive.

There are bright spots in our state. For example, there is a program called the Nurse-Family Partnership that successfully brings at-risk young families into the health care system by sending nurses on home visits with low-income women expecting their first baby. The Nurse-Family Partnership helps vulnerable young women to have a healthy pregnancy and delivery, to become responsible and competent parents, to support strong child health and development, and to improve the economic self-sufficiency of the family. The program has demonstrated improved prenatal health, reduced childhood injuries and abuse, and lessened mental health problems for the children. This, in turn, has resulted in cost reductions to government and society, as well as better lives for families starting out on the lowest rungs of the economic and health care ladders.

The Nurse-Family Partnership is an example of how we can provide access to the right health care services for Michigan in a smart and cost-effective way and represents the kind of "best practice" that I hope will be identified during the summit. The federal government is making over $1.5 billion in funding available over the next five years for the Maternal, Infant and Early Childhood Home Visiting Program. Because these programs have been shown to improve public health and reduce health care costs over time, I am directing the MDCH to pursue funding for Michigan to expand current programming. I look forward to a full report on the results of the October summit.

Obesity, Nutrition, & Food Safety

Obesity is another major public health problem facing Michigan and the United States. Michigan now ranks eighth in the nation with an adult obesity rate of 31.7%. Michigan's combined rate of obese and overweight adult residents is 67%. Obesity is a significant contributor to diabetes, heart disease, cancer, stroke, renal disease related to hypertension, circulatory diseases, and dementia. Statewide, nearly $3 billion in annual medical costs are attributed to obesity. The potential savings in both health care costs and productivity from reducing obesity are immense.

Of special concern are the 12.4% of Michigan youths who are now obese. These young people have a head start on developing chronic health conditions that will threaten their quality of life and potentially compromise Michigan's economic prospects for years to come. Studies show that 70% of overweight youths already have at least one risk factor for cardiovascular disease, such as high cholesterol or high blood pressure. If these young people do not adopt healthier lifestyles, they likely will be the first generation in the history of this state that will not live as long as their parents.

To combat the problem of childhood obesity, I will be encouraging the Michigan Department of Education (MDE) to work with schools to facilitate participation in physical activity and health education throughout all grade levels. I also encourage all schools to adopt healthier nutrition standards. The MDE has recommended a set of nutritional standards, which has been the subject of a pilot program supported by the Centers for Disease Control & Prevention. The goal of this program is to achieve better nutrition in a cost neutral manner. On November 7 through 12 of this year, school and community leaders will be trained in the Michigan Nutrition Standards as part of the statewide implementation of the Michigan Nutritional Standards project. Our schools can and must serve as models of nutrition.

I have also directed the Michigan Department of Agriculture and Rural Development (MDARD) to focus on ways that Michigan's farmers can help alleviate Michigan's obesity problem. Toward this end, MDARD will expand the access to a safe and healthy food supply by partnering with food corporations such as Meijer, Spartan Stores, Kroger, Gerber, and Kellogg to promote healthy lifestyles with local products.

To further ensure a safe and healthy food supply and reduce the risk of food borne illnesses, I encourage the Legislature to pass an update to the Michigan Food Law of 2000. This proposed change in law will adopt the current United States Food and Drug Administration (FDA) model Food Code. It will keep our law up to date with current science and streamline licensing requirements for many food establishments. The proposed changes to Michigan's food safety rules will also adopt a number of federal regulations relating to food processing establishments, which will ensure that state evaluators have the same authority and cite the same laws as the FDA when inspecting a processing establishment.

MDARD is also working with local, state, and federal partners to strengthen our Farm to School Network for access to local/fresh foods in the school meal programs. Three months ago, the United States Department of Agriculture (USDA) announced that Michigan will be one of only two states to participate in a new pilot program giving schools increased ability to use locally produced fruits and vegetables in school lunches. This program, overseen by the USDA, will help

boost Michigan's growing agriculture industry and provide healthy and fresher produce to school children. I also support the expansion of the Double Up Food Bucks program, now run by the Fair Food Network, which allows Michigan residents using the Supplemental Nutrition Assistance Program to double their purchasing power at farmers' markets without any additional cost to the state.

I have also directed the MDCH to incorporate information about BMI in the Michigan Care Improvement Registry (MCIR), which tracks childhood immunization records. This rule change will allow a health care provider to report height and weight measurements on MCIR. The goal is to increase obesity screening rates and improve treatment of childhood obesity, which is significantly under-diagnosed in children. This will improve the quality of care by highlighting the need for an annual screening of BMI, which correlates with future obesity, hypertension, and diabetes. Determining BMI is an important first step in managing pediatric obesity. Although the proposed rule would apply only to persons under the age of 18, I will support expanding MCIR to apply to persons of all ages, which would give all Michiganders greater awareness of and control over the state of their own health.

Today, children are spending too much time indoors, adversely affecting their health. Besides obesity, we are seeing increased vitamin D deficiency, early onset of diabetes, reduced attention spans, increased aggressiveness, and sleep deprivation. The Department of Environmental Quality is partnering with the Department of Natural Resources, the National Wildlife Federation, and hundreds of organizations comprising the Michigan "No Child Left Inside" Coalition, to get children outdoors in an effort to promote healthier lifestyles and environmental stewardship. I fully support these efforts.

Finally, because obesity is a matter of such great concern, the MDCH has organized a summit to develop a statewide plan to reduce obesity. Headlined, *Michigan Call to Action to Reduce and Prevent Obesity*, summit health experts and stakeholders will provide solutions and outline targeted interventions throughout the state to make a difference. The summit will convene in Lansing on September 21, 2011, with the support of Michigan's foundation community. As with the infant mortality summit, I expect the participants in the obesity summit to develop practical, implementable policy recommendations that will improve Michigan's health.

Wellness Programs

Throughout Michigan, communities, employers, providers, non-profits and citizens are developing innovative programs to promote health and wellness. In many cases, multiple community stakeholders are combining their efforts and resources to educate Michiganders on healthy lifestyles and encourage healthy decisions. This community-based collaboration is the key to advancing wellness and making Michigan a leader in the national wellness movement.

Michigan hospitals are demonstrating innovative leadership by adopting best practices to build healthier communities and reduce costs. Hospitals like Allegiance Health in Jackson, Michigan have won national recognition for forming community partnerships to identify and address the unique health needs of their local residents by creating a culture of wellness. Allegiance set about achieving this transformation by developing a network of partners, including government, local businesses, schools and other nonprofit organizations. They partnered with the University of Michigan to identify specific health risks that were plaguing the community - risks like smoking, obesity, and stress. They also began working with neighborhoods and social service agencies to address complex, generational problems like teen pregnancy and infant mortality. To track their progress, they developed, like we have, a dashboard. And they invested over $20 million to accomplish these goals.

The Michigan Health and Hospital Association has committed to supporting the sharing of best practices like these and facilitating collaboration among state hospitals to preserve and expand access to health care. I applaud this commitment and encourage Michigan's hospitals to remain dedicated to creating a culture of wellness in their communities.

