HOUSE BILL No. 4167

February 5, 2003, Introduced by Rep. Stewart and referred to the Committee on Insurance.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 501, 503, 2059, 2212b, 2213, 2403, 2406, 2418, 2420, 3406f, 3539, 5104, and 7705 (MCL 500.501, 500.503, 500.2059, 500.2212b, 500.2213, 500.2403, 500.2406, 500.2418, 500.2420, 500.3406f, 500.3539, 500.5104, and 500.7705), sections 501 and 503 as added by 2001 PA 24, section 2059 as amended by 1986 PA 253, section 2212b as amended by 2000 PA 486, section 2213 as amended by 2002 PA 707, sections 2403, 2406, 2418, and 2420 as amended by 1993 PA 200, section 3406f as added by 1996 PA 517, section 3539 as added by 2000 PA 252, section 5104 as amended by 1999 PA 211, and section 7705 as amended by 1996 PA 548, and by adding chapters 36A and 37; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

HOUSE BILL No. 4167

Sec. 501. (1) This chapter applies to the treatment of nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes from licensees whether through an individual or group plan. This chapter does not apply to information about companies or about individuals who obtain products or services for business, commercial, or agricultural purposes.

(2) This chapter does not modify, limit, or supersede any provision of section 1243.

(3) This chapter does not modify, limit, or supersede statute or rules governing the confidentiality or privacy of individually identifiable health and medical information, including, but not limited to, all of the following:

(a) Section 2157 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2157.

(b) Section ~~1750~~ **750** of the mental health code, 1974 PA 258, MCL 330.1750.

(c) The public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

~~(d) Section 406 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1406.~~

(d) ~~(e)~~ Sections 410 and ~~492A~~ **492a** of the Michigan penal code, 1931 PA 328, MCL 750.410 and 750.492a.

(e) ~~(f)~~ Section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

(f) ~~(g)~~ Section 34 of the third party administrator act,

1984 PA 218, MCL 550.934.

Sec. 503. As used in this chapter:

(a) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(b) "Annual notice" means the privacy notice required in section 513.

(c) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

(d) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(e) "Company" means any corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization.

(f) "Consumer" means an individual, or the individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes. As used in this chapter:

(*i*) "Consumer" includes, but is not limited to, all of the following:

(A) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment, or economic advisory services relating to

an insurance product or service. An individual is a consumer under this subparagraph regardless of whether the licensee establishes an ongoing advisory relationship.

(B) An applicant for insurance prior to the inception of insurance coverage.

(C) An individual that a licensee discloses nonpublic, personal financial information about to a nonaffiliated third party other than as permitted under sections 535, 537, and 539, if the individual is any of the following:

(I) A beneficiary of a life insurance policy underwritten by the licensee.

(II) A claimant under an insurance policy issued by the licensee.

(III) An insured under an insurance policy or an annuitant under an annuity issued by the licensee.

(IV) A mortgagor of a mortgage covered under a mortgage insurance policy.

(*ii*) So long as the licensee provides the initial, annual, and revised notices under this chapter to the plan sponsor, group or blanket insurance policyholders, and group annuity contract holder and does not disclose to a nonaffiliated third party nonpublic personal financial information other than as permitted under sections 535, 537, and 539, "consumer" does not include an individual solely because he or she meets 1 of the following:

(A) Is a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary.

(B) Is covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(*iii*) "Consumer" does not include an individual solely because he or she meets 1 of the following:

(A) Is a beneficiary of a trust for which the licensee is a trustee.

(B) Has designated the licensee as trustee for a trust.

(g) "Consumer reporting agency" has the same meaning as in section 603(f) of the ~~federal~~ fair credit reporting act, title VI of the consumer credit **protection** act, Public Law 90-321, 15 U.S.C. 1681a.

(h) "Customer" means a consumer who has a customer relationship with a licensee. However, customer does not include an individual solely because he or she meets 1 of the following:

(*i*) Is a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary.

(*ii*) Is covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(*iii*) Is a beneficiary or claimant under a policy of insurance.

(i) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides 1 or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

(j) "Initial notice" means the privacy notice required in

section 507.

(k) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state or pursuant to a federal insurance program. Insurance service includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

(*l*) "Licensee" means a licensed insurer or producer, and other persons licensed or required to be licensed, authorized or required to be authorized, registered or required to be registered, or holding or required to hold a certificate of authority under this act. Licensee includes, except as otherwise provided, ~~a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, and~~ a nonprofit dental care corporation operating pursuant to 1963 PA 125, MCL 550.351 to 550.373. Licensee includes an unauthorized insurer who places business through a licensed surplus line agent or broker in this state, but only for the surplus line placements placed under chapter 19. Licensee does not include any of the following:

~~(*i*) A nonprofit health care corporation for member personal data and information otherwise protected under section 406 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1406.~~

(*i*) ~~(*ii*)~~ The Michigan life and health guaranty association and the property and casualty guaranty association.

(*ii*) ~~(*iii*)~~ The Michigan automobile insurance placement facility, the Michigan worker's compensation placement facility, and the assigned claims facility created under section 3171. However, servicing carriers for these facilities are licensees.

(m) "Nonaffiliated third party" means any person except a licensee's affiliate or a person employed jointly by a licensee and any company that is not the licensee's affiliate. Nonaffiliated third party includes the other company that jointly employs a person with a licensee. Nonaffiliated third party also includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) of the bank holding company act of 1956, chapter 240, 70 Stat. 135, 12 U.S.C. 1843, or insurance company investment activities of the type described in section 4(k)(4)(I) of the bank holding company act of 1956, chapter 240, 70 Stat. 135, 12 U.S.C. 1843.

(n) "Nonpublic personal financial information" means personally identifiable financial information and any list, description, or other grouping of consumers and publicly available information pertaining to them that is derived using any personally identifiable financial information that is not publicly available. Nonpublic personal financial information does not include any of the following:

(*i*) Health and medical information otherwise protected by state or federal law.

(*ii*) Publicly available information.

(*iii*) Any list, description, or other grouping of consumers and publicly available information pertaining to them that is derived without using any personally identifiable financial information that is not publicly available.

(o) "Opt out" means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by sections 535, 537, and 539.

(p) "Personally identifiable financial information" means any of the following:

(*i*) Information a consumer provides to a licensee to obtain an insurance product or service from the licensee.

(*ii*) Information about a consumer resulting from any transaction involving an insurance product or service between a licensee and a consumer.

(*iii*) Information the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

(q) "Producer" means a person required to be licensed under this act to sell, solicit, or negotiate insurance.

(r) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records by wide distribution by the media or by disclosures to the general public that are required to be made by federal, state, or local law. A licensee has a reasonable basis

to believe that information is lawfully made available to the general public if both of the following apply:

(*i*) The licensee has taken steps to determine that the information is of the type that is available to the general public.

(*ii*) If an individual can direct that the information not be made available to the general public, that the licensee's consumer has not directed that the information not be made available to the general public.

(s) "Revised notice" means the privacy notice required in section 525.

Sec. 2059. (1) ~~No~~ **A** person shall **not** maintain or operate any office in this state for the transaction of the business of insurance, except as provided for in this ~~code~~ **act**, or use the name of any insurer, fictitious or otherwise, in conducting or advertising any business not related or connected with the business of insurance as governed by the provisions of this ~~code~~ **act** except as otherwise provided in subsection (2).

(2) Subsection (1) shall not be construed to prohibit an agent licensed under chapter 12 from marketing or transacting any of the following:

(a) Subject to the health benefit agent act, health care coverage provided by a ~~health care corporation regulated pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws~~ **nonprofit health insurer under chapter 37**.

(b) Subject to the health benefit agent act, health care coverage provided by a health maintenance organization regulated ~~pursuant to part 210 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.21001 to 333.21098 of the Michigan Compiled Laws~~ **under chapter 35**.

(c) Subject to the health benefit agent act, dental care coverage provided by a dental care corporation regulated pursuant to ~~Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws~~ **1963 PA 125, MCL 550.351 to 550.373**.

(d) Administrative services of a third party administrator regulated pursuant to the third party administrator act, ~~Act No. 218 of the Public Acts of 1984, being sections 550.901 to 550.962 of the Michigan Compiled Laws~~ **1984 PA 218, MCL 550.901 to 550.960**.

Sec. 2212b. (1) This section applies to a policy or certificate issued under section 3405 or 3631**, to a certificate issued under chapter 37,** and to a health maintenance organization contract.

(2) If participation between a primary care physician and an insurer terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each insured who has chosen the physician as his or her primary care physician. If an insured is in an ongoing course of treatment with any other physician that is participating with the insurer and the participation between the physician and the insurer terminates, the physician may provide

written notice of this termination to the insured within 15 days after the physician becomes aware of the termination. The notices under this subsection may also describe the procedure for continuing care under subsections (3) and (4).

(3) If participation between an insured's current physician and an insurer terminates, the insurer shall permit the insured to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days from the date of notice to the insured by the physician of the physician's termination with the insurer.

(b) If the insured is in her second or third trimester of pregnancy at the time of the physician's termination, through postpartum care directly related to the pregnancy.

(c) If the insured is determined to be terminally ill prior to a physician's termination or knowledge of the termination and the physician was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the insured's life for care directly related to the treatment of the terminal illness.

(4) Subsection (3) applies only if the physician agrees to all of the following:

(a) To continue to accept as payment in full reimbursement from the insurer at the rates applicable prior to the termination.

(b) To adhere to the insurer's standards for maintaining quality health care and to provide to the insurer necessary medical information related to the care.

(c) To otherwise adhere to the insurer's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations, and treatment plans.

(5) An insurer shall provide written notice to each participating physician that if participation between the physician and the insurer terminates, the physician may do both of the following:

(a) Notify the insurer's insureds under the care of the physician of the termination if the physician does so within 15 days after the physician becomes aware of the termination.

(b) Include in the notice under subdivision (a) a description of the procedures for continuing care under subsections (3) and (4).

(6) This section does not create an obligation for an insurer to provide to an insured coverage beyond the maximum coverage limits permitted by the insurer's policy or certificate with the insured. This section does not create an obligation for an insurer to expand who may be a primary care physician under a policy or certificate.

(7) As used in this section:

(a) "Physician" means an allopathic physician, osteopathic physician, or podiatric physician.

~~(b) "Terminal illness" means that term as defined in section 5653 of the public health code, 1978 PA 368, MCL 333.5653.~~

(b) ~~(c)~~ "Terminates" or "termination" includes the nonrenewal, expiration, or ending for any reason of a

participation agreement or contract between a physician and an insurer, but does not include a termination by the insurer for failure to meet applicable quality standards or for fraud.

Sec. 2213. (1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, ~~or~~ 36**, or 37** that includes all of the following:

(a) Provides for a designated person responsible for administering the grievance system.

(b) Provides a designated person or telephone number for receiving complaints.

(c) Ensures full investigation of a complaint.

(d) Provides for timely notification in plain English to the insured or enrollee as to the progress of an investigation.

(e) Provides an insured or enrollee the right to appear before the board of directors or designated committee or the right to a managerial-level conference to present a grievance.

(f) Provides for notification in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation and for advisement of the insured's or enrollee's right to review the grievance by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) Provides summary data on the number and types of

complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(h) Provides for periodic management and governing body review of the data to assure that appropriate actions have been taken.

(i) Provides for copies of all complaints and responses to be available at the principal office of the insurer or health maintenance organization for inspection by the commissioner for 2 years following the year the complaint was filed.

(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.

(*l*) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after

receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health

care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(*i*) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

(*iii*) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

Sec. 2403. (1) All rates shall be made in accordance with this section and all of the following:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state; to catastrophe

hazards; to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses, both countrywide and those specially applicable to this state; to underwriting practice, judgment, and to all other relevant factors within and outside this state. For worker's compensation insurance, in determining the reasonableness of the margin for underwriting profit and contingencies, consideration shall be given to all after-tax investment profit or loss from unearned premium and loss reserves attributable to worker's compensation insurance, as well as the factors used to determine the amount of reserves. For all other kinds of insurance to which this chapter applies, all factors to which due consideration is given under this subdivision shall be treated in a manner consistent with the laws of this state that existed on December 28, 1981.

(b) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that measure variations in hazards,

expense provisions, or both. The rating plans may measure any differences among risks that may have a probable effect upon losses or expenses as provided for in subdivision (a).

(d) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist with respect to the classification, kind, or type of risks to which the rate is applicable. Except as otherwise provided in this subdivision, a rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. For commercial liability insurance a rate shall not be held to be inadequate unless the rate, after consideration of investment income and marketing programs and underwriting programs, is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of

applicants who are in good faith entitled to procure the insurance through ordinary methods. As used in this subdivision, "commercial liability insurance" means insurance that provides indemnification for commercial, industrial, professional, or business liabilities. For worker's compensation insurance provided by an insurer that is controlled by a ~~nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws~~ **nonprofit health insurer regulated under chapter 37**, a rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided. A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage, if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because the rate reflects differences in expenses for individuals or risks with similar anticipated losses, or because the rate reflects differences in losses for individuals or risks with similar expenses. Rates are not unfairly discriminatory if they are averaged broadly among persons insured

on a group, franchise, blanket policy, or similar basis.

(2) Except to the extent necessary to meet the provisions of subsection (1)(d), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

Sec. 2406. (1) Except for worker's compensation insurance, every insurer shall file with the commissioner every manual of classification, every manual of rules and rates, every rating plan, and every modification of any of the foregoing that it proposes to use. Every such filing shall state the proposed effective date ~~thereof~~ **of the filing** and shall indicate the character and extent of the coverage contemplated. If a filing is not accompanied by the information upon which the insurer supports the filing, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall within 10 days of the filing give written notice to the insurer to furnish the information upon which it supports the filing. The information furnished in support of a filing may include the experience or judgment of the insurer or rating organization making the filing, its interpretation of any statistical data it relies upon, the experience of other insurers or rating organizations, or any other relevant factors. A filing and any supporting information shall be open to public inspection after the filing becomes effective.

(2) Except for worker's compensation insurance, an insurer may satisfy its obligation to make such filings by becoming a

member of, or a subscriber to, a licensed rating organization that makes such filings, and by filing with the commissioner a copy of its authorization of the rating organization to make such filings on its behalf. Nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(3) For worker's compensation insurance in this state the insurer shall file with the commissioner all rates and rating systems. Every insurer that insures worker's compensation in this state on the effective date of this subsection shall file the rates not later than the effective date of this subsection.

(4) Except as provided in subsection (3) and as otherwise provided in this subsection, the rates and rating systems for worker's compensation insurance shall be filed not later than the date the rates and rating systems are to be effective. However, if the insurer providing worker's compensation insurance is controlled by a ~~nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws~~ **nonprofit health insurer regulated under chapter 37**, the rates and rating systems that it proposes to use shall be filed with the commissioner not less than 45 days before the effective date of the filing. These filings shall be considered to meet the requirements of this chapter unless and until the commissioner disapproves a filing pursuant to section 2418 or 2420.

(5) Each filing under subsections (3) and (4) shall be

accompanied by a certification by the insurer that, to the best of its information and belief, the filing conforms to the requirements of this chapter.

Sec. 2418. If at any time after approval of any filing either by act or order of the commissioner or by operation of law, or before approval of a filing made by a worker's compensation insurer controlled by a ~~nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws~~ **nonprofit health insurer regulated under chapter 37**, the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than 10 days' written notice, specifying the matters to be considered at the hearing, to every insurer and rating organization that made the filing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this chapter, and stating for a filing that has gone into effect when, within a reasonable period thereafter, that filing shall be considered no longer effective. Copies of the order shall be sent to every such insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Sec. 2420. (1) Any person or organization aggrieved with respect to any filing that is in effect may apply in writing to the commissioner for a hearing on the filing. The application

shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, and that the grounds otherwise justify holding a hearing, the commissioner shall, within 30 days after receipt of the application, hold a hearing upon not less than 10 days' written notice to the applicant and to every insurer and rating organization that made the filing.

(2) If, after a hearing under subsection (1), the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying in what respects he or she finds that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing shall be considered no longer effective. Copies of the order shall be sent to the applicant and to every insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(3) Upon receipt of a rate or rating system filing by an insurer providing worker's compensation insurance that is controlled by a ~~nonprofit health care corporation formed pursuant to the nonprofit health care corporation act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws~~ **nonprofit health insurer regulated under chapter 37**, the commissioner shall immediately notify each person of the filing who has requested in writing notice of the filing within the 2 years immediately preceding the

filing. Notice to the person shall identify the location, time, and place where a copy of the filing will be open to public inspection and copying. The filing shall become effective on the filing's proposed effective date unless stayed or disapproved by the commissioner. An aggrieved person, which shall include any insurer transacting worker's compensation insurance in this state and any person acting on behalf of 1 or more such insurers, who claims a rate in the filing is inadequate is entitled to a contested case hearing pursuant to the administrative procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws~~ **1969 PA 306, MCL 24.201 to 24.328**. The request for this hearing shall be filed with the commissioner within 30 days of the date of the filing alleged to contain inadequate rates and shall state the grounds upon which a rate contained in the filing is alleged to be inadequate. The notice of hearing shall be served upon the insurer and shall state the time and place of the hearing and the grounds upon which the rate is alleged to be inadequate. Unless mutually agreed upon by the commissioner, the insurer, and the aggrieved person, the hearing shall occur not less than 15 days or more than 30 days after notice is served. Within 10 days of receipt of the request for hearing, the commissioner shall issue an order staying the use of any rate alleged to be inadequate and with respect to which, on the basis of affidavits and pleadings submitted by the aggrieved person and the insurer, it appears likely that the aggrieved person will prevail in the hearing. The nonprevailing party shall have the right to an interlocutory

appeal to circuit court of the commissioner's decision granting or denying the stay, and the court shall review de novo the commissioner's decision.

(4) An insurer or rating organization shall not use this section to obtain a hearing with the commissioner on the insurer's or rating organization's own filing.

Sec. 3406f. (1) An insurer may exclude or limit coverage for a condition as follows:

(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b), ~~or (c),~~ only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

~~(b) For an individual covered under a group policy or certificate covering 2 to 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.~~

(b) ~~(c)~~ For an individual covered under a group policy or certificate covering **100 or** more ~~than 50 individuals~~ **eligible employees**, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment

was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

(2) As used in this section: ~~, "group"~~

(a) "Eligible employee" means that term as defined in section 3663.

(b) "Group" means a group health plan as defined in section 2791(a)(1) and (2) of part C of title XXVII of the public health service act, chapter 373, 110 Stat. 1972, 42 U.S.C. 300gg-91, and includes government plans that are not federal government plans.

(3) This section applies only to an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate. This section does not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, or 1-time limited duration policy or certificate of no longer than 6 months.

~~(4) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by preexisting condition limitations or exclusions under subsection (1)(a), (b), and (c) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit~~

~~prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:~~

~~(a) Cost of crediting prior continuous health care coverages.~~

~~(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.~~

~~(c) Types and scope of prior health care coverages that are permitted to be credited.~~

~~(d) Any exceptions or exclusions to crediting prior health care coverage.~~

~~(e) Uniform method of certifying periods of prior creditable coverage.~~

Sec. 3539. (1) For an individual covered under a nongroup contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.

(2) A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract.

(3) Except as provided in subsection (5), a health maintenance organization that has issued a nongroup contract

shall renew or continue in force the contract at the option of the individual.

(4) Except as provided in subsection (5), a health maintenance organization that has issued a group contract shall renew or continue in force the contract at the option of the sponsor of the plan.

(5) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(6) As used in this section, "group" means a group of ~~2~~ **100** or more ~~subscribers~~ **eligible employees as defined in section 3663**.

CHAPTER 36A

SMALL EMPLOYER HEALTH INSURANCE

Sec. 3663. As used in this chapter:

(a) "Actuarial certification" means a written statement signed by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 3667 based upon the person's examination and including a review of the appropriate records and actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

(b) "Adjusted community rating" means a method used to develop a carrier's premium that spreads financial risk in

accordance with the requirements in section 3667.

(c) "Affiliation period" means a period of time required by a small employer carrier that must expire before health insurance coverage becomes effective.

(d) "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit health insurer, or any other entity providing a plan of health insurance, health benefits, or health services.

(e) "COBRA" means the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82.

(f) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(*i*) A group health plan including coverage provided to an eligible sole proprietor.

(*ii*) A health benefit plan.

(*iii*) Part A or part B of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395c to 1395i and 1395i-2 to 1395i-5, and 42 U.S.C. 1395j to 1395t, 1395u to 1395w, and 1395w-2 to 1395w-4.

(*iv*) Title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v, other than coverage consisting solely of benefits under section 1929 of

title XIX of the social security act, 42 U.S.C. 1396t.