Employers can also play an important role in alleviating Michigan's health problems. Research has shown that employers who promote their employees' healthy life choices reap direct economic benefits in the form of reduced health care costs and increased productivity. One recent study concluded that each employer dollar spent on intervention resulted in $6 worth of savings. Accordingly, I call on employers to consider both the economic and civic benefits of instituting employee wellness programs. Throughout Michigan, a number of private and public employers, including Steelcase, Peckham, and Oakland County, have instituted a variety of successful wellness programs. These programs help employees improve their quality of life, increase productivity at work, and reduce both employer and employee health care costs.

Community-based foundations and non-profit organizations can play an important role in improving the wellness of Michiganders. A best practice is the work being done by the Chelsea-Area Wellness Foundation, which has instituted the Five Healthy Towns Project (5H) with the goal of making Chelsea, Dexter, Manchester, Grass Lake and Stockbridge the five healthiest towns in the Midwest. The 5H is a comprehensive, community-based project designed to expand wellness programs, infrastructure, and policies that spotlight wellness issues, foster collaboration, and close wellness gaps. Similarly, the Grand Rapids YMCA, with grants from the Kellogg Foundation, the Frey Foundation, and the Van Andel Institute, is providing new walking clubs, community gardens and fitness classes to Michigan residents in the Grand Rapids area.

Communities are also increasing physical activity by improving safety, access and availability for daily recreation and transportation. The City of Marquette is proving that creating a healthier physical environment produces economic benefits. Marquette is one of the few communities in Michigan to have gained population in the last decade. This is due, in part,

to the fact that Marquette has been a leader in providing residents with a high quality of life. Marquette has passed three "Complete Street" policies to improve the walkability and bike-ability of its streets, completed infrastructure improvements giving its children "Safe Routes to School," developed hands-on projects to help students learn about gardening, planted four community gardens, constructed a non-motorized trail connecting seven communities, assisted in the establishment of two new farmer's markets, and developed worksite wellness policies supporting fitness and good nutrition. I encourage other Michigan communities to follow Marquette's lead.

Seniors

Michiganders are living longer and Michigan's senior population is increasing at an unprecedented rate. These realities mirror national trends and require us to look at new, innovative ways to support older residents in a manner that respects their independence, choice and dignity.

The vast majority of Michigan's older population is concerned about their ability to maintain independence at home. While long-term care facilities are important options, older individuals should be able to live in the setting of their choice, which in most cases is at home. The Office of Services to the Aging (OSA) is working to develop innovative approaches to community-based care with a focus on evidence-based programs and outcomes. For example, OSA funds a statewide care management program that sends caseworkers into an individual's home to provide assessments and connect individuals with services to help those who might otherwise default to nursing home placement.

I have directed the MDCH to develop new practices to reduce the MI Choice waiting period for home-based services. Under current practice, seniors leaving nursing home facilities are given priority for MI Choice home care over those who never left home. Incentivizing seniors to move out of nursing home care when they are physically able is a laudable goal, but it has the unintended consequence of causing seniors to enter nursing home care as a means to accessing MI Choice home care.

Finally, another important issue for all Michiganders is stopping elder abuse, the fastest growing crime in Michigan. I support the elder abuse legislation, Senate Bills 454-468, now pending in the legislature. This legislation will increase coordination between state and local authorities to expedite investigations, better define forms of elder abuse, create stricter penalties, and implement necessary guardianship reforms to further protect elderly adults from financial and physical harm. Michigan's most vulnerable adults deserve these protections.

Oral Health

Increasingly, research supports the connection between oral health and systemic health. Oral health complications exacerbate general health conditions. Periodontal disease is associated with diabetes, cardiovascular disease, coronary heart disease, respiratory disease, and adverse pregnancy outcomes. Poor oral health results in school absences and inappropriate use of emergency rooms. The 2011 Institute of Medicine Report, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, concluded that oral health care is an essential component of comprehensive health care.

I am asking the MDCH, with assistance from the Department of Licensing and Regulatory Affairs (LARA), to work with the dental community to develop and disseminate educational materials to the public and policy makers on the importance of adequate access to oral health care, the link between systemic and oral health, and the consequences of not having access to oral health care services.

I also encourage Michigan's dentists to volunteer their services to programs like the Michigan Donated Dental Services (MDDS) program, which treats patients who are disabled and elderly with seriously neglected dental problems. As a result of their age or disability, many cannot work and depend on public assistance for their health care. Medicare, however, does not provide dental benefits and Michigan's Medicaid program limits eligibility, procedures and the frequency of procedures for adult recipients. The Michigan Dental Association and the National Foundation of Dentistry for the Handicapped launched the statewide MDDS project in 1995. Delta Dental Plan of Michigan is a major partner in the Michigan effort and donates office space as well as many other support services. At an annual cost of $125,000 (for administration and some laboratory costs), the MDDS program annually provides over $1 million worth of dental care, provided by over 850 dentists and 217 dental laboratories. The return on investment is $7.63 of donated treatment per dollar of operating costs.

Another excellent program treating a different population in need of care is the Healthy Kids Dental (HKD) program, which serves 308,000 Medicaid-enrolled children in 65 counties. The HKD program has been a great success where it operates, raising the number of Medicaid-eligible children who visit the dentist by 64.7% compared to counties without the program. Unfortunately, the HKD program is absent from some of our most populous counties, where the greatest disparities in dental care exist. Because of the positive results obtained through the HKD program, the expansion of HKD to all of Michigan's 83 counties will be given every consideration during the Fiscal Year 2013 budget cycle.

Tobacco Use

Tobacco use is dangerous and expensive. It is the leading cause of preventable death, killing 14,419 Michiganders in 2009. It contributes significantly to heart disease, cancer, chronic respiratory illness, influenza, pneumonia, renal disease related to hypertension, and circulatory diseases. Despite the long term decrease in the percentage of smokers, tobacco use continues to be one of the biggest public health problems confronting Michigan. The adult smoking rate is currently 18.9%. For youths, the rate is 18.1%. These rates are dramatically higher for low-income residents, Medicaid participants,

and disabled people. Tobacco users cost the state over $3.4 billion per year in tobacco related health care costs. The annual cost to Medicaid alone is $1.1 billion. Even though tobacco users live significantly shorter lives, smokers incur an average of $15,000 to $17,000 more in lifetime health care costs than non-smokers.

While tobacco use is down significantly, now is not the time to let up. Therefore, I want to make it clear that I will veto any legislative attempt to reduce taxes on cigarettes or other tobacco products.

I also ask that the legislature give the Department of Natural Resources authority to implement a policy requiring all state owned and operated beaches to be smoke free to promote a clean and healthy environment.

Finally, MDCH will review state policy regarding Medicaid coverage of FDA-approved smoking cessation treatments. At present, only three of Michigan's fourteen Medicaid managed care plans cover all smoking cessation medications. I have asked MDCH to begin work evaluating the efficacy of smoking cessation treatments currently covered by Medicaid and complete an internal assessment of the opportunity for coverage expansion.

Access

By improving access, we can achieve both wellness and cost savings. Michiganders will have improved access to health care through better utilization of benefits for our veterans, updated technology, and an increased focus on developing better services to underserved areas and populations. The current health care system focuses primarily on the treatment of physical aspects of diseases as opposed to an integrated approach of managing a person's health status and preventing illnesses. Insufficient focus on prevention and early diagnosis results in high utilization of hospital emergency rooms. A number of steps can be taken to improve access.

Veterans

According to data provided by the United States Department of Veterans Affairs (VA), Michigan veterans rank 53rd, on a per-capita basis, as recipients of federal VA dollars for total veterans' benefits, when compared to the 50 states, Puerto Rico, Washington, D.C., and Guam. This is simply unacceptable. I will work with our policymakers, community partners, and veterans' service providers to ensure that Michigan veterans receive the best possible assistance in accessing their benefits.

All Michigan veterans have the opportunity to apply and potentially qualify for VA health care. Eligibility can only be determined, however, through the VA enrollment process. While many Michigan veterans would qualify for VA medical treatment, only 30% of Michigan veterans complete the enrollment process and only 19% of Michigan's total veteran population utilizes their VA health benefits. Peer states' veteran populations enroll for VA health care at rates closer to 40% and utilize care at rates closer to 25%. Increasing enrollment in VA health care will, in turn, increase access to quality health care for our veterans as well as their standing as an overall recipient of VA assistance.

In the past, veterans participating in the VA health system felt that the only location for treatment was one of the VA hospitals. The VA has recently undertaken a concerted effort to locate outpatient medical facilities for veterans throughout Michigan so veterans have access to high quality, affordable and convenient outpatient care. Today, most veterans are within a 30-minute drive of a community-based outpatient clinic providing excellent care without the difficulties many experienced seeking primary care at a hospital. Just this year, the VA opened a new outpatient clinic in Cadillac and an additional clinic will be completed in Mackinaw City this fall. It is imperative that all state service providers and their community partners continue to educate veterans and their dependents on the increased availability of outpatient care.

Michigan's veterans face a host of health challenges related to their military service. Veterans' health challenges are often best treated by a VA physician. Accordingly, I am committed to ensuring that every veteran is educated about the importance of enrollment in VA health care. Outreach will be a collaborative effort between state agencies, veteran service organizations, county veterans' offices, and non-traditional partners. Michigan is proud of our veterans. We need to serve them better and I am committed to making that happen.

As we forge new partnerships and improve existing relationships, I have directed the Department of Military and Veterans Affairs to seek state accreditation from the U.S. Secretary of Veterans Affairs. This action will help Michigan become a more committed partner with the United States Department of Veterans Affairs in the provision of veterans' benefits.

We need help to solve access to benefits issues for our veterans, which is why I am calling on the President and our Congressional delegation to provide additional support for veterans here in Michigan. In addition to enrollment in VA health care, veterans have the ability to file for disability compensation for injuries that have occurred as a result of their service. The claims process is cumbersome and many of our veterans are not getting the assistance they need. For example, it would take the Detroit Regional Office at least nine months to respond to the current workload without any new claims being filed. This is nine months that a patient with an illness like heart disease or diabetes cannot always wait for their claim to be examined, and the financial burden of such an illness is significant. We must do better. I will be urging the Congress and the President to assure that Michigan veterans are treated with the respect and sense of urgency they deserve.

Technology

Advances in technology offer excellent opportunities to efficiently connect individuals, government, and the private sector. We must take advantage of these opportunities to increase the quality of health care, promote wellness, and reduce health care costs. In addition, Michigan must become more efficient at providing health care by using technologies that

remotely monitor patients and make it easier for doctors and nurses to care for some of their sickest patients before their medical problems reach a crisis. Moreover, in a state with a shortage of primary care providers, technology can reduce the burden on doctors' offices by keeping people healthier at home.

We will develop platforms for sharing electronic health information. The state is in the process of implementing the Michigan Health Information Network (MiHIN), which is Michigan's initiative to improve health care quality, efficiency, and patient safety through the sharing of electronic health information, while reducing costs. The MiHIN is essential to ensuring that Michigan's health care providers can utilize Electronic Health Records (EHRs) in a meaningful way that will allow for a patient's health information to be available when needed most—at the point of care. With the MiHIN infrastructure in place, health care providers will be in a position to access and share the information within EHRs regardless of specific technology used or where the patient is from. Just one benefit of a network of EHRs will be the ability of physicians to access vital health information in the event that anyone needs emergency medical care.

Individuals can also utilize technology to help manage their own health. The internet affords a wonderful opportunity for leaders in government and the private sector to communicate with and provide useful tools to Michigan residents. These opportunities must be maximized. The MDCH will implement an on-line wellness program with resources for Michiganders to take an active role in achieving a healthy lifestyle. Currently, Michigan government maintains multiple fitness and health websites. A single "Healthy Michigan" portal will be established to aggregate this content in one place, and the redundant websites will be discontinued.

Federally Qualified Health Centers

The recent federal decision not to select Michigan for one of the new FQHC locations was ill-advised, especially given the impact the recession has had on our state. FQHCs are federally funded community organizations that provide primary and preventive care (including oral care and behavioral health care), to persons of all ages, regardless of their ability to pay. They are particularly valuable to underserved populations in urban and rural areas. FQHCs improve the quality of care and save money by providing low income populations with access to medical care before expensive emergency room visits become necessary. For example, the treatment charge for an inner ear infection at an FQHC would be $75, compared to average billed charges of $460.70 for the same treatment at an emergency room in eastern Michigan. Michigan has too few of our nation's FQHCs. Only 29 out of 1,048 FQHCs are located in Michigan. I continue to support FQHCs and the role they have in improving access and the quality of health care for our underserved populations. I have directed MDCH to competitively pursue new FQHCs and seek assistance from the Michigan Congressional delegation to help solve this problem.

Behavioral Health & Developmental Disability

Behavioral health is essential to general health. In the United States, persons with mental illness live an average of 25 years less than those without mental illness. We can reduce this disparity if we build a stronger and better coordinated system of care for persons with mental illness, substance use disorders, children with serious emotional disturbance, and persons with developmental disabilities. I have directed MDCH to develop a plan to integrate physical and behavioral health care throughout the continuum of care. I am also asking MDCH to evaluate the spectrum of care from community-based services to inpatient services to ensure appropriate and compassionate care is delivered. This includes the simplification and reduction of administration to ensure maximum dollars are devoted to direct services. Administrative structures should exist only where they improve health outcomes, increase access, or lower costs.