(*v*) Chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1110. For purposes of chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1110, "uniformed services" means the armed forces and the commissioned corps of the national oceanic and atmospheric administration and of the public health service.

(*vi*) A medical care program of the Indian health service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under the employees health benefits program, chapter 89 of title 5 of the United States Code, 5 U.S.C. 8901 to 8914.

(*ix*) A public health plan, which for purposes of this chapter means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan.

(*x*) A health benefit plan under section 5(e) of title I of the peace corps act, Public Law 87-293, 22 U.S.C. 2504.

(g) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of anywhere between at least 17.5 and 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all of the employer's employees and without regard to health status-related factors. Persons covered under a health benefit plan pursuant to COBRA are

not eligible employees for purposes of minimum participation requirements pursuant to section 3679.

(h) "Eligible sole proprietor" means a person who is a sole proprietor, sole shareholder, or partner in a trade or business through which the sole proprietor attempts to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule c or f, for the previous taxable year; who is a resident of this state on the date of enrollment; and who is actively employed in the operation of the business, working at least 30 hours per week, at least 6 months out of the calendar year.

(i) "Enrollment date" means the date on which the group contract goes into effect.

(j) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(k) "Family composition" means any of the following:

(*i*) Enrollee.

(*ii*) Enrollee, spouse, and children.

(*iii*) Enrollee and spouse.

(*iv*) Enrollee and children.

(*v*) Child only.

(*l*) "Genetic information" means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory

tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

(m) "Geographic area" is an area established by the small group carrier and approved by the commissioner and used for adjusting the rates for a health benefit plan.

(n) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C. 1002, to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. As used in this chapter, all of the following apply to the term group health plan:

(*i*) Any plan, fund, or program that would not be, but for section 2721(e) of subpart 4 of part A of title XXVII of the public health service act, chapter 373, 110 Stat. 1967, 42 U.S.C. 300gg-21, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to subparagraph (*ii*), as an employee welfare benefit plan that is a group health plan.

(*ii*) For a group health plan, the term "employer" also includes the partnership in relation to any partner.

(*iii*) For a group health plan, the term "participant" also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to receive a benefit under the plan, if in connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership or in connection with a group health plan maintained by a self-employed individual, under which 1 or more employees are participants, the individual is the self-employed individual.

(o) "Health benefit plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Except as otherwise specifically exempted in this definition, health benefit plan includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis. Health benefit plan does not include any of the following:

(*i*) Accident-only, credit-only, or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; worker's compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; and other similar insurance coverage, specified in federal regulations

issued pursuant to the health insurance portability and accountability act of 1996, Public Law 104-191, 110 Stat. 1936, under which benefits for medical care are secondary or incidental to other insurance benefits.

(*ii*) If provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of a plan: limited benefit health insurance; limited scope dental or visions benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar, limited benefits specified in federal regulations issued pursuant to the health insurance portability and accountability act of 1996, Public Law 104-191, 110 Stat. 1936.

(*iii*) If the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance.

(*iv*) If offered as a separate policy, certificate, or contract of insurance: medicare supplemental policy as defined under section 1882(g)(1) of title XVIII of the social security act, 42 U.S.C. 1395ss; coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code,

10 U.S.C. 1071 to 1110; or similar supplemental coverage provided to coverage under a group health plan.

(p) "Health status-related factor" means any of the following:

(*i*) Health status.

(*ii*) Medical condition, including both physical and mental illnesses.

(*iii*) Claims experience.

(*iv*) Receipt of health care.

(*v*) Medical history.

(*vi*) Genetic information.

(*vii*) Evidence of insurability, including conditions arising out of acts of domestic violence.

(*viii*) Disability.

(q) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least 30 days. Late enrollee does not include an eligible employee or dependent who meets any of the following:

(*i*) The individual was covered under creditable coverage at the time of the initial enrollment; lost coverage under creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce, or legal

separation; and the individual requests enrollment within 30 days after termination of the creditable coverage or the change in conditions that gave rise to the termination of coverage.

(*ii*) If, where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period.

(*iii*) If the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(*iv*) If a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(*v*) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within 30 days after the change in status.

(*vi*) If the individual had coverage under a continuation provision under the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, and the coverage under that provision has been exhausted.

(*vii*) If the individual meets the requirements for special enrollment pursuant to section 3677.

(r) "Limited benefit health insurance" means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for 1 or more named conditions, named diseases, or accidental injury.

(s) "Medical care" means amounts paid for the diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; transportation primarily for and essential to this care; and insurance covering this care.

(t) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

(u) "Plan sponsor" means that term as defined under section 3(16)(b) of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C. 1002.

(v) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months preceding the enrollment date of the coverage. Preexisting condition does not include a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the plan, provided that the prior creditable coverage was continuous to a date not more than 90 days before the enrollment date of the new coverage. Genetic information shall not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

(w) "Premium" means all money paid by a small employer, eligible employees, or eligible persons as a condition of receiving coverage from a carrier subject to this chapter, including any fees or other contributions associated with the health benefit plan.

(x) "Producer" or "insurance producer" means that term as defined in section 1201.

(y) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(z) "Small employer" means any person that is actively engaged in business that on at least 50% of its working days during the preceding calendar year employed no more than 99 eligible employees, the majority of whom were employed within this state; is not formed primarily for purposes of buying health insurance; and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered 1 employer. After the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan

anniversary following the date the small employer no longer meets the requirements of the definition of small employer. Small employer includes an eligible sole proprietor. Small employer includes any person that is actively engaged in business that on at least 50% of its working days during the preceding calendar quarter employed a combination of no more than 99 eligible employees and part-time employees, the majority of whom were employed within this state; is not formed primarily for purposes of buying health insurance; and in which a bona fide employer-employee relationship exists.

(aa) "Small employer carrier" means a carrier that issues or offers to issue health benefit plans covering eligible employees of 1 or more small employers pursuant to this chapter, regardless of whether coverage is offered through an association or trust or whether the policy or contract is situated out of state.

(bb) "Waiting period" means, with respect to a group health plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to section 3674, a waiting period shall not be considered a gap in coverage.

Sec. 3665. This chapter applies to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following are met:

(a) A portion of the premium or benefits is paid by or on behalf of the small employer.

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for a portion of the premium.

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the internal revenue code of 1986.

(d) The health benefit plan is marketed to individual employees through an employer.

Sec. 3667. (1) Premium rates for health benefit plans subject to this chapter are subject to all of the following:

(a) The small employer carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for geographic area, family composition, and age.

(b) The adjustment for age pursuant to subdivision (a) shall not use age brackets smaller than 5-year increments. The age brackets shall not begin before age 20 and shall end with age 65.

(c) A small employer carrier may charge the lowest allowable adult rate for child only coverage.

(d) A small employer carrier may develop separate rates for individuals age 65 or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates are otherwise subject to this subsection.

(e) Effective 5 years after the effective date of this chapter, the adjustments for age pursuant to subdivision (a)

shall not result in a rate per enrollee for the health benefit plan of more than 200% of the lowest rate for all adult age groups. During the first 2 years after the effective date of this chapter, the permitted rates for any age group shall be no more than 400% of the lowest rate for all adult age groups, and effective 2 years after the effective date of this chapter, the permitted rates for any age group shall be no more than 300% of the lowest rate for all adult age groups.

(2) The premium charged for a health benefit plan shall not be adjusted more frequently than annually except that the rates may be changed to reflect changes to the enrollment of the small employer, changes to the family composition of the employee or eligible person, or changes to the health benefit plan requested by the small employer.

(3) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to health plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

Sec. 3669. In connection with the offering for sale of a health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates.

(b) The provisions relating to renewability of policies and

contracts.

(c) The provisions relating to any preexisting condition provision.

(d) A listing of, and descriptive information including benefits and premiums about, all benefit plans for which the small employer is qualified.

Sec. 3671. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier that is not required to file small group rates for approval by the commissioner shall file with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

Sec. 3673. A small employer carrier shall renew small employer health benefit plans as provided in sections 2213b and 3539 except that a small employer carrier may nonrenew a small employer health benefit plan for either of the following:

(a) Noncompliance with the carrier's minimum participation requirements.

(b) Noncompliance with the carrier's employer contribution requirements.

Sec. 3674. A period of creditable coverage shall not be counted for enrollment of an individual under a group health plan if, after this period and before the enrollment date, there was a 90-day period during all of which the individual was not covered under any creditable coverage.

Sec. 3675. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that small employer carrier. A small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter. A small employer carrier shall not offer or sell to small employers a health benefit plan that excludes or limits coverage for a preexisting condition except as otherwise provided in subsection (3).

(2) A small employer carrier is not required to issue a health benefit plan to an eligible sole proprietor who is covered by, or is eligible for coverage under, a health benefit plan

offered by an employer.

(3) A small employer carrier may offer and sell a health benefit plan to an eligible sole proprietor that excludes or limits coverage for a preexisting condition as provided in this subsection. A health benefit plan covering an eligible sole proprietor shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than 6 months following the enrollment date of the individual's coverage due to a preexisting condition, or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 3663.

(4) A small employer carrier shall reduce the period of any preexisting condition exclusion allowed under subsection (3) without regard to the specific benefits covered during the period of creditable coverage by the aggregate of the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than 90 days before the enrollment date of new coverage. The aggregate period of creditable coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility.

(5) If applied uniformly to all employees of the small employer and without regard to any health status-related factor, a small employer carrier may impose for health plans offered to

all small employers other than sole proprietors an affiliation period that does not exceed 60 days for new entrants and does not exceed 90 days for late enrollees and for which the carrier charges no premiums and the coverage issued is not effective.

(6) A small employer carrier shall not offer or sell to small employers a health benefit plan that contains a waiting period applicable to new enrollees or late enrollees.

(7) A health benefit plan offered to a small employer by a small employer carrier shall provide for the acceptance of late enrollees subject to this chapter.

(8) A small employer carrier shall not impose a preexisting condition exclusion that relates to pregnancy as a preexisting condition or with regard to a child who is covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage and provided that the child was adopted or placed for adoption before attaining 18 years of age.

(9) A small employer carrier shall not impose a preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care, or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than 90 days before the enrollment date of the new coverage.

Sec. 3677. (1) A small employer carrier shall permit an

employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the small employer group health plan during a special enrollment period if all of the following apply:

(a) The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time.