Improving the system of care will require early intervention with priority populations. A disproportionate share of persons with behavioral health issues ultimately end up behind bars. Accordingly, I am asking the MDCH to facilitate meetings of community stakeholders—the Department of Corrections (MDOC), jails, courts, community mental health boards—to create an action plan for Recommendations 1 through 4 of the "2008 Mental Health Workgroup Report," to (1) improve mental health services in the community, in the jails, and in the court system, (2) institute diversion programs, (3) improve the management of individuals in jail, and (4) share information appropriately across the criminal justice system. These are consensus recommendations that were developed by MDOC-MDCH and a broad base of community stakeholders toward reducing the number of persons with mental illness, substance use disorders, and disabilities in our prisons and jails.

Finally, Michigan faces significant health care challenges posed by autism. Autism is a pervasive developmental disorder that affects 1 out of every 110 children born today. Autism diagnoses are increasing rapidly with no known cause or cure. Without treatment, the average lifetime cost to Michigan of a single person suffering from autism is $3.7 million. With early treatment, however, children can achieve much better outcomes and many of these costs can be avoided. Half of diagnosed children can reach normal functionality with appropriate assessment and treatment. Another 40% will show significant improvement. Results are best when treatment is received early.

Michigan is considered one of the 10 worst states in which to raise a child with autism. This is because evidenced-based treatment is largely excluded from insurance coverage. With such widespread exclusion of coverage, treatment options are nearly or totally non-existent throughout most of the state. To date, 27 other states have implemented changes in law to require insurers to cover evidence based therapies for autism that will save taxpayers billions of dollars. It is time for Michigan to join the majority of states in this effort to contain costs and give families access to clinically proven treatment.

Health Care Reform

The MI Health Marketplace

I strongly support establishing a Michigan-based on-line health insurance exchange that will emphasize free market principles and serve as a competitive marketplace for individuals and businesses to obtain health insurance, including some of our most vulnerable residents who are currently uninsured.

The Affordable Care Act (ACA) requires each of the states to establish a health insurance exchange by 2014. If Michigan does not establish its own exchange, then the federal government will step in to operate one for Michigan. While I recognize that all or a portion of the ACA may be repealed or found to be unconstitutional in lawsuits that are currently pending, Michigan must be prudent and plan to reach the best possible outcome under the existing law. Because Michigan needs a health insurance marketplace that best serves Michiganders, I am asking the Legislature to adopt legislation to create the MI Health Marketplace. This legislation should both satisfy the requirements of the ACA and improve the experience of purchasing health insurance coverage in Michigan.

I do not support a "one size fits all" federal approach to health reform, which is where we would be if we were to allow the federal government to run a health insurance exchange in Michigan. But even if the act of establishing a health insurance exchange were not mandated by the ACA, I would still be in favor of utilizing technology to create a better customer service experience for Michiganders. Done right, the MI Health Marketplace legislation will allow customers and small businesses to make more efficient and better informed decisions about buying health insurance coverage. When customers are provided with unfettered access to companies, products, pricing, and related information, there is higher confidence in the price and the quality of the products.

To achieve this goal, the MI Health Marketplace must operate under the following set of guiding principles.

1. The MI Health Marketplace must empower individuals and small businesses by enabling them to easily compare health insurance options. Giving customers an additional, streamlined tool to compare health care plans will allow Michiganders to more easily find a plan that best fits their needs. Creating a simple, clear system in which individuals and small businesses can compare plans will encourage health insurance carriers to compete for business by keeping costs down and providing high quality coverage.

2. The MI Health Marketplace must not add bureaucracy and complexity that increases the cost to customers. As the Legislature develops the MI Health Marketplace, it should focus on creating a structure that is simple and straightforward. It should not create a duplicative regulatory structure for health insurance in Michigan, but should focus on creating an efficient mechanism for customers to easily compare different plans. It should encourage healthy competition rather than simply add new transaction costs to the expenses that individuals and small businesses already face. The MI Health Marketplace should be established as a non-profit entity, existing outside of the government rather than another level of government bureaucracy.

3. The MI Health Marketplace should be another tool for health insurance customers, but not be the only available option for purchasing health insurance coverage. While the MI Health Marketplace will enhance the market for health insurance in Michigan, it should not be the only available option for customers. Many Michigan businesses and individuals are pleased with their current health coverage and have been well served by the current system. The MI Health Marketplace should not force these satisfied customers onto to a health insurance exchange that they do not need.

4. The MI Health Marketplace must be customer-service oriented, accountable, reliable, transparent, and expedient. Excellent customer service must be a hallmark of the MI Health Marketplace. Unlike other sectors of our economy, our health care system has not adopted many technological advances, especially for customers to interact with the health system. Today we can use a smart phone to make reservations at restaurants, pay bills or even make major purchases for our homes. But finding affordable health coverage or even having access to your medical records continues to be a real challenge that technology has not yet been fully tapped to address. Moreover, unlike other sectors of the economy, such as retail or shopping for car insurance, the customer service experience in health care is often frustrating. By using technology, the MI Health Marketplace can make the on-line experience of selecting and purchasing health insurance coverage as easy as selecting and purchasing travel arrangements through websites like Travelocity and Orbitz. This design will incentivize insurance carriers to work hard to earn your business by offering innovative products that strive to control costs and improve quality. The MI Health Marketplace must also be accountable and transparent, by being made subject to the Open Meetings Act and the Freedom of Information Act. The operating costs should be available for public review through simple and reasonable reporting requirements.

These recommendations have been developed through a process of consulting stakeholders in the health care industry, including consumers, employers, health plans, a diversity of health care providers, insurance agents and brokers, labor, local governments, and universities. The Department of Technology, Management, and Budget has developed a technology plan that would allow for the seamless integration of the commercial health insurance products offered on the MI Health Marketplace with new state Medicaid eligibility rules mandated by the ACA. The new technology will establish a MI Health Marketplace portal with a single point of entry for individuals and employers to access information about health care coverage. The internet portal will enable insurance plan shopping and comparisons, validate eligibility and demographics,

and enable insurance plan enrollment and payment. We will take all steps necessary to safeguard customer privacy and confidentiality. This plan will leverage existing state technical systems to the extent possible and be funded, to a large extent, by federal grants.

In order to meet the rigid federal guidelines for states to establish their own health insurance exchanges, and to utilize the federal funding, I urge the legislature to enact legislation creating the MI Health Marketplace before this Thanksgiving. Moving quickly will also put Michigan in a position to shape the development of federal health care reform.

Blue Cross and Blue Shield of Michigan

Blue Cross Blue Shield of Michigan plays a critical role in our health care system in Michigan. Approximately 4.3 million Michiganders are insured through Blue Cross, and it is estimated that Blue Cross enjoys a 70% health insurance market share in our state. Blue Cross employs more than 7,000 Michiganders, and has made significant and continuing investments in our state's important urban areas.

The legislation under which Blue Cross operates is more than 30 years old. That legislation has served Michigan well. Our individual and small business health insurance rates are lower than the national average. In fact, we have the 12th lowest individual health insurance rates in the nation. But the ACA requires the state to make certain changes to the way insurance rates are established and reviewed. We do not know whether the ACA will withstand the legal challenges against it, but if it survives, Michigan will have to implement changes this fall. Those changes will include market reforms such as requiring health insurance plans to cover immunizations and preventive care for children and women, prohibiting annual or lifetime limits on coverage, preventing denial of coverage because of a pre-existing condition, continuing children on a parent's plans until 26 years of age, reviewing unreasonable health insurance premium increases, and providing enrollees internal and external reviews of coverage denials.

Beyond these immediate changes, it is time to take a fresh look at the way Blue Cross operates and is regulated. Over the long term, we want to create a health care regulatory environment in Michigan that encourages competition, market speed and innovation, efficiency and cost reduction, and high quality, affordable, and accessible care. This will position Michigan to take advantage of the important market changes that are being driven by ACA and other health care reform, if the Act does survive.

So, we plan to begin examining whether our 30-year-old statute and Blue Cross' current legal and regulatory structure best meet these goals for the Michigan health care marketplace, in this time of great change. Blue Cross belongs to you and me, as a charitable trust established for Michigan's residents to deliver quality and affordable health care coverage. We look forward to working with the legislature to determine the best ways to maximize the long term value of this important asset to Michiganders.

Persons covered dually by Medicare and Medicaid

Michigan has over 205,000 residents who are dually eligible for both Medicare and Medicaid. While this is only 12.5% of our Medicaid population, these individuals account for 38% of Medicaid spending. A strategic priority of our MDCH is to move these persons with dual eligibility from an uncoordinated fee-for-service environment into a coordinated managed care environment. The goal is to take two government programs that traditionally do not work well together—Medicare and Medicaid—and create a coordinated health care delivery system. There is great potential for improving services through integration. There is also great potential for cost savings through better management of services, because approximately $7.5 billion is spent annually on this population, including both Medicare and Medicaid, of which over $1 billion comes from Michigan's general fund.

Michigan has received a $1 million federal grant to plan for this transition. The target date for the transition is October 2012. We are in the process of getting input from stakeholders (consumers, community based organizations, area agencies on aging, nursing homes, behavioral health care providers, home health providers, hospice, rehabilitation centers, hospitals, doctors, and the insurance industry). I am encouraged that this process will result in better health outcomes, better customer service, and cost savings. I look forward with great anticipation to the report of this stakeholder group.

Improved Governance

In 1978 the Michigan Public Health Code was enacted, creating the regulatory framework for health care in Michigan. Although there have been a significant number of amendments of the Public Health Code, many of the requirements in the Code are now over thirty years old. A number of provisions within the Code are outdated and there are new issues that should be addressed but are not included in the current Act.

One of the problems hospitals and providers encounter when trying to incorporate new technologies is that the new technology may not be acceptable under the current Public Health Code. This delays or prevents implementation of new technologies. For example, medical records are now available electronically or can be forwarded electronically but there is no discussion in the Public Health Code of electronic records and no provision for electronic communications or telemedicine. Similarly, the current Public Health Code also assumes that medical services must be provided face-to-face, but there is a growing trend in mental health arenas to offer counseling via technologies like Skype.

After 33 years, it is time to revisit how we regulate health care in Michigan. I propose that we undertake a comprehensive review of the Michigan Public Health Code. Such a review would be consistent with other initiatives to reinvent regulation in our state. To that end I am directing the MDCH, in conjunction with a newly-appointed Public Health Code Advisory

Committee of public health experts, to conduct a systematic review of all existing provisions of the Public Health Code to determine the need to amend or rescind existing language or add new language to accommodate the changing health care environment. The MDCH will submit recommendations for regulatory changes to the Executive Office. Completing the review process and developing recommendations will require a significant investment of time and resources.

Seven years ago we had 17 boards and task forces regulating various health care professions. We now have 25 health profession licensing boards and task forces. In its current form, the Public Health Code does not provide for a sunset review process to determine whether there is value in continuing to regulate a particular health care profession, so the number of boards and regulated professions has continued to grow, unchecked. Likewise, under the current Code, health entities that are credentialed by nationally recognized organizations are required to go through additional regulatory processes by the state. To reduce unnecessary or additional regulation, and cut down on red tape, the Public Health Code could accept national accreditation or certification instead of requiring additional review at the state level.

The Office of Regulatory Reinvention (ORR), created earlier this year, is looking at these various licensed occupations and supporting boards, to make sure that we are not excessively regulating our health occupations and that our regulations are tailored to provide health and safety benefits. Another area of focus is addressing our current and projected health care professional shortages. Physician shortages, for example, are projected to range from 4,400 to 6,000 by the year 2020. It has been estimated that as a result of the ACA, the size of our shortages may quadruple. Should this estimate hold true, Michigan's physician shortage could be anywhere from 16,000 to 24,000 by 2020. This will make it harder to get an appointment with a physician and access to specialized care may become more difficult. We need to find a way to ensure that Michiganders continue to have access to quality care.

Resolving the issue requires that we take a look at how other members of the health care team can partner with the medical community to deliver those services. Understanding the role of physician extenders such as advanced practice nurses and physicians' assistants in the delivery of primary care services is critical to addressing access issues. The ability to more effectively utilize mid-level practitioners is limited, however, by our current regulatory system. Accordingly, I have asked ORR to work closely with the MDCH to develop and implement a strategic plan to address our current and anticipated shortages in the health care sector and identify the regulatory reform necessary to successfully posture Michigan for future needs.

Conclusion

In order to see real improvement in our public health, and to make rising health care costs as manageable as possible, all levels of government, the private sector, and individual Michiganders have a part to play. Government and the private sector can and should empower Michiganders with the tools necessary to access quality health care and live a healthy lifestyle. We should act expeditiously and with compassion. At the same time, Michiganders can improve the quality of their own lives, while also reducing the economic burden of health care expenditures, by assuming personal responsibility for their own health and wellness.

Health is the foundation for Michigan's economic transformation—it allows our children to thrive and learn, it readies our graduates for meaningful careers, and it permits our current workforce to grow and adapt to a dynamic economy. In this message, we lay the groundwork for a healthier Michigan, a Michigan in which residents of all ages prosper and contribute.

The message was referred to the Secretary for record.

The following messages from the Governor were received and read:

August 29, 2011

I respectfully submit to the Senate the following appointments to office:

Midwest U.S. - Japan Association Board

Bruce A. Brownlee of 39755 Dun Rovin Drive, Northville, Michigan 48168, county of Wayne, succeeding himself, is reappointed for a term expiring December 31, 2011.

Doug J. Smith of 874 Helston Road, Bloomfield Hills, Michigan 48304, county of Oakland, succeeding Jill Murphy, is appointed for a term expiring December 31, 2011.

August 30, 2011

I respectfully submit to the Senate the following appointments to office:

Electrical Administrative Board

Corey D. Hannahs of 2700 Byington Boulevard, Ann Arbor, Michigan 48105, county of Washtenaw, representing master electricians serving as a supervisor, succeeding Mark A. Bauer, is appointed for a term expiring August 10, 2014.