(c) The employee's or dependent's coverage described in subdivision (a) was either under a COBRA continuation provision and that coverage has been exhausted or was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including because of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward that other coverage have been terminated. In either case, under the terms of the group health plan, the employee must request enrollment not later than 30 days after the date of exhaustion of coverage or

termination of coverage or employer contribution. If an employee requests enrollment pursuant to this subdivision, the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(2) A small employer carrier that makes dependent coverage available under a group health plan shall provide for a dependent special enrollment period during which the person may be enrolled under the group health plan as a dependent of the individual or, if not otherwise enrolled, the individual may be enrolled under the group health plan and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage. This subsection applies only if both of the following occur:

(a) The individual is a participant under the health benefit plan or has met any affiliation period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period.

(b) The person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) The dependent special enrollment period under subsection (2) for individuals shall be a period of not less than 30 days and begins on the later of the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption. If an individual seeks to enroll a

dependent during the first 30 days of the dependent special enrollment period under subsection (2), the coverage of the dependent shall be effective as follows:

(a) For marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

(b) For a dependent's birth, as of the date of birth.

(c) For a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Sec. 3679. (1) Except as provided in this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier shall not require a minimum participation level greater than 100% of eligible employees working for groups of 3 or fewer employees or greater than 75% of eligible employees working for groups with more than 3 employees.

(3) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall only consider those employees who do not have other group coverage available through their spouse or employees who have selected another

health benefit plan offered by their employer if the employer allows employees the choice of more than 1 health benefit plan.

(4) A small employer carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

Sec. 3681. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(2) A small employer carrier shall not place any restriction in regard to any health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

(3) Except as permitted under section 3675(3), a small employer carrier shall not modify a health benefit plan for a small employer or any eligible employee or dependent, through riders or endorsements, or otherwise, that restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 3683. (1) A small employer carrier is not required to offer coverage to a small employer if the small employer is not

physically located in the carrier's established geographic service area. A small employer carrier shall apply this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

(2) A small employer carrier is not required to provide coverage to small employers if for any period of time the commissioner determines the small employer carrier does not have the financial reserves necessary to underwrite additional coverage and the small employer carrier is applying this subsection uniformly to all small employers in the small group market, consistent with applicable state law, and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents. A small employer carrier that denies coverage under this subsection shall not offer coverage in the small group market for the later of a period of 180 days after the date the coverage is denied or until the small employer carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

(3) A small employer carrier is not required to provide new coverage to small employers if the small employer carrier elects not to offer new coverage to small employers in this state. However, a small employer carrier that elects not to offer new coverage to small employers under this subsection remains subject to sections 2213b and 3539. A small employer carrier that elects

not to offer new coverage to small employers shall provide notice of its election to the commissioner and shall not write new business in the small employer market in this state for a period of 5 years beginning on the date the carrier ceased offering new coverage in this state.

Sec. 3687. (1) A small employer carrier shall provide written certification of creditable coverage to individuals as follows:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision.

(b) For an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision.

(c) At the time a request is made on behalf of an individual if the request is made not later than 24 months after the date of cessation of coverage described in subdivision (a) or (b), whichever is later.

(2) A small employer carrier may provide the certification of creditable coverage required under subsection (1)(a) at a time consistent with notices required under any applicable COBRA continuation provision.

(3) The certificate of creditable coverage required to be provided under subsection (1) shall contain both of the following:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the

coverage, if any, under the applicable COBRA continuation provision.

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(4) To the extent medical care under a group health plan consists of group health insurance coverage, the plan has satisfied the certification requirement under subsection (1) if the health carrier offering the coverage provides for certification in accordance with subsection (1).

(5) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to section 3675 and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (1), on request of the group health plan, the entity that issued the certification to the individual shall promptly disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan. The entity providing this information may charge the requesting group health plan the reasonable cost of disclosing the information.

Sec. 3689. (1) Subject to section 3675(1) and (2), each small employer carrier shall actively market all health benefit plans sold by the carrier to eligible small employers in the state.

(2) Except as provided in subsection (3), a small employer carrier or producer shall not, directly or indirectly, do any of

the following:

(a) Encourage or direct small employers or individuals to refrain from filing an application for coverage with the small employer carrier because of any health status-related factor, industry, occupation, or geographic location of the small employer or individual.

(b) Encourage or direct small employers or individuals to seek coverage from another carrier because of any health status-related factor, industry, occupation, or geographic location of the small employer or individual.

(3) Subsection (2) does not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(4) A small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation, or geographic location of the small employer or individual. This subsection does not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage does not vary because of any health status-related factor, industry, occupation, or geographic area of the small employer or individual.

(5) A small employer carrier shall not terminate, fail to

renew, or limit its contract or agreement of representation with a producer for any reason related to an initial or renewal health status-related factor, occupation, or geographic location of the small employers or individuals placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer or individual shall be in writing and shall state the reason or reasons for the denial.

(8) The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) A small employer carrier shall not enter into a "noncompete" agreement with any person.

(10) If a small employer carrier enters into a contract, agreement, or other arrangement with a third party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third party administrator is subject to this chapter as if it were a small employer carrier.

Sec. 3691. The commissioner may require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this chapter,

to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier on or after January 1, 2003. The commissioner may prescribe, for the reissue of coverage, those terms the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

Sec. 3692. A violation of this chapter by a small employer carrier or a producer is an unfair trade practice under chapter 20.

CHAPTER 37

NONPROFIT HEALTH INSURER

PART 1

Sec. 3701. As used in this chapter:

(a) "Bargaining representative" means a representative designated or selected by a majority of employees for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment relative to the employees represented.

(b) "Certificate" means a contract between a nonprofit health insurer and a subscriber or a group of subscribers under which health care benefits are provided to members. A certificate includes the employer agreement or group agreement and any approved riders amending the certificate.

(c) "Collective bargaining agreement" means an agreement entered into between the employer and the bargaining representative of its employees, and includes those agreements entered into on behalf of groups of employers with the bargaining

representative of their employees pursuant to the national labor relations act, chapter 372, 49 Stat. 449, 29 U.S.C. 151 to 158 and 159 to 169, under 1939 PA 176, MCL 423.1 to 423.30, or under 1947 PA 336, MCL 423.201 to 423.217.

(d) "Health care benefit" means the right under a certificate to have payment made by a nonprofit health insurer for a specified health care service, regardless of whether or not the payment is made pursuant to an administrative services only or cost-plus arrangement.

(e) "Health care provider" means a health facility or person licensed, certified, or authorized to deliver health care services in accordance with state law.

(f) "Health care services" means services provided, ordered, or prescribed by a health care provider, including health and rehabilitative services and medical supplies, medical and rehabilitative services and medical supplies, medical prosthetics and devices, and medical services ancillary or incidental to the provision of those services.

(g) "Medium/large subscriber group" means an underwritten group of 100 or more subscribers.

(h) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

(i) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28,

1395x to 1395yy, and 1395bbb to 1395ggg.

(j) "Member" means a subscriber, a dependent of a subscriber, or any other individual entitled to receive health care benefits under a nongroup or group certificate.

(k) "Nongroup subscriber" means an individual subscriber who is not enrolled as a subscriber through any subscriber group.

(*l*) "Participating contract" means an agreement, contract, or other arrangement, including a prudent purchaser agreement, under which a health care provider agrees to accept the approved amount as determined by the nonprofit health insurer as payment in full for the rendering of health care services covered under a certificate.

(m) "Participating provider" means a health care provider that has entered into a participating contract with a nonprofit health insurer.

(n) "Personal data" means a document incorporating medical or surgical history, care, treatment, or service; or any similar record, including an automated or computer accessible record, relative to a member, which is maintained or stored by a nonprofit health insurer.

(o) "Proposed rate" means any of the following:

(*i*) A proposed increase or decrease in the rates to be charged to nongroup subscribers.

(*ii*) For group subscribers, any proposed changes in the methodology or definitions of any rating system, formula, component, or factor subject to prior approval by the commissioner.

(*iii*) A proposed increase or decrease in deductible amounts or coinsurance percentages.

(*iv*) A proposed extension of benefits, additional benefits, or a reduction or limitation in benefits.

(*v*) A review pursuant to section 3753(2).

(p) "Self-insured group" means a group whose contract with a nonprofit health insurer consists solely of an administrative services or cost-plus arrangement authorized under this chapter.

(q) "Small subscriber group" means an underwritten group of fewer than 100 subscribers.

(r) "Subscriber" means an individual who contracts for health care benefits, either individually or through a group, with a nonprofit health insurer. Subscriber includes an individual whose contract contains an administrative services only or cost-plus arrangement.

Sec. 3702. (1) Each nonprofit health care corporation operating under former 1980 PA 350 on the effective date of this chapter shall become a nonprofit health insurer subject to this chapter without formal reorganization under this chapter, and shall be considered to exist under this act. However, within 120 days following the effective date of this chapter, the nonprofit health insurer shall amend its articles of incorporation and bylaws to conform to the requirements of this chapter, subject to legal review by the attorney general and certification of the commissioner as provided in subsection (2) and shall obtain from the commissioner a new certificate of authority.

(2) Relative to the changes required by this chapter,

amendments to the articles and bylaws and a written description of the board restructuring shall be submitted to the attorney general for legal review and to the commissioner for approval. If the attorney general finds that the amendments and restructuring conform to all statutory requirements, and that they comply with this chapter and ensure fair and equitable representation of the subscribers of the nonprofit health insurer, the attorney general shall certify these findings to the commissioner. In reviewing the amendments and description of the board restructuring, the attorney general may consult with the board of directors, officers, or employees of a nonprofit health insurer and with any other individual or organization.

(3) If the commissioner approves the amendments and restructuring, the commissioner shall certify his or her approval to the board. The approved amendments and restructuring shall take effect 10 days after the certification. If the commissioner disapproves all or any part of the amendments or restructuring, or both, the commissioner shall return the disapproved amendments or the written description of the restructuring, or both, to the board with a written statement stating the reasons for the disapproval and any recommendations for change the commissioner suggests.

(4) If the amendments, written description of restructuring, or both, required by this chapter are not submitted to the attorney general and the commissioner within 120 days after the effective date of this chapter, or if the amendments, written description, or both, are disapproved as provided in this

section, the commissioner and the attorney general shall, and the nonprofit health insurer may, seek judicial remedies as provided for by law in the Ingham county circuit court.

(5) If a nonprofit health insurer fails to comply with this section, the commissioner may issue an order suspending the right and privilege of the nonprofit health insurer to sell or issue new certificates until this section has been fully complied with.