Thomas A. Erdman of 6725 Sohn Road, Vassar, Michigan 48768, county of Tuscola, representing electrical parts distributors, succeeding Joseph F. Reyes, is appointed for a term expiring August 10, 2014.

Ernest A. Harju of 1269 County Road FN, Champion, Michigan 49814, county of Marquette, representing electrical journeymen, succeeding himself, is reappointed for a term expiring August 10, 2014.

September 1, 2011

I respectfully submit to the Senate the following appointment to office:

Utility Consumer Participation Board

Susan L. Haroutunian of 14926 Rosemont Drive, Detroit, Michigan 48223, county of Wayne, representing a qualified person submitted by the Attorney General, succeeding Marc Shulman, is appointed for a term expiring January 13, 2013.

September 9, 2011

I respectfully submit to the Senate the following appointments to office:

General Industry Safety Standards Commission

William L. Borch, Jr., of 2686 22nd Street, Bay City, Michigan 48708, county of Bay, representing labor, succeeding himself, is reappointed for a term expiring March 26, 2014.

Andrew J. Mosser of 6312 Peck Lake Road, Portland, Michigan 48875, county of Ionia, representing labor, succeeding Karl E. Heim, is appointed for a term expiring March 26, 2014.

Jennifer A. Ewing of 1003 Webster Street, Traverse City, Michigan 48686, county of Grand Traverse, representing management of principal industries of this state, succeeding herself, is reappointed for a term expiring March 26, 2014.

Jeffrey A. Spencer of 10845 Rattalee Lake Road, Davisburg, Michigan 48350, county of Oakland, representing management of public employers of this state, succeeding Elizabeth F. Koto, is appointed for a term expiring March 26, 2014.

September 15, 2011

I respectfully submit to the Senate the following appointments to office:

Commissioner, Michigan Public Service Commission

John D. Quackenbush of 46320 Station Road, New Buffalo, Michigan 49117, county of Berrien, representing Republicans, succeeding Monica Martinez, is appointed for a term expiring July 2, 2017.

Chairman, Michigan Public Service Commission

John D. Quackenbush of 46320 Station Road, New Buffalo, Michigan 49117, county of Berrien, is appointed for a term expiring at the pleasure of the Governor.

Sincerely,
Rick Snyder
Governor

The appointments were referred to the Committee on Government Operations.

By unanimous consent the Senate proceeded to the order of

Third Reading of Bills

Senator Meekhof moved that the following bills be placed at the head of the Third Reading of Bills calendar:

Senate Bill No. 566
Senate Bill No. 567
Senate Bill No. 568
House Bill No. 4788

The motion prevailed.

Senator Kahn entered the Senate Chamber.

The following bill was read a third time:

Senate Bill No. 566, entitled

A bill to amend 1984 PA 270, entitled "Michigan strategic fund act," by amending sections 5, 88c, and 88h (MCL 125.2005, 125.2088c, and 125.2088h), section 5 as amended by 2008 PA 224 and sections 88c and 88h as added by 2005 PA 225.

The question being on the passage of the bill,

The bill was passed, a majority of the members serving voting therefor, as follows:

Roll Call No. 487 **Yeas—36**

Anderson	Green	Jones	Proos
Bieda	Gregory	Kahn	Richardville

Booher
Brandenburg
Casperson
Caswell
Colbeck
Emmons
Gleason
Hansen
Hildenbrand
Hood
Hopgood
Hune
Hunter
Jansen
Kowall
Marleau
Meekhof
Moolenaar
Nofs
Pappageorge
Pavlov
Robertson
Rocca
Schuitmaker
Smith
Walker
Warren
Whitmer

Nays—0

Excused—2

Johnson
Young

Not Voting—0

In The Chair: Hansen

The Senate agreed to the title of the bill.

The President, Lieutenant Governor Calley, assumed the Chair.

The following bill was read a third time:
Senate Bill No. 567, entitled
A bill to amend 1984 PA 270, entitled "Michigan strategic fund act," (MCL 125.2001 to 125.2094) by adding chapter 8C.
The question being on the passage of the bill,
The bill was passed, a majority of the members serving voting therefor, as follows:

Roll Call No. 488

Yeas—35

Anderson
Bieda
Booher
Brandenburg
Casperson
Caswell
Colbeck
Emmons
Gleason
Green
Gregory
Hansen
Hildenbrand
Hood
Hopgood
Hune
Hunter
Jansen
Jones
Kahn
Kowall
Marleau
Moolenaar
Nofs
Pappageorge
Pavlov
Proos
Richardville
Robertson
Rocca
Schuitmaker
Smith
Walker
Warren
Whitmer

Nays—1

Meekhof

Excused—2

Johnson
Young

Not Voting—0

In The Chair: President

The Senate agreed to the title of the bill.

The following bill was read a third time:

Senate Bill No. 568, entitled

A bill to amend 1984 PA 270, entitled "Michigan strategic fund act," (MCL 125.2001 to 125.2094) by adding sections 90c and 90d.

The question being on the passage of the bill,

The bill was passed, a majority of the members serving voting therefor, as follows:

Roll Call No. 489 **Yeas—35**

Anderson	Green	Jones	Richardville
Bieda	Gregory	Kahn	Robertson
Booher	Hansen	Kowall	Rocca
Brandenburg	Hildenbrand	Marleau	Schuitmaker
Casperson	Hood	Moolenaar	Smith
Caswell	Hopgood	Nofs	Walker
Colbeck	Hune	Pappageorge	Warren
Emmons	Hunter	Pavlov	Whitmer
Gleason	Jansen	Proos	

Nays—1

Meekhof

Excused—2

Johnson Young

Not Voting—0

In The Chair: President

The Senate agreed to the title of the bill.

The following bill was read a third time:

House Bill No. 4788, entitled

A bill to amend 1974 PA 198, entitled "An act to provide for the establishment of plant rehabilitation districts and industrial development districts in local governmental units; to provide for the exemption from certain taxes; to levy and collect a specific tax upon the owners of certain facilities; to impose and provide for the disposition of an administrative fee; to provide for the disposition of the tax; to provide for the obtaining and transferring of an exemption certificate and

to prescribe the contents of those certificates; to prescribe the powers and duties of the state tax commission and certain officers of local governmental units; and to provide penalties," by amending section 2 (MCL 207.552), as amended by 2010 PA 273.

The question being on the passage of the bill,

The bill was passed, a majority of the members serving voting therefor, as follows:

Roll Call No. 490 **Yeas—34**

Anderson	Gregory	Kowall	Richardville
Bieda	Hansen	Marleau	Robertson
Booher	Hildenbrand	Meekhof	Rocca
Brandenburg	Hood	Moolenaar	Schuitmaker
Casperson	Hopgood	Nofs	Smith
Caswell	Hunter	Pappageorge	Walker
Emmons	Jansen	Pavlov	Warren
Gleason	Jones	Proos	Whitmer
Green	Kahn		

Nays—2

Colbeck Hune

Excused—2

Johnson Young

Not Voting—0

In The Chair: President

The question being on concurring in the committee recommendation to give the bill immediate effect,

The recommendation was concurred in, 2/3 of the members serving voting therefor.

The Senate agreed to the title of the bill.

By unanimous consent the Senate proceeded to the order of

General Orders

Senator Meekhof moved that the Senate resolve itself into the Committee of the Whole for consideration of the General Orders calendar.

The motion prevailed, and the President, Lieutenant Governor Calley, designated Senator Green as Chairperson.

After some time spent therein, the Committee arose; and the President, Lieutenant Governor Calley, having resumed the Chair, the Committee reported back to the Senate, favorably and with a substitute therefor, the following bill:

Senate Bill No. 160, entitled

A bill to amend 1931 PA 328, entitled "The Michigan penal code," (MCL 750.1 to 750.568) by adding section 90h.

Substitute (S-2).

The Senate agreed to the substitute recommended by the Committee of the Whole, and the bill as substituted was placed on the order of Third Reading of Bills.

The Committee of the Whole reported back to the Senate, favorably and with amendment, the following bill:

Senate Bill No. 161, entitled

A bill to amend 1927 PA 175, entitled "The code of criminal procedure," by amending section 16d of chapter XVII (MCL 777.16d), as amended by 2010 PA 132.

The following is the amendment recommended by the Committee of the Whole:

1. Amend page 4, following line 5, by inserting:

"Enacting section 1. This amendatory act takes effect January 1, 2012." and renumbering the remaining enacting section.

The Senate agreed to the amendment recommended by the Committee of the Whole, and the bill as amended was placed on the order of Third Reading of Bills.

The Committee of the Whole reported back to the Senate, favorably and with amendment, the following bill:

Senate Bill No. 525, entitled

A bill to amend 1927 PA 372, entitled "An act to regulate and license the selling, purchasing, possessing, and carrying of certain firearms and gas ejecting devices; to prohibit the buying, selling, or carrying of certain firearms and gas ejecting devices without a license or other authorization; to provide for the forfeiture of firearms under certain circumstances; to provide for penalties and remedies; to provide immunity from civil liability under certain circumstances; to prescribe the powers and duties of certain state and local agencies; to prohibit certain conduct against individuals who apply for or receive a license to carry a concealed pistol; to make appropriations; to prescribe certain conditions for the appropriations; and to repeal all acts and parts of acts inconsistent with this act," by amending section 5*l* (MCL 28.425*l*), as amended by 2008 PA 406.

The following is the amendment recommended by the Committee of the Whole:

1. Amend page 2, line 15, after "**THE**" by striking out the balance of the subsection and inserting "**EFFECTIVE DATE OF THE LICENSE.**".

The Senate agreed to the amendment recommended by the Committee of the Whole, and the bill as amended was placed on the order of Third Reading of Bills.

During the Committee of the Whole, Senator Johnson entered the Senate Chamber.

Resolutions

The question was placed on the adoption of the following resolution consent calendar:

Senate Resolution No. 78

The resolution consent calendar was adopted.

Senators Caswell, Jones, Proos, Booher and Jansen offered the following resolution:

Senate Resolution No. 78.

A resolution to observe September 2011 as National Recovery Month in the state of Michigan.

Whereas, Behavioral health is an essential part of health and one's overall wellness. People can and do recover from substance use and mental disorders; and

Whereas, All people have the fundamental and inherent value to be accepted and treated with respect, human dignity, and worth; and

Whereas, Individuals should have access to fully participate in community life, including economic advancement and prosperity; fair and decent housing; quality education; and positive opportunities to benefit from and contribute to material, cultural, and social progress; and

Whereas, It is critical to educate our policymakers, friends and family, health care providers, and businesses. Substance use and mental disorders are treatable, and people should seek assistance for these conditions with the same urgency as they would any other health condition; and

Whereas, Substance use and mental disorders are serious public health problems. In 2009, 4.3 million people received treatment for a substance use disorder and 30.2 million people for mental health problems, according to the 2009 National Survey on Drug Use and Health. We must continue to reach the millions more who need help; and

Whereas, To help more people achieve long-term recovery and learn how recovery positively benefits the nation's overall well-being, the U.S. Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the White House Office of National Drug Control Policy (ONDCP), and Recovery Network, Inc., and its Recovery Month Coalition invite all residents of Michigan to participate in National Recovery Month; now, therefore, be it

Resolved by the Senate, That the members of this legislative body observe September 2011 as National Recovery Month. We call upon the residents of Michigan to observe this month with appropriate programs, activities, and ceremonies.

Senators Brandenburg, Colbeck, Emmons, Gleason, Hopgood, Kowall, Meekhof, Pappageorge and Richardville were named co-sponsors of the resolution.

By unanimous consent the Senate proceeded to the order of

Introduction and Referral of Bills

Senator Kahn introduced

Senate Bill No. 682, entitled

A bill to make, supplement, and adjust appropriations for various state departments and agencies for the fiscal year ending September 30, 2011; and to provide for the expenditure of the appropriations.

The bill was read a first and second time by title and referred to the Committee on Appropriations.

Senator Kahn introduced

Senate Bill No. 683, entitled

A bill to make, supplement, and adjust appropriations for various state departments and agencies for the fiscal year ending September 30, 2011; and to provide for the expenditure of the appropriations.

The bill was read a first and second time by title and referred to the Committee on Appropriations.

Senator Emmons introduced

Senate Bill No. 684, entitled

A bill to amend 1915 PA 123, entitled "An act to provide for the recording and use in evidence of affidavits affecting real property; and to provide a penalty for the making of false affidavits," (MCL 565.451a to 565.453) by adding section 1d.

The bill was read a first and second time by title and referred to the Committee on Local Government and Elections.

Senators Proos, Pavlov, Rocca, Jones, Moolenaar, Jansen, Hansen, Brandenburg, Marleau and Kowall introduced

Senate Bill No. 685, entitled

A bill to amend 1994 PA 451, entitled "Natural resources and environmental protection act," by amending section 40114 (MCL 324.40114), as amended by 2010 PA 87.

The bill was read a first and second time by title and referred to the Committee on Outdoor Recreation and Tourism.

Senators Anderson, Gregory, Hunter, Smith, Bieda, Young, Hopgood, Whitmer, Hood, Rocca, Jones, Brandenburg, Nofs, Colbeck, Kowall, Marleau, Gleason and Green introduced

Senate Bill No. 686, entitled

A bill to amend 1967 PA 281, entitled "Income tax act of 1967," by amending section 30 (MCL 206.30), as amended by 2011 PA 38.

The bill was read a first and second time by title and referred to the Committee on Reforms, Restructuring and Reinventing.

Senators Booher, Jones and Hansen introduced

Senate Bill No. 687, entitled

A bill to amend 2001 PA 142, entitled "Michigan memorial highway act," (MCL 250.1001 to 250.2080) by adding section 71.

The bill was read a first and second time by title and referred to the Committee on Transportation.