(6) The corporate existence of each nonprofit health insurer operating in this state shall be considered to be extended, and its powers in all other respects undiminished, during the 120-day implementation period prescribed in subsection (1).

Sec. 3703. (1) All of the provisions of this act that apply to a domestic disability mutual insurer apply to a nonprofit health insurer under this chapter unless specifically excluded or otherwise specifically provided for in this chapter.

(2) Sections 411 and 901 and chapter 77 do not apply to a nonprofit health insurer.

(3) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage and to ascertain the interests of senior citizens regarding the administration of the medicare program when acting as fiscal intermediary in this state, a nonprofit health insurer shall consult with the office of services to the aging and with senior citizens' organizations in this state.

Sec. 3704. (1) A nonprofit health insurer subject to this chapter is declared to be a charitable and benevolent

institution, and its funds and property are exempt from taxation by this state or any political subdivision of this state.

(2) A person shall not act as a nonprofit health insurer or issue a certificate except as authorized by and pursuant to a certificate of authority granted to the person by the commissioner pursuant to this chapter.

Sec. 3705. (1) A nonprofit health insurer, in addition to the requirements of this chapter, shall subscribe to articles of incorporation that shall contain the purposes of the nonprofit health insurer, which shall be:

(a) To provide health care benefits.

(b) To secure for all of the people of this state who apply for a certificate the opportunity for access to coverage for health care services at a fair and reasonable price.

(c) To assure for nongroup and group subscribers reasonable access to, and reasonable cost and quality of, health care services.

(d) To offer supplemental coverage to all medicare enrollees as provided in chapter 38.

(e) To engage in activity otherwise authorized by this act, within the purposes for which nonprofit health insurers may be organized under this chapter.

(2) By action of its board of directors, a nonprofit health insurer may integrate into a single instrument the provisions of its articles of incorporation. Any amendment or restatement of the articles are subject to legal review by the attorney general and approval by the commissioner.

Sec. 3707. (1) A nonprofit health insurer wishing to maintain a certificate of authority in this state after the effective date of this chapter shall possess and maintain unimpaired surplus in an amount determined adequate by the commissioner to comply with section 403. The commissioner shall take into account the risk-based capital requirements as developed by the national association of insurance commissioners in order to determine adequate compliance with section 403.

(2) If a nonprofit health insurer files a risk-based capital report that indicates that its surplus is less than the amount determined adequate by the commissioner under subsection (1), the nonprofit health insurer shall prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. Among the remedies that a nonprofit health insurer may employ are planwide viability contributions to surplus by subscribers.

(3) If contributions for planwide viability under subsection (2) are employed, those contributions shall be made in accordance with the following:

(a) If the nonprofit health insurer's surplus is less than 200% but more than 150% of the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 0.5% of the rate charged to subscribers for the benefits provided.

(b) If the nonprofit health insurer's surplus is 150% or less than the authorized control level under risk-based capital requirements, the maximum contribution rate shall be 1% of the

rate charged to subscribers for the benefits provided.

(c) The actual contribution rate charged is subject to the commissioner's approval.

(4) As used in subsection (3), "authorized control level" means the number determined under the risk-based capital formula in accordance with the instructions developed by the national association of insurance commissioners and adopted by the commissioner.

Sec. 3709. (1) The funds and property of a nonprofit health insurer shall be acquired, held, and disposed of only for the lawful purposes of the nonprofit health insurer and for the benefit of the nonprofit health insurer's subscribers as a whole. A nonprofit health insurer shall only transact such business, receive, collect, and disburse such money, and acquire, hold, protect, and convey such property, as are properly within the scope of the purposes of the nonprofit health insurer as provided in section 3705(1), for the benefit of the nonprofit health insurer subscribers as a whole, and consistent with this chapter.

(2) A nonprofit health insurer shall not market or transact, as provided in sections 402a and 402b, any type of insurance described in chapter 6. This subsection does not prohibit the provision of prepaid health care benefits.

Sec. 3711. A nonprofit health insurer, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) With the commissioner's approval, borrow money and issue its promissory note, surplus note, or bond for the repayment of the borrowed money with interest.

(b) With the commissioner's approval, participate with others in any joint venture with respect to any transaction that the nonprofit health insurer would have the power to conduct by itself.

Sec. 3713. A nonprofit health insurer shall not do any of the following:

(a) Take any action to change its nonprofit status.

(b) Dissolve, merge, consolidate, mutualize, or take any other action that results in a change in direct or indirect control of the nonprofit health insurer or sell, transfer, lease, exchange, option, or convey assets that results in a change in direct or indirect control of the nonprofit health insurer.

PART 2

Sec. 3720. Chapter 52 applies to a nonprofit health insurer except as otherwise provided in this chapter.

Sec. 3721. (1) The board of directors of a nonprofit health care corporation operating pursuant to former 1980 PA 350 shall become the board of directors for a nonprofit health insurer under this chapter subject to all of the following:

(a) The terms of all provider board members serving pursuant to section 301(3) of former 1980 PA 350 shall end on the effective date of this chapter.

(b) All board members whose terms expire in April of 2003 shall not be reappointed or replaced.

(c) By June 30, 2003, the board of directors shall submit a plan to the commissioner detailing how it will reduce the size of the board by December 31, 2003 to 13 members including the chief executive officer. The plan shall be consistent with the requirements of this part and shall provide that an individual shall not serve more than 2 consecutive terms on the board. If a plan is not submitted by June 30, 2003, then the commissioner, after consultation with the board of directors, shall formulate and place into effect a plan consistent with this part. The plan submitted by the board of directors shall be considered to meet the requirements of this part if it is not disapproved by written order of the commissioner on or before October 1, 2003. As part of a disapproval order, the commissioner shall notify the board of directors in what respect all or any part of the plan submitted by the board of directors fails to meet the requirements of this part. Not later than 30 days after the date of the disapproval order, the board of directors shall submit a revised plan that meets the requirements of this part. If the board of directors fails to submit a revised plan or if the submitted revised plan does not meet the requirements of this part, as determined by the commissioner, then the commissioner shall immediately formulate and place into effect a plan consistent with this part.

(2) Effective January 1, 2004, the board of directors of a nonprofit health insurer shall consist of 13 members as follows:

(a) Three public members appointed by the governor with the advice and consent of the senate, at least 1 of whom shall be 62

years of age or older, and who shall represent the public interest in the charitable and benevolent mission of the nonprofit health insurer.

(b) One member representing nongroup subscribers.

(c) Two members representing self-insured groups.

(d) Three members representing small subscriber groups.

(e) Three members representing medium/large subscriber groups.

(f) The chief executive officer of the nonprofit health insurer.

(3) The method of selection of the directors, other than the directors who are representatives of the public, shall be specified in the bylaws. The method for filling vacancies in the offices of directors, other than the directors who are representatives of the public, shall be provided in the bylaws. The term of office of any director except the term of office of the director under subsection (2)(f) shall not exceed 3 years, and at least 1/3 of the members of the board, excluding the director under subsection (2)(f), shall be selected each year. The bylaws shall provide that all members of the board shall be reimbursed only for all reasonable and necessary expenses incurred in carrying out their duties under this chapter and shall not receive any compensation for services to the nonprofit health insurer as director.

(4) The method of selection of each category of subscribers entitled to representation on the board shall maximize subscriber participation to the extent reasonably practicable. This

subsection permits, but does not require, the statewide election of a director. The method of selection neither permits nor requires nomination, endorsement, approval, or confirmation of a candidate or director by the board of directors or the management of the nonprofit health insurer, or by any member or members of the board of directors or the management of the nonprofit health insurer. This subsection does not limit the rights of any director or employee or officer of the nonprofit health insurer to participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

(5) A director shall not be an employee, agent, officer, or director of an insurance company writing disability insurance inside or outside this state.

Sec. 3722. (1) The board of directors may establish advisory councils and, unless otherwise provided in the articles of incorporation or bylaws, committees it considers necessary to perform its duties. With respect to board committees, the bylaws shall include provisions regarding all of the following:

(a) Provisions that assure that the membership of each committee provides for representation of all of the components of directors, as defined in the bylaws, to the greatest extent practicable.

(b) Provisions regarding emergency meetings of the nonprofit health insurer executive committee, and action by that committee on behalf of the board in cases of emergency, as defined in and authorized by the bylaws.

(2) The board of directors shall establish a provider advisory council by not later than 90 days after the effective date of this chapter. The provider advisory council shall consist of not more than 12 members who shall fairly represent the classes of health care providers with whom the nonprofit health insurer contracts for services.

(3) The provider advisory council established under subsection (2) shall provide advice to the board of directors on matters concerning the impact of board policies on health care providers, including, but not limited to, participating contracts, coverage for medical services, billing and payment procedures and practices, and subscriber access to an appropriate number and mix of health care providers in this state.

(4) Except as otherwise provided in subsection (1)(b), a council or committee established under this section shall act in an advisory capacity to the board of directors. Except as otherwise provided in subsection (1)(b), the board of directors shall meet and approve a council or committee recommendation before it can be implemented. The minutes of all meetings of councils and committees established under this section shall be given to the members of the board of directors and shall be included in the minutes of the board of directors' meetings.

Sec. 3723. (1) The board of directors shall adopt initial bylaws and may amend or repeal those bylaws or adopt new bylaws, subject to legal review by the attorney general and prior approval by the commissioner. The bylaws may contain any provision for the regulation and management of the affairs of the

nonprofit health insurer not inconsistent with the articles of incorporation, this act, or any other applicable provision of law.

(2) The initial bylaws, and any new bylaws, amendments, or repealers shall be submitted to the attorney general for legal review and for approval by the commissioner. The commissioner shall approve the initial bylaws, new bylaws, amendments, or repealers if the commissioner determines that they comply with this act.

(3) If the commissioner disapproves all or any part of the initial bylaws, new bylaws, amendments, or repealers, he or she shall return them to the board with a written statement stating the reasons for the disapproval and any recommendations for change that he or she may wish to suggest, not later than 30 days following their receipt. Bylaws, amendments, and repealers not returned to the nonprofit health insurer within this 30-day period are considered to comply with this chapter and are considered approved.

Sec. 3724. (1) Regular or special meetings of the board of directors or a board committee shall be held within this state. With respect to regular or special meetings of the board or a board committee, the bylaws shall include provisions regarding all of the following:

(a) The minimum number of regular meetings to be held each year.

(b) The publication and advance distribution of an agenda, including provisions respecting the time and place of the meeting

and the business to be conducted. Notice of meetings and the agenda for the meeting shall be posted on the nonprofit health insurer's website as soon as practical after publication or dissemination under this subdivision.

(c) The voting procedures to be used. The use of proxies or round-robins shall not be allowed.

(2) Notice of a regular meeting shall be given at least 15 days before the meeting and notice of a special meeting shall be given at least 24 hours before the meeting. All meetings shall be open to the public except as otherwise provided in section 3725(2).

(3) Unless otherwise restricted by the articles of incorporation or bylaws, a member of the board or of a board committee may participate in a meeting by means of conference telephone or similar communications equipment by means of which all individuals participating in the meeting can hear each other. Participation in a meeting pursuant to this subsection constitutes presence in person at the meeting.

(4) A majority of board members then in office, or of the members of a board committee, constitutes a quorum for the transaction of business, unless the articles or bylaws provide for a larger number. The vote of the majority of members present at a meeting at which a quorum is present constitutes the action of the board or of the committee, unless the vote of a larger number is required by this chapter, the articles, or the bylaws. The following actions shall require the vote of not less than a majority of the members of the board then in office:

(a) Adoption of bylaws, amendments to bylaws, or repealers of bylaws.

(b) Adoption of articles of incorporation, amendments to articles, or repealers of articles.

(c) Adoption of compensation for officers of the nonprofit health insurer.

(5) The bylaws shall provide that a record roll call vote shall be taken at the request of any board member. The vote of each member during a record roll call vote shall be recorded in the minutes.

Sec. 3725. (1) A nonprofit health insurer shall keep accurate books and records of account and complete and detailed minutes of the proceedings of the board of directors and board committees. The books, records, and minutes may be in written form or in any other form capable of being converted into written form within a reasonable time and shall be made available electronically in a form prescribed by the commissioner. One copy of the minutes or draft minutes from each meeting of the board of directors shall be transmitted to the commissioner within 15 days after the meeting was held. Upon request, a subscriber shall receive, within 15 days after receipt of the request, a copy of the minutes or draft minutes of 1 or more meetings of the board or board committee and may be charged not more than the reasonable cost of copying and postage.

(2) Minutes shall be kept and need not be disclosed, except to the commissioner, for those portions of meetings that are held for the following purposes:

(a) To consider the hiring, promotion, dismissal, suspension, or discipline of an employee.

(b) To consider the purchase, lease, or sale of real property.

(c) For strategy and negotiation sessions connected with the negotiations of a collective bargaining agreement when either party requests a closed meeting.

(d) For trial or settlement strategy sessions in connection with specific contemplated or pending litigation. If these sessions are with respect to litigation to which the commissioner or the attorney general is a party, minutes regarding these sessions are not subject to examination and free access by the commissioner.

(e) To consider medical records of an individual.

(f) To consider the acquisition or disposal of certificates of stock, bonds, certificates of indebtedness, and other intangibles in which the nonprofit health insurer may invest funds under this chapter, if the information regarding proposed acquisition or disposal may affect the price paid or received.

(g) To consider provider appeals when the provider has requested a closed hearing.

(h) To discuss marketing strategy with regard to a particular customer or limited group of customers, or to discuss a new or changed benefit, the premature disclosure of which would have an adverse impact on the nonprofit health insurer.

(i) To consider the removal of a director from the board when the director requests a closed hearing.

(3) The date and time of preparation and existence of the minutes described in subsection (2), the contents of which shall not be disclosable except to the commissioner, shall be noted in the minutes required to be kept under subsection (1). Once action is taken by the board to implement a consideration or discussion described in subsection (2)(b), (f), (g), or (h), once a collective bargaining agreement is reached as described in subsection (2)(c), once litigation is no longer pending as described in subsection (2)(d), or once a closed hearing is concluded as described in subsection (2)(i), and upon the request of the director to whom the hearing pertained, the minutes relating to the consideration, discussion, or strategy session shall be published and disseminated with the next succeeding set of minutes published and disseminated under subsection (1).

Sec. 3726. The board shall establish a compensation plan for executive and senior level management of the nonprofit health insurer, including any bonus plan tied to performance of the nonprofit health insurer, which shall be filed with and approved by the commissioner before it becomes effective. The commissioner shall be notified of any bonus issued to an executive or senior level member of management of the nonprofit health insurer within 10 days of issuance of the bonus. The board shall identify in the compensation plan, subject to the commissioner's approval, those executive and senior level management positions covered under the compensation plan.

Sec. 3727. (1) A contract or other transaction between a nonprofit health insurer and 1 or more of its directors or

officers, or between a nonprofit health insurer and any other corporation, firm, or association of any type or kind in which 1 or more of its directors or officers are directors or officers, or are otherwise interested, is not void or voidable solely because of this common directorship, officership, or interest, or solely because the directors are present at the meeting of the board that authorizes or approves the contract or transaction, if all of the following conditions are satisfied:

(a) The contract or other transaction is fair and reasonable to the nonprofit health insurer when it is authorized, approved, or ratified.

(b) The material facts as to the officer's or director's relationship or interest and as to the contract or transaction are disclosed or known to the board, and the board authorizes, approves, or ratifies the contract or transaction by a vote sufficient for the purpose. The conditions of this subdivision shall be considered satisfied only if the officer or director has announced the potential conflict before the vote, the minutes of the meeting reflect that announcement, and the officer or director abstained from the vote.

(2) If the validity of a contract described in subsection (1) is questioned, the burden of establishing its validity on the grounds prescribed is upon the director, officer, corporation, firm, or association asserting its validity.

(3) Common or interested directors shall not be counted in determining the presence of a quorum at a board meeting at the time a contract or transaction described in subsection (1) is

authorized, approved, or ratified.

(4) The bylaws of a nonprofit health insurer may include provisions regarding conflict of interest that are more stringent than this section.

PART 3

Sec. 3731. (1) A nonprofit health insurer established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the insurer specifies with the approval of the commissioner.

(2) A nonprofit health insurer may limit the health care benefits that it will furnish, except as provided in this act, and may divide the health care benefits that it elects to furnish into classes or kinds.

(3) A nonprofit health insurer shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a nonprofit health insurer, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the nonprofit health insurer and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(4) A nonprofit health insurer has the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(5) A nonprofit health insurer shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A nonprofit health insurer shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if the facility meets the standards set by the nonprofit health insurer for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of

hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility that is to be used for acute care.

Sec. 3732. (1) A nonprofit health insurer delivering, issuing for delivery, or renewing in this state a medium/large subscriber group certificate shall furnish to a payor, within 30 days after receiving a written request therefore and upon payment of a reasonable charge, all of the following information by coverage component for the certificate incurred during the immediately preceding 24-month period:

(a) Total number of individuals covered.

(b) Total number of claims.

(c) Total dollar amount of claims.

(d) Amount paid or allocated to providers on a per individual basis not included in subdivisions (a) to (c).

(e) All pertinent information used by the nonprofit health insurer to make its rates for that group. This subdivision does not require the release of any information otherwise exempt from disclosure under this chapter. The commissioner shall determine

not less often than annually what is pertinent information under this subdivision.

(2) Information furnished under subsection (1) shall not disclose personal data that may reveal the identity of a covered individual. Information furnished under subsection (1) shall be collected and provided to a payor based on the group the payor sponsors.

(3) As used in this section:

(a) "Coverage component" includes, but is not limited to, in-patient and out-patient facility coverage, professional provider coverage, and pharmacy coverage.

(b) "Payor" means the purchaser of group coverage whether the purchase is made directly from the nonprofit health insurer or is made through a third party administrator, an agency, or another entity.

Sec. 3733. (1) If a group or nongroup certificate of a nonprofit health insurer provides for health care benefits for a health care service and if that service was legally performed, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist.

(2) As used in this section, "dentist" means an individual licensed under part 166 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648.

(3) This section applies to certificates issued or renewed on or after the effective date of this section and applies notwithstanding any certificate provision to the contrary.

Sec. 3734. (1) Subject to subsections (2) and (3), if a nonprofit health insurer group or nongroup certificate provides for health care benefits for services performed by a physician's assistant, those benefits or reimbursement for those benefits at the prevailing rate shall not be denied if the services were performed by a physician's assistant acting within the scope of his or her license and if the following are met:

(a) If the services were performed by a physician's assistant working for a physician or facility specializing in a particular area of medicine, a physician that specializes in that area of medicine was physically present on the premises when the physician's assistant performed the services.

(b) If the services were performed by a physician's assistant working for a physician or facility engaging in general family practice, a physician need not have been physically present on the premises when the physician's assistant performed the services so long as a consulting physician is within 150 miles or 3 hours' commute to where the services are performed.

(2) This section applies to a physician's assistant who performs services in any of the following:

(a) A county with a population of 25,000 or less.

(b) A certified rural health clinic.

(c) A health professional shortage area.

(3) For purposes of subsection (1), a physician supervising a physician's assistant shall do so from within Michigan or from a state bordering Michigan.

(4) As used in this section:

(a) "Health professional shortage area" means that term as defined in section 332(a)(1) of subpart II of part D of title III of the public health service act, chapter 373, 90 Stat. 2270, 42 U.S.C. 254e.

(b) "Physician's assistant" means an individual licensed as a physician's assistant under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(c) "Rural health clinic" means a rural health clinic as defined under section 1861 of part D of title XVIII of the social security act, 42 U.S.C. 1395x, and certified to participate in medicaid and medicare.

Sec. 3735. (1) A health care provider who has reason to believe that a nonprofit health insurer has violated section 2005a, 2006, 2024, or 2026 concerning that health care provider is entitled to a private informal managerial-level conference with the nonprofit health insurer and to a review before the commissioner if the conference fails to resolve the dispute.

(2) A nonprofit health insurer shall establish reasonable internal procedures to provide a health care provider with a private informal managerial-level conference as provided in subsection (1). These procedures shall provide for all of the following:

(a) That the nonprofit health insurer shall make a final written determination not later than 35 calendar days after a grievance is submitted in writing by the health care provider. The timing for the 35-calendar-day period may be tolled, however, for any period of time the provider is permitted to take under

the grievance procedure.

(b) A method of providing the health care provider, upon request and payment of a reasonable copying charge, with information pertinent to the matter in dispute.