Senator Schuitmaker introduced

Senate Bill No. 688, entitled

A bill to amend 1931 PA 328, entitled "The Michigan penal code," by amending section 423 (MCL 750.423).

The bill was read a first and second time by title and referred to the Committee on Judiciary.

Senator Schuitmaker introduced

Senate Bill No. 689, entitled

A bill to amend 1961 PA 236, entitled "Revised judicature act of 1961," by amending section 2102 (MCL 600.2102) and by adding chapter 21A.

The bill was read a first and second time by title and referred to the Committee on Judiciary.

Senator Hunter introduced

Senate Bill No. 690, entitled

A bill to amend 1961 PA 236, entitled "Revised judicature act of 1961," by amending section 3205c (MCL 600.3205c), as added by 2009 PA 31.

The bill was read a first and second time by title and referred to the Committee on Banking and Financial Institutions.

House Bill No. 4683, entitled

A bill to amend 1986 PA 32, entitled "Emergency 9-1-1 service enabling act," by amending section 405 (MCL 484.1405), as amended by 2007 PA 165.

The House of Representatives has passed the bill and ordered that it be given immediate effect.

The bill was read a first and second time by title and referred to the Committee on Energy and Technology.

House Bill No. 4770, entitled

A bill to prohibit public employers from providing certain benefits to public employees.

The House of Representatives has passed the bill and ordered that it be given immediate effect.

The bill was read a first and second time by title and referred to the Committee on Reforms, Restructuring and Reinventing.

House Bill No. 4771, entitled

A bill to amend 1947 PA 336, entitled "An act to prohibit strikes by certain public employees; to provide review from disciplinary action with respect thereto; to provide for the mediation of grievances and the holding of elections; to declare and protect the rights and privileges of public employees; to require certain provisions in collective bargaining agreements; and to prescribe means of enforcement and penalties for the violation of the provisions of this act," by amending section 15 (MCL 423.215), as amended by 2011 PA 103.

The House of Representatives has passed the bill and ordered that it be given immediate effect.

The bill was read a first and second time by title and referred to the Committee on Reforms, Restructuring and Reinventing.

House Bill No. 4929, entitled

A bill to amend 1947 PA 336, entitled "An act to prohibit strikes by certain public employees; to provide review from disciplinary action with respect thereto; to provide for the mediation of grievances and the holding of elections; to declare and protect the rights and privileges of public employees; to require certain provisions in collective bargaining agreements; and to prescribe means of enforcement and penalties for the violation of the provisions of this act," by amending section 10 (MCL 423.210).

The House of Representatives has passed the bill and ordered that it be given immediate effect.

The bill was read a first and second time by title and referred to the Committee on Reforms, Restructuring and Reinventing.

Committee Reports

The Committee on Economic Development reported

House Bill No. 4452, entitled

A bill to amend 1936 (Ex Sess) PA 1, entitled "Michigan employment security act," by amending section 27 (MCL 421.27), as amended by 2011 PA 14.

With the recommendation that the substitute (S-1) be adopted and that the bill then pass.

The committee further recommends that the bill be given immediate effect.

Michael W. Kowall
Chairperson

To Report Out:
Yeas: Senators Kowall, Hildenbrand, Nofs, Emmons, Hansen, Hunter and Smith
Nays: None
The bill and the substitute recommended by the committee were referred to the Committee of the Whole.

COMMITTEE ATTENDANCE REPORT

The Subcommittee on K-12, School Aid, Education submitted the following:
Joint meeting held on Thursday, September 15, 2011, at 8:00 a.m., Room 519, South Tower, House Office Building
Present: Senators Walker (C), Caswell and Pappageorge
Excused: Senator Hopgood

COMMITTEE ATTENDANCE REPORT

The Committee on Natural Resources, Environment and Great Lakes submitted the following:
Meeting held on Thursday, September 15, 2011, at 8:30 a.m., Room 210, Farnum Building
Present: Senators Casperson (C), Pavlov, Kowall, Meekhof and Warren
Excused: Senators Green and Hood

COMMITTEE ATTENDANCE REPORT

The Joint Committee on Administrative Rules submitted the following:
Meeting held on Thursday, September 15, 2011, at 9:00 a.m., Room 426, Capitol Building
Present: Senators Pappageorge (C) and Marleau
Absent: Senators Meekhof, Hunter and Johnson

Scheduled Meetings

Appropriations - Wednesday, September 21, 2:00 p.m., Senate Appropriations Room, 3rd Floor, Capitol Building (373-1760)

Subcommittees -

Capital Outlay - Thursday, September 22, 9:00 a.m., Room 426, Capitol Building (373-8080)

Human Services Department - Thursday, September 29, 9:00 a.m., Senate Hearing Room, Ground Floor, Boji Tower (373-2768)

Human Services Department; Families, Seniors and Human Services; House Human Services Appropriations Subcommittee; and House Families, Children, and Seniors - Thursdays, September 22 and October 6, 8:00 a.m., House Appropriations Room, 3rd Floor, Capitol Building (373-2768)

Judiciary - Wednesday, September 21, 8:00 a.m., Room 210, Farnum Building (373-2768)

Economic Development - Wednesday, September 21, 1:30 p.m., Room 110, Farnum Building (373-5312)

Education - Wednesday, September 21, 12:00 noon, Senate Hearing Room, Ground Floor, Boji Tower (373-5314)

Families, Seniors and Human Services; Human Services Department Appropriations Subcommittee; House Families, Children, and Seniors; and House Human Services Appropriations Subcommittee - Thursdays, September 22 and October 6, 8:00 a.m., House Appropriations Room, 3rd Floor, Capitol Building (373-5312)

Finance - Wednesday, September 21, 12:30 p.m., Room 210, Farnum Building (373-5307)

Legislative Council - Thursday, September 22, 8:45 a.m., Senate Appropriations Room, 3rd Floor, Capitol Building (373-0212)

Legislative Retirement Board of Trustees -

Subcommittee -

Investment - Friday, September 23, 1:00 p.m., Room H-65, Capitol Building (373-0575)

Local Government and Elections - Wednesday, September 21, 3:00 p.m., Room 100, Farnum Building (373-5323)

Outdoor Recreation and Tourism - Thursday, September 22, 12:30 p.m., Room 210, Farnum Building (373-5323)

Regulatory Reform - Thursday, September 22, 12:30 p.m., Room 110, Farnum Building (373-5307)

Senate Fiscal Agency Board of Governors - Thursday, September 22, 9:00 a.m., Room S-324, Capitol Building (373-2768)

State Drug Treatment Court Advisory Committee - Tuesday, September 27, 9:30 a.m., Legislative Council Conference Room, 3rd Floor, Boji Tower (373-0212)

Senator Meekhof moved that the Senate adjourn.
The motion prevailed, the time being 10:31 a.m.

The President, Lieutenant Governor Calley, declared the Senate adjourned until Wednesday, September 21, 2011, at 10:00 a.m.

CAROL MOREY VIVENTI
Secretary of the Senate