(c) A method for resolving the dispute promptly and informally, while protecting the interests of both the health care provider and the nonprofit health insurer. The method under this subdivision shall include at least all of the following:

(*i*) That the nonprofit health insurer shall hold a private informal managerial-level conference under this section within a reasonably accessible distance from the Michigan address of the health care provider and at a time reasonably convenient to the health care provider or the health care provider's agent or representative. At the request of the health care provider, the conference shall be held by telephone.

(*ii*) That not later than 20 days after the conference, the nonprofit health insurer shall provide the health care provider with all of the following:

(A) The nonprofit health insurer's proposed resolution.

(B) The facts, with supporting documentation, upon which the proposed resolution is based.

(C) The specific section or sections of the law, certificate, contract, or other written policy or document upon which the proposed resolution is based.

(D) A statement explaining the health care provider's right to appeal the matter to the commissioner within 120 days after receipt of the nonprofit health insurer's final determination.

(E) A statement describing the status of the claim involved.

(3) A nonprofit health insurer shall do all of the following:

(a) At the time of a refusal to pay a claim made by a health care provider, the nonprofit health insurer shall provide in writing to the health care provider a clear, concise, and specific explanation of all the reasons for the refusal. This notice shall notify the health care provider of his or her right to a private informal managerial-level conference if the health care provider believes the refusal to be in violation of section 2005a, 2006, 2024, or 2026.

(b) In addition to the notice required in subdivision (a), at least annually provide notice to each health care provider with whom the nonprofit health insurer has contact of the health care provider's right to a private informal managerial-level conference under this section. The notice shall reasonably inform health care providers of their rights under this section.

(4) If the nonprofit health insurer fails to provide a conference and a final determination within 35 days after a request by a health care provider, or if the health care provider disagrees with the proposed resolution of the nonprofit health insurer after completion of the conference, the health care provider is entitled to a determination of the matter by the commissioner. To be entitled to a determination by the commissioner under this subsection, the health care provider shall file a written request with the commissioner not later than 120 days after the date of the final determination, 120 days

after the completion of the conference, or 120 days after the expiration of the initial 35 days, as applicable. The commissioner may extend this 120-day time limit if he or she believes there is just cause to do so.

(5) If either the nonprofit health insurer or a health care provider disagrees with a determination of the commissioner under this section, the commissioner, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. The commissioner shall notify the nonprofit health insurer and health care provider in his or her determination under this section of the right to a contested case hearing. To be entitled to a contested case hearing under this subsection, the person requesting the contested case hearing shall file a written request with the commissioner on or before the expiration of 60 days after the date of the determination.

Sec. 3736. (1) A nonprofit health insurer shall, in order to ensure the confidentiality of records containing personal data that may be associated with identifiable members, use reasonable care to secure these records from unauthorized access and to collect only personal data necessary for the proper review and payment of claims. Except as is necessary for claims adjudication, claims verification, or when required by law, a nonprofit health insurer shall not disclose records containing personal data that may be associated with an identifiable member, or personal information concerning a member, to a person other than the member, without the prior and specific informed consent

of the member to whom the data or information pertains. The member's consent shall be in writing. Except when a disclosure is made to the commissioner or another governmental agency, a court, or any other governmental entity, a nonprofit health insurer shall make a disclosure for which prior and specific informed consent is not required upon the condition that the person to whom the disclosure is made protect and use the disclosed data or information only in the manner authorized by the nonprofit health insurer under subsection (2). If a member has authorized the release of personal data to a specific person, a nonprofit health insurer shall make a disclosure to that person upon the condition that the person shall not release the data to a third person unless the member executes in writing another prior and specific informed consent authorizing the additional release. This subsection does not preclude either of the following:

(a) The release of information to a member, pertaining to that member, by telephone, if the identity of the member is verified.

(b) A representative of a subscriber group, upon request of a member of that subscriber group, or an elected official, upon request of a constituent, from assisting the individual in resolving a claim.

(2) The board of directors of a nonprofit health insurer shall establish and make public the policy of the nonprofit health insurer regarding the protection of the privacy of members and the confidentiality of personal data. The policy, at a

minimum, shall do all of the following:

(a) Provide for the nonprofit health insurer's implementation of provisions in this act and other applicable law respecting collection, security, use, release of, and access to personal data.

(b) Identify the routine uses of personal data by the nonprofit health insurer; prescribe the means by which members will be notified regarding those uses; and provide for notification regarding the actual release of personal data and information that may be identified with, or that concern, a member, upon specific request by that member. As used in this subdivision, "routine use" means the ordinary use or release of personal data compatible with the purpose for which the data were collected.

(c) Assure that no person shall have access to personal data except on the basis of a need to know.

(d) Establish the contractual or other conditions under which the nonprofit health insurer will release personal data.

(e) Provide that enrollment applications and claim forms developed by the nonprofit health insurer shall contain a member's consent to the release of data and information that is limited to the data and information necessary for the proper review and payment of claims, and shall reasonably notify members of their rights pursuant to the board's policy and applicable law.

(f) Provide that applicants for new or renewed certificates shall be advised that the nonprofit health insurer does not

require the use of the applicant's federal social security account number and that, when applicable, another authority does require use of the number.

(3) A nonprofit health insurer that violates this section is guilty of a misdemeanor punishable by a fine of not more than $1,000.00 for each violation.

(4) A member may bring a civil action for damages against a nonprofit health insurer for a violation of this section and may recover actual damages or $200.00, whichever is greater, together with reasonable attorneys' fees and costs.

(5) This section does not limit access to records or enlarge or diminish the investigative and examination powers of governmental agencies, as provided for by law.

Sec. 3737. A civil action for negligence based upon, or arising out of, the health care provider-patient relationship shall not be maintained against a nonprofit health insurer.

Sec. 3738. (1) A nonprofit health insurer shall offer benefits for the inpatient treatment of substance abuse by a licensed allopathic physician or a licensed osteopathic physician in a health care facility operated by this state or approved by the department of community health for the hospitalization for, or treatment of, substance abuse.

(2) Subject to subsection (3), a nonprofit health insurer may enter into contracts with providers for the rendering of inpatient substance abuse treatment by those providers.

(3) A contracting provider rendering inpatient substance abuse treatment for patients other than adolescent patients shall

be a licensed hospital or a substance abuse service program licensed under article 6 of the public health code, 1978 PA 368, MCL 333.6101 to 333.6523, and shall meet the standards set by the nonprofit health insurer for contracting health care facilities.

(4) In addition to the requirements of this section, a nonprofit health insurer shall comply with sections 3425 and 3609a.

Sec. 3739. (1) A nonprofit health insurer shall offer or include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual whose covered illness or injury has required the removal of that body part. However, certificates resulting from collective bargaining agreements are exempt from this subsection. This coverage shall provide that reasonable charges for medical care and attendance for an individual fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability for a proposed course of rehabilitative treatment.

(2) In all group and nongroup certificates, a nonprofit health insurer shall provide benefits for prosthetic devices to maintain or replace the body part of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has

certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this subsection.

Sec. 3739a. (1) A nonprofit health insurer shall establish and provide to members and participating providers a program to prevent the onset of clinical diabetes. This program for participating providers shall emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

(2) A nonprofit health insurer shall regularly measure the effectiveness of a program provided pursuant to subsection (1) by regularly surveying group and nongroup members covered by the certificate. By March 28, 2003, each nonprofit health insurer shall prepare a report containing the results of the survey and shall provide a copy of the report to the department of community health.

(3) A nonprofit health insurer certificate shall provide benefits in each group and nongroup certificate for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet

devices.

(c) Insulin.

(d) Syringes.

(e) Insulin pumps and medical supplies required for the use of an insulin pump.

(f) Nonexperimental medication for controlling blood sugar.

(g) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

(4) A nonprofit health insurer certificate shall provide benefits in each group and nongroup certificate for medically necessary medications prescribed by an allopathic, osteopathic, or podiatric physician and used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.

(5) Coverage under subsection (3) for diabetes self-management training is subject to all of the following:

(a) Is limited to completion of a certified diabetes education program upon occurrence of either of the following:

(*i*) If considered medically necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

(*ii*) If an allopathic or osteopathic physician diagnoses a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in a patient's

self-management or a significant change in medical protocol or treatment modalities.

(b) Shall be provided by a diabetes outpatient training program certified to receive medicare or medicaid reimbursement or certified by the department of community health. Training provided under this subdivision shall be conducted in group settings whenever practicable.

(6) Benefits under this section are not subject to dollar limits, deductibles, or copayment provisions that are greater than those for physical illness generally.

(7) As used in this section, "diabetes" includes all of the following:

(a) Gestational diabetes.

(b) Insulin-dependent diabetes.

(c) Non-insulin-dependent diabetes.

PART 4

Sec. 3741. A nonprofit health insurer subject to this chapter may enter into participating contracts with health care providers as provided in this part.

Sec. 3742. (1) A nonprofit health insurer may enter into participating contracts with or employ health care providers on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the nonprofit health insurer, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health care providers to which the health care provider belongs.

(2) A nonprofit health insurer shall enter into participating contracts with health care providers through which covered health care services are usually provided to members.

(3) A participating contract shall prohibit the participating provider from seeking payment from a member for health care services covered under the certificate, except that the participating contract may allow participating providers to collect deductibles and copayments directly from members.

(4) A participating contract shall provide for all of the following:

(a) That the participating provider meet and maintain applicable licensure or certification requirements.

(b) For appropriate access by the nonprofit health insurer to records or reports concerning service to its members.

(c) That the participating provider cooperate with the nonprofit health insurer's quality assurance activities.

(d) For the reimbursement methodology that is used to pay the participating provider.

(e) For a reasonable dispute resolution process.

(f) Procedures for the termination of the participating contract.

(g) Procedures for amendments to the contract, including notification to providers.

Sec. 3743. (1) A participating contract may cover all members or may be a separate and individual contract on a per claim basis, if, in entering into a separate and individual contract on a per claim basis, the participating provider

certifies to the nonprofit health insurer:

(a) That the provider will accept the nonprofit health insurer's approved amount as payment in full for health care services rendered for the specified claim for the member indicated.

(b) That the provider will accept the nonprofit health insurer's approved amount as payment in full for all cases involving the procedure specified, for the duration of the calendar year. As used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation of the member entitled to health care benefits.

(2) A participating contract shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law.

(3) A nonprofit health insurer shall provide to a member, upon request, a current list of providers with whom the nonprofit health insurer has entered into participating contracts.

Sec. 3744. A nonprofit health insurer shall submit to the commissioner for approval standard participating contract formats and any substantive changes to those participating contract formats. The contract format or change is considered approved 30 days after filing with the commissioner unless approved or

disapproved within the 30 days. As used in this section, "substantive changes to those participating contract formats" means any change to a participating contract that alters the method of payment to a health care provider, alters the risk, if any, assumed by each party to the contract, or affects a provision required by law.

Sec. 3745. (1) A nonprofit health insurer shall provide evidence to the commissioner that it has executed participating contracts with a sufficient number of health care providers to enable the nonprofit health insurer to deliver health care services covered under a certificate.

(2) A nonprofit health insurer shall establish and maintain adequate participating contracts to ensure reasonable proximity between participating providers and members for the delivery of covered health care services. In determining whether a nonprofit health insurer has complied with this subsection, the commissioner shall give due consideration to the relative availability of health care providers in a geographic area.

PART 5

Sec. 3751. Administrative costs for administrative services and cost-plus arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under this part and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges.

Sec. 3752. (1) Except as otherwise provided in subsection (2), if a nonprofit health insurer wants to offer a new

certificate, change an existing certificate, or change a rate charge, a copy of the proposed revised certificate or proposed rate shall be filed with the commissioner and shall not take effect until 60 days after the filing unless the commissioner approves the change in writing before the expiration of the 60 days. The commissioner may subsequently disapprove any certificate or rate change.

(2) The commissioner shall exempt from prior approval certificates resulting from a collective bargaining agreement.

(3) The commissioner may disapprove, or approve with modifications, a certificate and applicable rates under 1 or more of the following circumstances:

(a) If the rate charged for the benefits provided is not equitable, not adequate, or excessive, as defined in section 3756.

(b) If the certificate contains 1 or more provisions that are unjust, unfair, inequitable, misleading, or deceptive or that encourage misrepresentation of the coverage.

(4) The commissioner shall approve a certificate and applicable proposed rates if all of the following conditions are met:

(a) If the rate charged for the benefits provided is equitable, adequate, and not excessive, as defined in section 3756.

(b) If the certificate does not contain any provision that is unjust, unfair, inequitable, misleading, or deceptive or that encourages misrepresentation of the coverage.

(5) The commissioner may disapprove a certificate and any applicable proposed rates under this section by issuing a notice of disapproval specifying how the filing fails to meet the requirements of this chapter. The notice shall state that the filing shall not become effective.

(6) The commissioner may approve, or approve with modifications, a certificate and any applicable proposed rates under this section by issuing a notice of approval or approval with modifications. If the notice is of approval with modifications, the notice shall specify what modifications in the filing are required for approval under this chapter, and the reasons for the modifications. The notice shall also state that the filing shall become effective after the modifications are made and approved by the commissioner.

(7) Upon request by a nonprofit health insurer, the commissioner may allow certificates and rates to be implemented before filing to allow implementation of a new certificate on the date requested.

Sec. 3753. (1) The rates charged to nongroup subscribers for each certificate shall be filed in accordance with section 3752. Annually, the commissioner shall approve, disapprove, or modify and approve the proposed or existing rates for each certificate subject to the standard that the rates must be determined to be equitable, adequate, and not excessive, as defined in section 3756. The burden of proof that rates to be charged meet these standards is on the nonprofit health insurer proposing to use the rates. The rates charged to nongroup

subscribers for each certificate shall be calculated on a community rating basis and may only vary by benefit plan and family composition. Rates shall not be based on age, health status, gender, or geographic location.

(2) The methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements, shall be filed in accordance with section 3752. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, is subject to the prior approval of the commissioner. The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 3756. In addition, the commissioner may from time to time review the records of the nonprofit health insurer to determine proper application of a rating system, formula, component, or factor for any group. The nonprofit health insurer shall refile every 3 years for approval under this subsection of the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate administrative costs for administrative services only

and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards is on the nonprofit health insurer proposing to use the rating system, formula, component, or factor.

Sec. 3755. (1) A proposed rate shall not take effect until a filing has been made with the commissioner and approved under section 3752 or this section, as applicable, except as provided in subsections (2) and (3).

(2) Upon request by a nonprofit health insurer, the commissioner may allow rate adjustments to become effective before approval, for federal or state mandated benefit changes. However, a filing for these adjustments shall be submitted before the effective date of the mandated benefit changes. If the commissioner disapproves or modifies and approves the rates, an adjustment shall be made retroactive to the effective date of the mandated benefit changes or additions.

(3) Implementation before approval may be allowed if the nonprofit health insurer is participating with 1 or more nonprofit health insurers to underwrite a group whose employees are located in several states. Upon request from the commissioner, the nonprofit health insurer shall file with the commissioner, and the commissioner shall examine, the financial arrangement, formulae, and factors. If any are determined to be unacceptable, the commissioner shall take appropriate action.

Sec. 3756. (1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively: provision for anticipated benefit

costs; provision for administrative expense; provision for cost transfers, if any; provision for a contribution to or from surplus that is consistent with the attainment or maintenance of unimpaired surplus as required by section 3707; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to these elements, individually or collectively, shall be based on the following: reasonable evaluations of recent claim experience; projected trends in claim costs; the allocation of administrative expense budgets; and the present and anticipated unimpaired surplus of the nonprofit health insurer. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified accordingly.

(2) The administrative expense budget of the nonprofit health insurer must be reasonable, as determined by the commissioner after examination of material and substantial administrative and acquisition expense items.

(3) A rate is equitable if the rate can be compared to any other rate offered by the nonprofit health insurer to its subscribers, and the observed rate differences can be supported by differences in anticipated benefit costs, administrative expense cost, differences in risk, or any identified cost transfer provisions.

(4) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of

recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and the present and anticipated unimpaired surplus of the nonprofit health insurer.

(5) Except for identified cost transfers, each line of business shall be self-sustaining over time. However, there may be cost transfers for the benefit of senior citizens and individual conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the nonprofit health insurer as reported in the most recent annual statement of the nonprofit health insurer. Individual conversion subscribers are those who have maintained coverage with the nonprofit health insurer on an individual basis after leaving a subscriber group.

Sec. 3757. Any final order or decision made, issued, or executed by the commissioner under this part after a hearing held before the commissioner or his or her designee pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, is subject to review without leave by the circuit court for Ingham county as provided in chapter 6 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.301 to 24.306.

Sec. 5104. (1) Subject to the requirements of this act applicable to domestic stock insurers, domestic mutual insurers, reciprocals or inter-insurance exchanges, and the further requirements of this chapter, 13 or more persons may organize a stock insurer or 20 or more persons may organize a mutual insurer for the purpose of transacting any or all of the following kinds of insurance: property, marine, inland navigation and

transportation, casualty, or fidelity and surety, all as defined in chapter 6. Once organized and authorized, the acquiring insurer is subject to all applicable provisions of this act.

(2) If the acquiring insurer is a domestic stock insurer owned by a ~~nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704~~ **nonprofit health insurer regulated under chapter 37**, then for insurance products and services the acquiring insurer under this chapter whether directly or indirectly shall only transact worker's compensation insurance and employer's liability insurance, transact disability insurance limited to replacement of loss of earnings, and act as an administrative services organization for an approved self-insured worker's compensation plan or a disability insurance plan limited to replacement of loss of earnings. This subsection does not preclude the acquiring insurer from providing either directly or indirectly noninsurance products and services as otherwise provided by law.

Sec. 7705. As used in this chapter:

(a) "Account" means either of the 2 accounts created under section 7706.

(b) "Association" means the Michigan life and health insurance guaranty association created under section 7706.

(c) "Contractual obligation" means an obligation under covered policies.

(d) "Covered policy" means a policy or contract or certificate under a group policy or contract, or portion thereof,

for which coverage is provided under section 7704.

(e) "Health insurance" means disability insurance as defined in section 606.

(f) "Impaired insurer" means a member insurer considered by the commissioner after May 1, 1982, to be potentially unable to fulfill the insurer's contractual obligations or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction. Impaired insurer does not mean an insolvent insurer.

(g) "Insolvent insurer" means a member insurer ~~which~~ **that** after May 1, 1982, becomes insolvent and is placed under an order of liquidation, by a court of competent jurisdiction with a finding of insolvency.

(h) "Member insurer" means a person authorized to transact a kind of insurance or annuity business in this state for which coverage is provided under section 7704 and includes an insurer whose certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include the following:

(*i*) A fraternal benefit society.

(*ii*) A cooperative plan insurer authorized under chapter 64.

(*iii*) A health maintenance organization ~~authorized or licensed under part 210 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.21001 to 333.21098 of the Michigan Compiled Laws~~ **regulated under chapter 35**.

(*iv*) A mandatory state pooling plan.

(*v*) A mutual assessment or any entity that operates on an

assessment basis.

(*vi*) A nonprofit dental care corporation operating under ~~Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws~~ **1963 PA 125, MCL 550.351 to 550.373**.

(*vii*) ~~A nonprofit health care corporation operating under the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws~~ **A nonprofit health insurer regulated under chapter 37**.

(*viii*) An insurance exchange.

(*ix*) Any entity similar to the entities described in this subdivision.

(i) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or a successor to that service.

(j) "Person" means an individual, corporation, partnership, association, or voluntary organization.

(k) "Premiums" means amounts received in a calendar year on covered policies or contracts less premiums, considerations, and deposits returned and less dividends and experience credits. The term "premiums" does not include an amount received for a policy or contract, or a portion of a policy or contract for which coverage is not provided under section 7704. However, accessible premiums shall not be reduced on account of sections 7704(3)(c) relating to interest limitations and 7704(4)(b), (c), and (d) relating to limitations with respect to any 1 individual, any 1

participant, and any 1 contract holder. Premiums shall not include a premium in excess of $5,000,000.00 on an unallocated annuity contract not issued under a governmental retirement plan established under section 401(k), 403(b), or 457 of the internal revenue code of 1986. ~~, 26 U.S.C. 401, 403, and 457.~~

(*l*) "Resident" means a person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed. A person shall be considered a resident of only 1 state, which in the case of a person other than a natural person, shall be its principal place of business.

(m) "Supplemental contract" means an agreement entered into for the distribution of policy or contract proceeds.

(n) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. The term shall also include, but not be limited to, guaranteed investment contracts, deposit administration contracts, and contracts qualified under section 403(b) of the internal revenue code of 1986. ~~, 26 U.S.C. 403.~~

Enacting section 1. This amendatory act applies to health policies, certificates, or contracts issued or renewed on and after the effective date of this amendatory act.

Enacting section 2. The nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, is repealed.